Three Faces of the Health Care State

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Abstract That health care is a subsystem of the welfare state has dominated the study of states and health care policy. But this conception omits two other faces of the state—as a putatively democratic organization and as the manager of industrial economies in a capitalist world. Policy can be analyzed fruitfully in terms of the tensions between these three faces of the health care state.

What is the best way to study health care policy? Every discipline, and indeed every scholar, will offer a different answer. I wrote this article because too often the answer is implicit: The way health care policy is conceived must be inferred from the kinds of problems and issues addressed in the literature. The study of health care policy, especially by political scientists, has been dominated by a welfarist view. The health care system was implicitly conceived as a subsystem of the welfare state. As a result, health care policy studies have been preoccupied with issues that dominate the wider literature on the welfare state—notably issues about entitlements and the role of professional power in making and delivering policy. These are important issues, but to allow them to dominate the study of health care policy is to neglect other parts of the system. Health care policy involves more than professional organization and health care entitlements. When we consider health care systems, we look at sub-

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systems of the welfare state; but we also examine important industrial undertakings and, because most modern health care systems exist in liberal democratic states, we study the systems of distributive struggle that lie at the heart of the political process in pluralist democracies. I try to link these three aspects using a pair of analytical devices: the simple image of different faces of a structure and the notion of the health care state to characterize it. Because I previously examined the problems and opportunities created by the concept of the health care state, here I appropriate the term without defense or much explanation (see Moran 1992).

The health care state describes a phenomenon characteristic of all capitalist economies. It can be summarized in two terms: the organization of health care as a series of vast industrial undertakings, and the participation of state institutions in regulating and promoting those enterprises. Health care industries include the service and the manufacturing sectors: Much of health care involves individual health care workers delivering personal services to individual patients; and much (in the pharmaceutical and medical goods industries, for example) involves creating and marketing products that are central to the competitive struggles that lie at the heart of modern capitalist economies. The many persons employed in those industries span the range of occupational hierarchies. Even within the service sector of health care, as distinct from manufacturing, the range encompasses medical professionals with the most prestige and the most exploited casual workers. Health care employees complete many tasks: Some empty patient bedpans, while others work in laboratories at the frontiers of scientific research. The institutions of the health care industries are similarly diverse: They include religious charities that altruistically recruit staff and deliver care, and multinational corporations central to competitive struggles in the most advanced capitalist sectors.

Because this extraordinarily diverse range of activities and institutions is so integral to state structures—with the state as regulator, financier, or provider—we can speak of the health care state. The phrase health care state obviously echoes welfare state, but health care states range more widely, and penetrate more deeply, than this suggests. States assume three forms, and these forms correspond to the three distinct faces I identify here. The first face describes the state as the regulator of the conditions under which personal health care services are delivered. The amount of regulation varies, but that regulatory role is performed by the state in every advanced capitalist society. Regulation generally encompasses some sort of control of the occupations organized to provide health care, and in some instances, the state is the major employer. In all
capitalist nations, the state pays much of the cost of care, both current costs and those for the physical and human capital employed in modern health care systems. That observation is true even of the United States, the most "marketized" of the large health care systems (see the standard measures in Organization for Economic Cooperation and Development 1992). States also have a wider responsibility to regulate the conditions under which care is obtained: This spans issues such as the conditions of access and the way providers can bill for their services.

This face of the health care state—as the regulator of patient care conditions—may be conceived as a subsystem of the wider welfare state. In contrast, a second face can be pictured most fruitfully as part of the capitalist industrial state. High technology plays a vital role in modern health care, notably in use of pharmaceuticals and medical equipment. These high-technology health care industries are vital to the success of any capitalist economy. That importance can be measured in various ways, including by the sheer size of the manufacturing industries that produce health care goods. It can be measured by the strategic importance of these industries in renewing and extending the technological base of advanced capitalist economies. And it can be measured by how the economic participants in these industries—who include some of the biggest multinational firms in the world—compete for market share and profits. In the advanced capitalist world, and especially in the G7 countries, states are intimately involved in the competitive struggles between these firms.

Beyond high technology, health care institutions can also be considered large industrial enterprises that are central to the prosperity of local and regional economies. Consider the employment effect of large hospitals in cities of the advanced industrial world and the way that effect complicates hospital planning processes.

The face of the health care state that is connected to the modern industrial state, in which the state is forced to participate in the competition among capitalist economies, is related in turn to the third face of the health care state. Health care systems distribute many economic resources, such as money, jobs, and prestige, around societies. As anyone familiar with the curve of health care spending in the last generation knows, the volume of those resources has increased. Resource allocation on this scale will provoke intense distributional struggles as conflicting interests try to appropriate resources and to escape the burden of raising those resources. The burden of health care costs has dominated health care policy for the last twenty years, an era marked in almost every health care system by the struggle to contain costs. Even an autocratic state would be
drawn into those distributional struggles, although most advanced capitalist states are, in sometimes a rough and ready way, pluralist democracies, which are organized to facilitate distributional struggles between competing interests. The democratic character of the state—and the evolving nature of that democracy—forms the third face of the health care state.

To study the health care state, we must examine it as the regulator of patient care conditions; as the participant in competition among producers of health care goods and services; and as the arena in which distributional conflicts occur.

Health Care as a Welfare State

This is the best-known and the most intensively studied face of the health care state. Indeed I suggest that it is studied too intensively and overshadows the two other faces I describe. The welfarist perspective has taken its cues from the wider literature on the welfare state, and as a result I examine three issues: citizenship, professional power, and the nature of policy outputs and effects.

In the Anglo-Saxon world, the centrality of citizenship in interpreting the importance of the welfare state can be traced to the influence of Marshall’s version of social history, which envisioned the welfare state as the final stage in the expansion of citizenship rights across a range of spheres—civil, political, and social (Marshall 1949, 1964; for commentary see Turner 1986). That account raises several questions for observers of the health care state. What sense, if any, does it allow us to make of the historic development of health care entitlements in authoritarian political systems, where these entitlements preceded the full development of civil and political rights? What sense does it allow us to make of systems, such as South Korea, where the creation of a modern health care system has apparently diverged from the established pattern of creating universal entitlements (Stano 1990; Tang 1991; Yu and Anderson 1992)? Finally, and most important, what sense, if any, does it allow us to make of the era of cost containment: The apparent retreat from the principles of entitlement as a right of citizenship—a radical retreat for some of the most highly stressed systems, like that of New Zealand, and a more measured retreat in other systems trying to widen copayment arrangements and commercialize the relationship between patients and providers? (For summaries of changes, see Moran 1994.)

The service-delivery functions of the welfare state, as distinct from its income-transfer functions, provide the second cue to study health care as
a welfare state. Welfare states deliver services to clients through specialized occupations commonly accorded the status of professions (Wilding 1982). Viewed in that way, modern health care systems are paradigms of welfare states, and most of the classic studies of professional power and the welfare state rely on studies of health care professions, notably of the medical profession (Freidson 1970; Johnson 1972).

This area is simultaneously one of the most closely explored and most neglected areas of the health care state. That odd combination arises from a well-known feature of the published research: The literature on the power of the medical profession is vast, yet comparatively little is written about the wide range of other occupations involved in delivery of care. On the medical professions we have exhaustive studies, although with a North American and Western European bias, tracing the historical relations between the profession and states; studies of both the structural power of physicians and of their power as lobbyists; and a growing debate about the extent to which professional power is declining. Perhaps the most obvious gap in the literature on the regulation of providers is the lack of attention to nursing. In numbers and in the importance of their role in patient care, nurses fulfill a central role in the health care state. The changing profile of disease—the displacement of acute by chronic disease in aging populations—has meant that a major task of modern health care systems is now managing death: In the United States, for instance, 80 percent of all deaths occur in health care facilities. Nurses play a central role in caring for dying patients (Kass 1993).

Studies of the welfare state have emphasized outcomes and effects of policy, and studies of the health care state have echoed these concerns at two levels: in the large literature considering the connection, if any, between health care and health status; and in the debate about the distributive effect of publicly provided, or publicly regulated, health care services. The implications in the latter debate are numerous and complex: They range from arguments about the detail of national systems, such as the long-standing English debate about the class distribution of services delivered by the National Health Service, to grand theoretical interpretations, such as those associated with the work of Navarro, about the connections between health care institutions and the needs of ruling classes in capitalist societies (Navarro 1976, 1993; Doyal and Pennell 1979).

The role of states in regulating access of individual patients to health care; the role of states in regulating the powers and structures of the occupations that deliver health care services; the effect of the state on the distribution of health care outcomes among different social groups; and
the effect of those outcomes on health status: All these concerns spring from a view of the health care state as a subsystem of the welfare state. But this view does not show us how provision of health care services is also central to a state’s industrial policy.

Health Care as a Capitalist Industrial State

The states of the advanced industrial world can be described as capitalist industrial states for three reasons. First, these states operate in economic systems whose defining characteristics include a continual struggle for competitive advantage, on national and global levels, between whole national economic systems, between competing national industries, and between firms. States can be described as capitalist because one of their functions is to regulate these competitive struggles, both by creating a general framework of law and security for exchange in markets and by providing more specialized regulatory frameworks adjusted to particular conditions of individual industries or sectors. Second, despite—or perhaps because of—globalization of markets and production, states commonly accept responsibility for managing national economies in a competitive world, although they discharge those responsibilities differently. Finally, states are more than regulators or referees; often they are players in the competition and have their own interests to defend.

These three features are central to the interaction between the state and health care manufacturers. The outcomes of competition in the pharmaceutical and medical equipment industries are central to the industrial policy of states because of their size, their technological importance, and their growth rate. The pharmaceutical industry is more than an important part of any modern health care system. It is a substantial component of the structure of big industrial states and is growing in importance: In the late 1980s, spending for pharmaceuticals accounted for 0.8 percent of gross domestic product in the European Community (Burstell 1991).

Competition in the health care manufacturing industries hinges on product innovation. For instance, the ascent of Glaxo to one of the world’s largest pharmaceutical firms has been due primarily to the success of Zantac, its ulcer medication. The role of product innovation in competition explains another source of the importance of health care institutions: Health care manufacturing industries occupy a disproportionately important position in the creation and renewal of the knowledge base of the modern industrial economy. For example, pharmaceutical firms spend about 16 percent of output for research and development, which is much
greater than the average for industry as a whole (Sharp 1991). Finally, key health care manufacturing industries recently have been among the most dynamic elements of the modern economy. The growth of diagnostic imaging technologies is a striking example. This technology allows noninvasive examination of the human body and began with the invention of X-rays in 1895, vastly expanded in the 1970s and 1980s through adaptations of developments in microelectronics, and culminated in the invention, marketing, and diffusion of innovations such as computed tomographic scanners and magnetic resonance imaging. The U.S. market for these technologies increased more than ten times between 1972 and 1987, to more than $2.3 billion. (The world market is about twice this size.) The growth rate in the period, at about 8 percent per year, made this one of the fastest growing sectors of the U.S. economy—at least matching, possibly exceeding, and in any case contributing to the growth of “glamorous” areas such as computing equipment (Trajtenberg 1990: 45–49).

The importance of health care manufacturing for the wider economy is magnified in some instances by two other considerations.

First, the symbolic and substantive importance of these industries varies according to the size and structure of national economies. The United Kingdom provides an obvious example. Pharmaceuticals remain one of the few important industries in which the United Kingdom, a manufacturing economy in decline for more than a century, still retains an important world presence. Indeed, whereas most British industries have been declining in world ranking, British pharmaceutical companies such as ICI and Glaxo have advanced to the top ranks in the last two decades (Sharp 1991: 216). Britain, an economy with a chronic balance-of-payment deficit, has a positive annual trade balance of more than £1 billion in pharmaceuticals and medical equipment, a rare consoling fact for the elites who must manage this declining industrial economy. (For a positive reflection on these lines from the Cabinet Office, see Advisory Council on Science and Technology 1993.) The pharmaceutical and medical equipment industries therefore have disproportionate importance to a capitalist industrial state such as Britain, because of their economic significance and because they provide state elites with a rare example of a prestigious, world-class industry.

Second, there is substantial integration between the health manufacturing industries and other sectors. The connection between the manufacture of technologically advanced items of medical equipment, such as scanners, and the electronics industry is a striking example. Another
is provided by the way the fate of the pharmaceutical industry is bound to different sectors in different countries. For instance, most American pharmaceutical giants originated as pharmaceutical firms and tended to diversify into other areas such as cosmetics and fine chemical products. In contrast, large European pharmaceutical companies tended to begin as producers of dyestuffs and organic chemicals and subsequently diversified into pharmaceutical firms (Hancher 1990: 38).

The features of the health care manufacturing industries just noted have consequences for the state's role as an industrial regulator, promoter, and player. Because of the struggle for competitive advantage, industries are constantly pushing at, and beyond, the regulatory limits set by the state. Pharmaceuticals provides the most obvious example. Wright's summary of the three issues that dominated relations between governments and drug firms in Britain and France for the last fifty years could represent a wider range of capitalist economies: "the cost of drugs supplied to the public sector; the safety of those drugs; and the costs and regulation of the activities of drug companies to promote and advertise their products" (Wright 1991: 503).

Obviously this regulatory role sometimes accords or conflicts with the state's second responsibility to promote competitive advantages. The potential conflict lies at the heart of the debate about the connection between licensing for product safety and "drug lag"—the alleged inhibiting effect of licensing controls on product innovation and marketing (Hancher 1990: 111–13). If the drug lag hypothesis is correct, states can compromise their role as the promoter of competitive advantage by their need to act as a regulator. But they can also turn their role as technology regulator to national competitive advantage. The possibilities are illustrated by the mercantilist stance of the French state, which tried to protect and foster the indigenous medical equipment manufacturing industry. Since the early 1980s, one of the most dynamic parts of that industry has been the manufacture of equipment used for noninvasive surgery. For example, extracorporeal shock wave lithotripsy uses shock waves to dissolve stones in the urinary tract and is an alternative therapy to invasive surgery. Introduction of the technique was delayed in France until a native firm could develop a machine to administer the treatment (Banta and Vondeling 1993: 127).

The face of the health care state revealed by its position as a capitalist industrial state can be examined in three dimensions, two of which we have now considered: the state as an industry regulator and as an industry promoter. Finally, the state can be an active player in competition
for health care manufacturing. States are more than referees or promoters because they have their own distinct interests in the outcomes of competition. The most direct source of these interests lies in their position as customers, or as institutions responsible for defending the interests of other health care payers. In tax-funded health care systems, such as in the United Kingdom, the connection is direct: Spending for pharmaceuticals in Britain comprises more than 10 percent of National Health Service expenditures (Ham 1992: 144). But even in systems in which the payers are quasi-public insurance funds, such as those variants of the German model, or in the American system, in which important payers are often private enterprises, the state has been forced to accept a major role in cost-containment efforts. Not all cost-containment efforts are aimed at service suppliers, and not all important service suppliers are part of the health service industries. Nevertheless, it is difficult to think of an advanced capitalist economy in which the state is not a player directly as a customer or as an institution with an interest in containing costs to maintain national economic competitiveness.

But the state’s role as a player is more complex than its role as a purchaser of care or as the agent of other purchasers trying to defend their competitive market advantage. Some states play in markets because they, or individual agencies of the state, have distinct institutional interests to advance. The competition that occurs in the world economy is not just among firms; it is also a struggle among whole national economies. States have important interests at stake in the outcomes of those struggles—notably the weight that state actors can command in international networks as a result of their industries’ successes, the opportunity to advance distinct national development strategies, and the chance to promote the position of individual agencies at the expense of others in the bureaucratic politics common within state structures.

Analyzing health care as a capitalist industrial state reveals great contradictions and tensions in the state’s different roles. As a regulator, it must control competitive processes in the interests of patient safety, the health and safety of workers in the regulated firms, and even the wider environmental health of the community. As a promoter, on the other hand, states that possess substantial indigenous industries must ensure that conditions are created in which these industries receive maximum opportunity in markets; and some weaker capitalist states must organize their regulatory structures so they make themselves attractive as locations for foreign firms. As a player, the state’s roles and interests are contradictory. To control the costs it incurs as a consumer, it must slow product innovation
in health care manufacturing. As a player championing domestic firms, or trying to attract foreign multinational investors, it must create the most favorable conditions in which firms can compete.

When we view health care as a capitalist industrialist state, we see an institution that operates amid severely conflicting pressures. These pressures are intensified by a third face of the health care state—the pluralist democratic state.

**Health Care as a Pluralist Democratic State**

Not all health care states are pluralist democracies, but most are, if only roughly. Two features central to pluralist democracies shape health care systems, especially amid economic turbulence and cost containment: how the principles of pluralist democracy institutionalize distributive struggles, and how they encourage the free, or relatively free, flow of information.

Group organization lies at the heart of the competition for resources in pluralist polities, whether organized through political parties or interest groups. The analysis of the relative power of organized groups, especially occupational groups, has always formed the bases of studies of health care politics. But group organization in health care recently became more complex and important. This is due in part to the sheer growth in the size of health care systems and the corresponding increase in the number of lives affected by health care institutions. Even if we study only those who actually work in health care, rather than those who consume health care services, the numbers are vast: more than 7 million persons in the United States, 1.5 million in Germany, and 1.25 million in the United Kingdom (Organization for Economic Cooperation and Development 1992: 90). Inside these raw figures is a vast range of organized occupations struggling for a share of the resources at stake in health care policy making: Think of our earlier example of the effect of hospitals on employment in metropolitan areas of the advanced industrial world. Indeed, the figures only suggest part of the range of actors and interests struggling to influence health care policy. In many countries—of which the most important is the United States—key financial institutions, such as insurance companies, also have a stake in health care policy. The Clinton reforms failed, in part, because they threatened the private insurance industry, which does good business within the existing arrangements and is exceptionally well organized in defending its interests.

Therefore, pressure-group struggles are central to health care policy making because of the many diverse persons and institutions with a stake
in the resources allocated by the health care system. But the group struggle has been intensified, paradoxically, by policy successes enjoyed by many health care systems. Two decades of relatively successful cost containment in many nations have made the stakes in those distributive struggles higher than ever. In the era of universal growth of health care budgets during the long boom in capitalist economies, the competitive games played by groups were positive sum. But the age of cost containment has made many of the distributive games zero sum. That may explain, for instance, much of the recent ferocity of occupational struggle in health care systems.

The intensity of distributive struggles among health care groups thus is partly a product of developments internal to health care systems, to the range and complexity of the interests they cover, and to the growing desperation as groups fight over the resources in a static or declining budget. But the character of group organization reflects changes occurring across a range of democratic polities. Social learning, the decline of political parties as channels of participation, and the way more formal education has expanded the proportion of the population with the skills needed for group participation have multiplied the number and range of groups (see Peterson 1993: 789–90). The effects of this have been felt in health care systems in the “explosion,” to use Klein’s word, in the groups active in health care lobbying. Perhaps the most striking example of the change is provided by the increasing willingness of patients to organize, using their disease as a principle for membership (Klein 1989: 111–17). (The lobbies organized for patients with acquired immunodeficiency syndrome are only the most visible examples.)

Organization of the health care policy arena into armies of groups clashing over the division of the spoils is linked, in turn, to the second feature of pluralist democracy just identified: the relatively free flow of information that characterizes a pluralist democracy. Cost containment has been the key policy issue of the last two decades, and effective cost containment depends on effective gatekeeping: creating institutions that limit patients’ and physicians’ access to the latest expensive technology. The most economical health care systems are those, such as in the United Kingdom, in which the gatekeeper (in the U.K., the general practitioner who stands between the patient and high-tech treatment) is effective. Many factors can reduce the effectiveness of gatekeeping, such as patients’ increasing knowledge of the treatments that lie beyond the gate. That knowledge is fostered by the media that report those possibilities, often in terms of the opportunities offered by the latest “miraculous” advances in medical technology. Thus recent studies of the diffusion of
minimally invasive therapies in different countries return time and again to the role of patient demand, in response to awareness of new techniques, as a source of pressure for diffusion (for a summary, see Banta and Vondeling 1993: 132).

But the circulation of information is not merely a matter of spontaneous reporting of medical advances by the free media. Many well-organized interest groups participating in the distributive struggles described previously are also actively manipulating the flow of information. A good example is provided by the pharmaceutical industry in the United Kingdom. By international standards, the rate of prescription of new drugs by physicians in the United Kingdom is low. The trade association for the pharmaceutical industry is engaged in a well-funded, highly professional campaign to undermine this effective gatekeeping, feeding the media with reports of the alleged consequences of the failure to adopt new drugs (Association of British Pharmaceutical Industries 1992, 1993). Another example of information manipulation is the publicity given waiting lists, the politics of which are explosive in those health care systems (such as in the United Kingdom and in some parts of Scandinavia) in which health care is rationed. The reporting of individually tragic cases—a staple in the British press has been infants denied urgent lifesaving treatment—provides material for a wide range of the actors at the center of the distributive struggles in pluralist polities: opposition politicians engaged in electoral competition with governing parties, patients demanding care, and interests within the health care system competing for scarce resources.

Health care systems operating within pluralist democracies face immense pressure, especially now with cost containment. At the center of health care policy making is an intense distributional struggle to control the many resources allocated by health care systems. That contest occurs even in nondemocratic systems, but the organization of pluralist politics allows it to be pursued openly.

**Conclusions**

“Three faces of the health care state” is offered as a metaphor to visualize the complexity of health care politics. But even if the notion of a metaphor appeals, the three faces image creates many difficulties. Metaphors convince because they engage our intuition and imagination. Taxonomies in the social sciences demand more than intuition and imagination; they should be exhaustive and exclusive, and the criteria of classification used must be consistent. If a taxonomy generates x number of categories, we
should be able to show that only $x$ categories can be generated. Nothing so rigorous can be claimed for the image of three faces. All I claim is that the health care state, like any other complex structure, yields more to the observer when it is viewed from various perspectives—just as an animal, a building, or a sculpture is best viewed from many different positions. In the past we have, more or less unwittingly, viewed it from a welfarist perspective, neglecting its industrial and political faces.

Even this modest claim presents difficulties, and they can be summarized using three headings: the number of faces; the relationship between those faces; and the explanatory functions of the whole metaphor. If we accept that we should approach the health care state from various perspectives, why choose three rather than two, or four, or ten? For instance, in considering the political face of the health care state, should we not separate the politics of resource distribution from the politics of revenue raising? The answer is plain. Because the essential justification for a metaphor is pragmatic, whether we separate two political faces depends on the kind of issues we are analyzing. But there is also a pragmatic case for working with three faces until their potentials are depleted.

The issue of eliminating one of the faces is more troubling. The welfare face and the industrial face of the health care state both illustrate different kinds of distributional struggle, and it would be an odd analysis indeed that failed to put the politics of distributional struggle at the center of any account of the welfare or industrial issues raised by health care. Would it not then be more sensible to speak of these two faces, instead of trying to place politics in a separate category? This would indeed be justified if the only politics that mattered in analyzing health care was sectoral—if we could analyze the politics of the health care sector by referring to the group struggles inside that sector. But obviously we cannot do that. The character of those sectoral struggles is strongly influenced by the wider political context (a democratic context) in which they are conducted. The emergence of group struggle in health care policy is due in part to the stakes in health care, although it is also due to the changing character of political organization across pluralist democracies. The democratic political process is not just a resource available to groups struggling with each other in health care; it is also an independent influence shaping the character of distributional conflict.

If the changing character of the democratic political context affects health politics generally, the enduring character of individual democracies also shapes continuities in the distributional struggles that occur in health care. The most striking example is provided by the United States,
where Morone has shown that the failure to develop a system of health insurance, and the character of what developed in its place, must be explained by two features of American democracy that are external to health care institutions: the decentralization that marks American democracy; and the cultural suspicion of politics and preference for neutral technical solutions to social problems, which is central to the political culture (Morone 1990).

These remarks bring us to the solution to the second problem I identified: the relationship between the three faces. Plainly the boundaries between the welfare, industrial, and political faces of the health care state overlap, and this gives the metaphor analytical potential. The story of health care policy is partly a story of the tensions when welfare, industry, and politics merge. Some of the case studies sketched in this article illustrate the possibilities. Consider the invention and introduction of new technology in health care: We have a complicated situation in which the problems of specifying entitlements, managing industrial sectors in a competitive world, and managing the consequences of pluralistic political organization intersect. In turn, this suggests a solution to the third problem: What is the explanatory function of the three faces metaphor? Of course, the exercise can be regarded as an opportunity allowing independent description of different aspects of the health care state. We could write an essay on health care entitlements and an entirely different one on industrial governance in the medical equipment industry. In addition, in different nations health care policy makes sense in different terms—the historical evolution of some health care systems is industry-driven, whereas in others it is welfare-driven. Plainly this is a matter for historical inquiry. But my purpose in offering the metaphor of three faces is to encourage us to do two things: to acquire some overarching conception of the meaning of health care politics, and to explore the tensions created by the different structures and processes working in health care systems.

References


