Governing Health Care Through Consumer Rights

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ABSTRACT

This comparative case study explores how neoliberal policy ideas play out in two radically different political settings—the Danish and American health care systems. Both countries introduced strong, neoliberal "free choice" reforms in the 1990s and early 2000s. We use two theories about neoliberalism as our conceptual lenses. One (David Harvey) emphasizes the goal of liberating market capitalism from government regulation and strengthening the power and wealth of business elites. The other (Michel Foucault) emphasizes how market-like social arrangements can be used as governing technologies that can be applied to any area of public policy.

In both countries, policymakers used consumer choice rhetoric and reforms to accomplish both kinds of objectives. In Denmark, with its universal public insurance and predominantly public hospital sector, free choice reforms were intended to reduce long waiting times in public hospitals by allowing private hospitals to compete with them, and thereby increase efficiency. In the U.S., consumer choice reforms were introduced into Medicare, a bastion of public insurance that resembled European social insurance, with equal coverage for all beneficiaries. These reforms were also intended to make the public health insurance system more efficient—specifically to restrain costs—by allowing private insurance plans to compete for beneficiaries.

We found some ways that the reforms in both countries did accomplish their objectives—mainly, growing the private sector by giving private insurers access to public tax revenues. We found that the goal of governing different actors (patients, doctors, hospitals and insurers) through economic incentives had much more varied results and sometimes was undermined by the goal of expanding the private sector.

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Introduction

Neoliberalism is a worldwide movement to transform the relationship between government and the economy. Efficiency and freedom are the movement's ideals and its buzzwords. The general claim behind neoliberalism asserts that free markets are always more efficient than government planning, and therefore, they lead to greater economic growth and social welfare. In addition, markets promote individual liberty, while government control necessarily restricts it. Institutionally, neoliberal ideas take the form of replacing government ownership, financing and regulation with privatization and free markets.

Health care is an area where neoliberal reforms have been widely adopted (or in the case of developing countries, often imposed by donors and lenders). Our paper compares the introduction of consumer choice reforms in two countries whose health care systems could not be more different. For Denmark, with its universal health insurance scheme and publicly-financed hospitals, we examine the introduction of a (limited) free choice of hospitals starting in 2002, a policy that also allowed private hospitals (limited) access to publicly insured patients. For the United States, with its patchwork system of mostly private, commercial health insurance but significant government programs for the elderly, disabled, poor and veterans, we examine the introduction of consumer choice and private insurance options into Medicare, a public system originally somewhat comparable to European social insurance systems.

In addition to radically different health systems, Denmark and the United States have radically different political cultures about the role of government in welfare state provision. Denmark's national health insurance and its system of public hospitals have been virtually unanimously supported by one of the most egalitarian political cultures in the world. Although the institutional configuration of health insurance developed in various steps over the 20th century, the core principle of "free and equal access" to treatment goes as far back as 1818 ,with additional schemes for insuring the poor set up in 1893 and 1933(Petersen & Blomquist 1996: 185). A 1971 reform replaced the patchwork of public and not-for-profit private insurance plans with universal, tax-financed public health insurance administered by five regions (formerly by counties until 2007). Until the last two decades or so, there was no private insurance and no private hospital sector. There was no political debate about the legitimacy of the public system, but only about how centralized political control over

health care should be. Nor was there any public or even elite clamor for marketizing the public health insurance system.[1]

In the U.S., by contrast, contentious debate embroiled every effort to establish public health insurance programs. Advocates of social responsibility and public insurance have repeatedly squared off against advocates of individual responsibility, commercial insurance, and competitive free markets. Medicare, the major single-payer, taxpayer-financed social insurance program, emerged precariously from a sharply divided Congress and a sharply divided political culture—divisions that persist to this day and that have allowed conservatives to move Medicare back towards the private insurance model each time they gained ascendency in national government (Oberlander 2003a, 2003b).

By comparing these two cases, we can illuminate how neoliberal ideas "work" in very different political settings. As we will argue, despite the differences, neoliberal ideas and reforms played similar roles in the two countries. Although elites used these ideas to accomplish specific policy objectives unique to each country, in both cases they also used free choice rhetoric and imagery to legitimate major policy changes that were hitherto unthinkable in their respective political environments. In both cases, too, elites used consumer choice and the competitive market mechanism as governing technologies to steer the behavior of health insurers and medical care providers in the desired direction. When viewed from the perspective of theories about neoliberalism, consumer choice reforms served the same more general neoliberal purposes in both systems: restructuring a predominantly public system into one where private markets and commercial providers play a larger role; and governing (steering, constraining, regulating) actors in the health policy sector primarily through the market instrument of consumer choice, or what economist Albert O. Hirschman (1970) called the "exit" option.

What is Neoliberalism?

Neoliberalism is not the easiest term to define, not least because no neoliberal intellectuals or politicians use the label about themselves. They usually refer to themselves as believing in freedom, free markets or limited government. We think there are two broad views of neoliberalism. One emphasizes the goal of liberating market capitalism from government regulation and strengthening the power of business elites. The other emphasizes how market-like social arrangements can be used as governing technologies that can be applied to any area of social relations or public policy. We use both these views as analytic lenses to examine the two cases. First, though, we juxtapose two prominent writers on neoliberalism to sketch out these two conceptual frameworks.

David Harvey's *A Brief History of Neoliberalism* (2005) tracks the rise and spread of neoliberal ideology from Thatcher and Reagan to most other parts of

[1] Currently The public share of total health costs is around 85% while the remaining part consists of private co-payments for dental care, pharmaceuticals and physical therapy (OECD 2011).

the world. The core idea is that while neoliberalism may incidentally promote markets, deregulation and free choice, its ultimate goal and achievement has been the "restoration of class power" (Harvey (2005: 16). Harvey shows a growing concentration of wealth in Western countries during the last decades of the 20th century and agues that neoliberal ideas were basically a cover for the economic interests of a new financial upper class, who had the most to gain from replacing the welfare state with free markets. Along with Mark Blyth (2002) and Naomi Klein (2007), Harvey interprets *neoliberal ideas as strategic tools for achieving an abstract relationship* between political economy and social classes.

If we follow this analysis of neoliberalism as ideology, we can ask whether and how free choice reforms in health care have changed the relative power of the public and private sectors. We can also ask how discourse about freedom and choice makes shifts in the balance of power and resources more politically acceptable, and how the discourse hides certain losses that go along with a policy reform promising citizens only gains.

Michel Foucault, in the 1979 lectures *The Birth of Biopolitics* (published 2008), insisted that neoliberalism constitutes a much more comprehensive technology – or art – of governing than suggested by the critique of ideology. Neoliberalism as represented by Milton Friedman and the Chicago School may share with classical liberalism the ideals of free markets and limited government, but rather than simply strengthening markets with laissez-faire policies, neoliberalism generalizes the model of market competition to all spheres of society (Foucault 2008: 120-1). The creation of market competition enables the state to expand its scope of governing, even if its formal legal authority may be limited. Unlike the understanding of neoliberal ideas ideological tools, for Foucault *ideas have power in their own right to influence individual behavior.*

According to Foucault, neoliberal political technology attempts to govern the individual by taking advantage of the motivational structure of *homo oeconomicus*. *Homo oeconomicus* as a self-interested and profit-maximizing economic agent was already a main character in classical liberalism, but 'he' played an entirely different role there, as a subject whose interests and property could not be infringed upon by public authorities. Expanding on Gary Becker's concept of *homo oeconomicus* as (in Foucault's words), "the person who accepts reality or who responds systematically and predictably to modifications in the variables of the environment," Foucault adds a managerial twist: this person "*appears precisely as someone manageable*, someone who responds systematically to *systematic modifications artificially introduced into the environment* (Foucault, 2008: 270, emphases added).

Rather than being someone who cannot be touched by the state, *homo oeconomicus* becomes someone who is "eminently governable" (Foucault 2008: 270). Elites can simply redesign public policies by "artificially introducing systematic modifications into the environment," so that it will always be in a person's best interest to behave in a certain way, just as B.F. Skinner manipulated a rat's environment to induce it to behave in a certain way. Whether the behavior entails a patient's demand for health services or a doctor's treatment decisions, neoliberal technology assumes that all types of behavior are amenable to manipulation through economic incentives.

Seen in this perspective, competition, incentives and choice are not just ideas, but also flexible tools that can be used for a variety of political and policy goals far beyond serving the economic interests of a particular class.

If we follow Foucault's concept of neoliberalism as technology, we can see how neoliberal health reforms under the rubric of "consumer-driven health care" (Jost 2007) are not simply about rolling back the state and leaving health care to the market, but often entail a more constructive process of creating structures and agents that operate like a free market. Thus, the free choice reforms in health care in Denmark and the U.S. are not simply examples of retrenchment, whereby public services are shut down and left to the market. While there may certainly be expectations of savings and cutback lurking in the background, the core idea in these free choice reforms is about creating market-like consumer choices within publicly financed health care systems.

Denmark: Extended Free Choice of Hospitals (2002)

Unlike the political constellation in the United States, the ideological support behind Denmark's universal health insurance is and always has been very strong. Moreover, before the advent of a few market-inspired reforms in the past decade, there were very few private insurers or health care providers, and therefore, weaker private interests ready to lobby for such reforms. Cost control had been a major policy focus during the 1980s (Pallesen 1997), and with some success, as Denmark kept its health care spending at around 8-9% of GDP until the early 2000s. The introduction of free choice was thus not the outcome of an acute cost crisis, but rather, the coalescence of four elements.

First, long waiting times for non-acute hospital care became defined as the major health policy issue during the 1990s and early 2000s. The first section below describes the issue of waiting time and how it was later framed as a "waiting list," a political problem that shaped the technical design of the Extended Free Choice of Hospitals. Second, this free choice reform was introduced as a technology of governing the existing public health care sector. At the time, the health minister openly acknowledged that giving citizens consumer rights was a new way of governing public hospitals and their regional management through economic incentives. Third, the free choice reform came right after a shift in government in 2001 in which the incoming Prime Minister, Anders Fogh Rasmussen, announced free choice ideas as part of a "cultural struggle" in the Danish welfare state. Finally, a fourth goal behind the free choice reform and other simultaneous reforms was to expand the private health care sector – including both insurers and providers – and to give them access to patients from the public system.

From Waiting Time to Waiting List

Long waiting times were the main target of a series of reforms before extended free choice was introduced in 2002, also with the aim of minimizing waiting time. It was

not as if patients had never waited for medical services before, but the successful cost control measures of the 1980s together with increasing demands for medical services had created a situation with relatively long waiting times.

In principle, patients can wait for many different reasons, for example, if they prefer to schedule an operation at a convenient time. But the systemic accumulation of long waiting times developed because public hospitals limited their supply to meet fixed-budget cost control measures. In order to get free or covered treatment in a hospital or from a specialist (the majority of whom are in public hospitals), patients must get a referral from their GP who is the gatekeeper to most medical services (Pallesen and Dahl Pedersen 2008: 231).[2] The GP's referral typically sends the patient to the nearest public hospital with the appropriate specialty—what we will call the patient's regional "home hospital," for lack of an official term. If this hospital cannot immediately expand its supply, the patient is given a later time for a scheduled operation or examination.

This is how waiting time emerges in general, but it is important to add how waiting time was also a socially constructed problem. For one thing, government had to define and develop accurate measures of the average waiting time. This was mainly an administrative process that involved several ministerial and regional working groups over the course of the 1980s and 1990s (Vrangbæk 2004: 25-6), but with little interest by the public. An institutional power struggle was built into this process, since the central government wanted to use accurate waiting time estimates to be able to better control the productivity of regional hospitals,; regional hospitals main interest was to hide actual waiting times. In this first period, controlling waiting times was mainly an administrative issue, but a very complex one, as both ageing and new technology tended to increase demand, despite a larger nominal production of hospital services (Vrangbæk 2004: 27).

During the 1990s, waiting time became the object of intense public and political attention, and was typically referred to as "the waiting list." The administrative complexity of producing accurate waiting time measures stands in contrast to the public perception of this so-called waiting list. Not only does it sound like there is a physical piece of paper according to which patients are admitted one after another, but the waiting list is also a powerful political symbol that conjures all the deprivations of Eastern European socialism. Even worse than standing in line is the image of dying while waiting for treatment. As early as 1991, the media tagged waiting lists as "lethal" (Olesen 2010: 79).

Many actors called for an expanded use of private hospitals to bring down the waiting lists, an idea that was also popular with voters (Olesen 2010: 80), but the Social-Democratic government in power between 1993 and 2001 preferred to solve the problem within the public sector. Aside from a largely ineffective agree-

[2] Technically, citizens have always had the option to choose the so-called Group 2 within the national health insurance, which allows them with direct access to all specialists in exchange for a few disadvantages in comparison with the regular Group 1. We omit this option in our discussion, since Group 2 coverage has never had large significance in relation to waiting time nor to free choice.

ment between regions and the central government to curb waiting time at three months (Olesen 2010: 86), the key policy change in this period was the initial 'free choice of hospitals' initiated in 1993 (Vrangbæk 2004: 38). Patients could now choose to get their care any *public* hospital, without any requirement to first seek an appointment at their home hospital. The reform was basically an attempt to even out regional variations and try to solve the waiting time problem within the public system. Only few people used this choice and it did not alleviate the problem of waiting lists nor the general perception that the Danish health care system continued to be underfunded. A 1999 reform created a waiting time guarantee for twelve life-threatening diseases, mainly cancer and heart disease, which obliged regions to offer treatment in public or private hospitals within a specified time frame. Since most public hospitals lacked capacity and there were very few private hospitals to send patients to, the reform did not substantially control waiting time (Olesen 2010: 89).

The 2001 election brought in a new liberal-conservative government whose leaders had promised to 'fix' the health care system using private providers. As one of their first health policy initiatives, they introduced the "Extended Free Choice of Hospitals" in 2002, along with a one-time investment of 1.5 billion kroners earmarked for increased production in the health care sector (Law L64 2002). The extended free choice reform is basically a maximum waiting time guarantee, saying that if a patient's home hospital cannot provide the prescribed treatment within two months, the patient can choose to obtain treatment from other public and private hospitals at no charge, provided that the chosen hospital has entered into an agreement with the health authorities. The main novelty was that patients now had a right to be treated *in private hospitals in Denmark or abroad*, but still paid for by the Danish taxpayers at existing DRG rates (L64, comments to the law). Patients bear no additional cost for exercising their right, except for travel costs to the chosen hospital. The law is still in place, although in 2007, the maximum waiting time was reduced to one month.[3]

Let the Money Follow the Patient

The Extended Free Choice of Hospitals was presented in the Danish Parliament on January 29, 2002 by Minister of Health and Domestic Affairs Lars Løkke Rasmussen. Løkke Rasmussen emphasized two main arguments in favor of the bill. First, extending free choice constituted "a new and significant right for the individual patient" (L64 written presentation), but relatively few details of this new right were presented or debated in Parliament, perhaps simply because few individuals were expected to actually use private hospitals on the government's tab (Olesen 2010: 94). Most of Løkke Rasmussen's presentation focused on the second argument, namely that free choice also constituted a "…*new way of governing the (public) health care sector* by giving the delivery units the appropriate economic incentives

[3] There law was temporarily suspended in 2008-9 following a nurses' strike.

(…) to shorten waiting times to an acceptable level" (L64, written presentation, emphasis added).

In further support of what the minister termed a new "principle of governing the health care sector," he argued that the basic premise behind this principle was to "let the money follow the patient" (L64, written presentation). In a way, the money already followed the patient, as most health care financing had been based on fee-for-service principles since the late 1990s and on DRGs since 2000 (Vrangbæk 2004: 48). Until this point, however, public money had stayed within public hospitals. The new reform opened the gateway to using public money in private hospitals. Significantly, the principle of letting the money follow the patient was now put forward as a direct reversal of the waiting list. Instead of letting patients wait in line until the system has time to treat them, the free choice reform makes health care providers chase and compete for patients.

The mbition to put the patient center stage is somewhat ambiguous, however, because the patient still appears to be a means to an end, namely, governing public hospitals through increased competition. Two details of the reform show how the goal of disciplining public providers was probably a higher priority than patient freedom of choice. First, the method of paying for treatment in private hospitals entailed a severe cost to the patient's home hospital. Normally, the regional health authority receives the fixed DRG rate for each medical service from the central government. The regional authority then pays the individual hospital or clinic, but only the marginal cost of the service, which is around 50% of the DRG rate. The rest of the DRG rate covers education, research, administration and 24-hour acute care facilities. If a hospital 'loses' a patient by failing to offer treatment within the waiting time guarantee so that free choice kicks in, the hospital is charged 100% of the DRG rate. The home hospital must pay for its patients wherever they receive treatment (Olesen 2010: 97). In other words, free choice, when exercised, is an economic sanction on the public hospitals that are not able to meet the deadline, and it obviously creates a strong economic incentive for hospitals to increase production.

The second reason why disciplining the public system should be considered the main policy objective is that free choice is made conditional on waiting time. Consider for a moment who actually gets to exercise a free choice under this reform. The large majority of patients in the health care system – 68% in 1995 – are acute patients (Vrangbæk 2004: 29). Since acute patients do not have to wait for treatment, they have no waiting time and they get no free choice. Only patients who must wait more than two months (one month since 2007) for planned treatment or specialist consultation get to choose between public and private providers. In fact, if the reform works as intended, public hospitals should be guided by the economic incentives and increase production to meet the waiting time limit, thus making free choice moot. Only when the guarantee doesn't work to perfection does actual choice kick in. In this respect, the extended free choice of hospitals is far from a complete voucher program in which all citizens get a fixed amount of money to spend on services chosen among a variety of providers, public as well as private.

The Danish free choice reform is no less neoliberal for this reason, perhaps even more so, since the possibility of governing through competition is more

important than the substantive content of individual rights. This is not to suggest that patients don't benefit from the free choice reform, because after all, they do get quicker access to treatment, even if only a smaller number gets to choose between public and private in practice. The key point is that at its core, the Danish free choice reform is first and foremost a technology or mechanism whereby the economic threat of losing patients to private hospitals, while still having to pay the full social cost of their care, pushes the public system to be more efficient and produce more. It is worth mentioning that waiting times *did* come down after 2002, at least in part as a result of the waiting time guarantee. However, because the free choice policy was launched along with a general increase in health funding, it is difficult to separate the effect of the law from the new funding.

Freedom and Cultural Struggle

The extended free choice of hospitals may look like a practical solution to a pressing problem, but it was more than that. It constituted one of the cornerstones of the new government's political program being launched only two months into office. In order to get elected, the new Prime Minister, Anders Fogh Rasmussen, had to renounce his 1993 book, *From Social State to Minimal State*. The book was heavily inspired by political philosopher Robert Nozick and famously accused the large Danish welfare state of having created a "pathetic slave nature that penetrates the entire Danish society" (Fogh Rasmussen 1993: 7). Fogh Rasmussen completely shelved these ideas when he became leader of the liberal Venstre party following its electoral defeat in 1998. Instead, the Venstre party platform for the 2001 election simply promised Danes no cutbacks in welfare or health care, along with much tougher crime and immigration control. While all plans of welfare state retrenchment were thus dropped, the new government still retained its ambition to break the alleged cultural hegemony of left-wing elitism in both the welfare state and Danish society as such.

In several key speeches and interviews, the new Prime Minister called for a 'cultural struggle' (*kulturkamp*) that included an expansion of free choice for citizens in areas such as health and elderly care. The term cultural struggle was later colonized by the 2005 Mohammad cartoon controversy, but before it was taken over by discussions about Islamism and freedom of speech, it was also a struggle about replacing welfare monopolies with tax-financed freedom of choice (Rasmussen 2002; Kastrup 2008). As the Prime Minister stated in a 2003 interview under the title 'the Golden Shopping Cart': "This is where the real struggle is. On one side the centralists who want to decide over people's everyday life, those who believe they know best and prefer standard solutions. On the other side those, who – while maintaining a common responsibility for solving problems in a modern welfare society – insist that we should have a personal freedom to choose between different public providers and between public and private providers" (Hardis & Mortensen 2003).

By not calling for massive welfare retrenchment, but still offering citizens a free choice in addition to what they were already paying for, the neoliberal welfare policy proposed here simply sounds like more for the same than under social-

democratic paternalism. This shows how right-wing governments can be surprisingly generous on areas of welfare provision where universal rights are so firmly established that marketization can only be achieved by compensating the middle class with extra benefits or choices (Jensen 2011).

It is likely that the long-standing ambition of right-wing parties to lower public expenditure and ultimately taxes was only temporarily put on hold; given how accustomed Danish voters are to the fixed offerings of the welfare state, a liberal transformation of Danish society can be achieved only in the very long run (Hardis 2006). The cultural struggle is thus also about educating Danes to exercise freedom of choice, instead of merely taking for granted that public solutions are better than the private market. Implicit in this ambition is, of course, the assumption that private markets always come with a larger variety of choices. It is interesting to notice that in these sometimes rather diffuse, high-toned debates about Danish culture, freedom of choice seems to be understood as a value in itself and less, if at all, as a means to an end. References to the economic aspect of exercising consumer choice are relatively rare compared to the character-reform aspect. The main point of having free choice is *making* individual choices, instead of falling back into the "slave nature" of depending on bureaucrats' decisions (Fogh Rasmussen 1993: 6).

Growing the Private Market

The fourth and final motive behind the free choice reform was to strengthen the private sector. It is difficult to avoid speculation here, since no Danish politician in their right mind would ever say they wanted to strengthen private hospitals at the expense of the public sector. Nevertheless, extended free choice was designed so that if citizens exercised their right, it would inevitably lead to public money being spent in private hospitals. Indeed, the 2002 reform did strengthen the private hospital sector tremendously by giving it access to patients paid for by public health insurance. The relative expansion of private hospitals during the past decade stands in stark contrast to how they were "dying out" in the preceding period (Olesen 2010: 74).

Private hospitals did not emerge in Denmark until the mid-1980s. Although the Social Democrats had tried unsuccessfully to ban them altogether in 1987, their public image remained very bad, even on the right wing as well as in the medical community, because making profit on health was widely regarded as wrong (Olesen 2010: 74-5). Apart from their poor public image, private hospitals lacked the ability to make a profitable business and the majority simply died out within a few years of startup. During the 1990s, right-wing politicians (then in the opposition) made a series of unsuccessful proposals about using private providers to lessen the pressure on the public system (Vrangbæk 2004: 44).

The market position of private hospitals was thus very weak when the new government came into power in 2001. As an effect of the 2002 free choice reform and other related initiatives, private hospitals and private health insurers boomed significantly during the 2000s, although they still comprise a relatively small proportion of all hospitals. The number of private hospitals grew from five in 2002 to

178 in 2008, but in size, these are hardly comparable to the 49 remaining public hospitals in 2006 since the latter have merged into very large units (Olesen 2010: 101). The relative weight of private hospitals is still small – around 3% of total health costs in 2008 – but an estimated 72% of patients in private hospitals were financed by public funds (Olesen 2010: 100).

As mentioned earlier, when patients use their right to obtain treatment in a private hospital, the hospital is paid a general DRG rate designed to cover educational, research and acute treatment obligations that Danish private hospitals simply do not have. Furthermore, there are no limits to how much private providers can specialize in a few, highly profitable operations, such as liposuction and some types of orthopedic surgery. It is no surprise, then, that running private hospitals has become a very profitable business thanks to patients coming from the public system (Olesen 2010: 97-100). This new business environment for private hospitals became all the more apparent after the waiting time guarantee was lowered to one month in 2007, which increased pressure on public hospitals and boosted the population of paying patients for private hospitals.

The extended free choice of hospitals is only one of the policy decisions behind the recent upsurge of private health care in Denmark. In 2002, the government created a tax exemption for supplementary private health insurance plans paid for by employers. Because all Danes have public health insurance that covers all their care in public hospitals, private supplementary insurance finds its niche by covering treatment in private hospitals and allowing policyholders to skip the public queues. In 2002, a minor pre-existing tax exemption for employer-paid alcohol rehabilitation was expanded to cover all supplementary private health insurances provided that they are offered to all employees in a workplace. This example of "policymaking without policy choice" led to a massive growth of private health insurance from a few percent in 2001 to covering close to one-third of the labor force in 2007 (Olesen 2009).

Finally, a large controversy emerged in 2009 when the new Prime Minister, Lars Løkke Rasmussen, was accused of systematically over-compensating private hospitals during his time as health minister (2001-7). According to a report issued by the government's own accounting institution, *Rigsrevisionen*, the minister had intervened to set prices for private providers delivering services for the public system at a level that was around 25% higher than necessary (Rigsrevisionen 2009). The surplus income comes not only from patients treated in the private sector under the free choice regulation, but also from another new development. In what is now a common situation, the regional health authorities purchase services from private providers even before the intervention of the patients' free choice.

In conclusion, the introduction of free choice in the Danish health care system was largely motivated by a dual ambition to shorten waiting time in public hospitals and expand the private health care sector. The reform has generally been successful in achieving both goals while at the same time disciplining public hospitals to increase production. The private health care industry may still amount to only a small proportion of the total health care system, but the mere existence of the private alternative creates competition that exerts great influence on the public system. Although patients have a free choice of hospitals only on relatively rare occasions, the

free choice reform still works in the sense that it pushes the public system to perform more efficiently in order to avoid economic sanctions. Yet, free choice and private competition may have given patients more, but not "more for less," as neoliberal arguments tend to promise. Total health care costs have roared in the past decade—in contrast with earlier very successful cost containment. Not all of the rise in health costs comes from activities performed in the private sector, because the mechanisms described above lead to higher health costs in the public system as well (Olesen 2010: 121).

United States: Medicare + Choice (1997)

The Cultural and Political Struggle Over Medicare

At the time of Medicare's passage in 1965, there was widespread agreement that the elderly were not being well-served—or even covered—by private health insurers, and that therefore, government should step in to make health insurance more available to them. The debates over what became Medicare pitted two conceptions of *how* government should step in to ensure access (Oberlander 2003a). One side, primarily conservatives, Republicans, southern Democrats, organized medicine and business wanted to preserve the private market. They proposed government subsidies to the elderly to help them purchase commercial policies. The other side, primarily liberals, non-southern Democrats and labor unions, believed the private market could not and would not adequately serve the elderly, and therefore, proposed a government-run, tax-financed public insurance program. In 1965, under a Democratically controlled House, Senate, and presidency (Lyndon Johnson), the liberal conception was written into law.

Although the public, social-insurance character of Medicare gained popularity and widespread political support, the ideological battle over it never subsided. Each time Republicans gained the upper hand in national government, new legislation tilted the program back towards the conservative vision of a competitive free market with government's role limited to helping beneficiaries purchase private commercial insurance (Oberlander 2003a and 2003b).

There were four key moments when the original 1965 legislation was modified to open Medicare to the private sector, each time by giving beneficiaries an element of free choice. First, in 1972, as part of a push to promote Health Maintenance Organizations (HMOs), the law was amended to allow Medicare beneficiaries to enroll in "federally qualified HMOs." However, the requirements for HMOs to qualify were so stringent that seven years later, only one had enrolled in Medicare (Oberlander 2003b: 1114-1115). The second moment came in 1982 with the Tax Equity and Fiscal Responsibility Act (TEFRA). In that law, policymakers loosened the requirements for insurance plans to serve Medicare, hoping to encourage greater participation. Enrollment in managed care plans grew slightly, but a decade later in 1993, it still stood at a paltry 5 percent of Medicare beneficiaries (Oberlander 2003b: 1115).

The third and most important legislative moment came in 1997, when legislators used the Balanced Budget Act to significantly widen access to the Medicare "market" for commercial insurance providers. The program was restructured so as to allow and encourage beneficiaries to choose among competing insurance plans, with the traditional Medicare fee-for-service plan still available. The new option to choose insurance plans other than traditional Medicare went by two names—"Part C" (because there were already parts A and B), and the somewhat jazzier, if geeky, marketing slogan, "Medicare + Choice," pronounced like an arithmetic problem, "medicare plus choice."

The debates leading up to the 1997 Balanced Budget Act revisited and rehearsed the earlier Medicare debates (Oberlander 2003b). This time, with Republicans controlling the House and Senate and a Democratic president (Bill Clinton) who had moved far to the right of Lyndon Johnson, the private market conception won out. But not completely. Conservatives had wanted to restrict Medicare to a voucher or "defined benefit," in which government would provide beneficiaries a fixed sum they could use to purchase insurance.[4] Even though Medicare + Choice uttterly failed to accomplish its objectives, the 1997 reforms are widely considered to be the turning point for Medicare, when its legislative framework changed from a purely public insurance program to a competitive market in which public insurance was only one option. For that reason, in our analysis we focus primarily on the 1997 Balanced Budget Act.

The fourth moment came in 2003, when President George W. Bush succeeded in getting Congress to pass the Medicare Modernization Act. Once again, the debates surrounding this legislation revived the earlier ideological arguments and policy visions. Bush originally wanted to transform the entire Medicare program into a federal contracting model, where the federal government would solicit bids from insurance companies and certify private plans from which beneficiaries could choose. The Bush administration had to back off major structural reform for all of Medicare, but built the contracting model into the new prescription drug benefit that was the centerpiece of the Modernization Act. Unlike hospital care and physicians' services, for which beneficiaries can still enroll in traditional Medicare, prescription drug coverage is available to Medicare enrollees *only* through private drug insurance plans that compete to be selected by beneficiaries (Blumenthal and Morone 2009, chap. 11). Beyond the unprecedented restriction of a public benefit to private insurers, the Medicare Modernization Act gave major financial concessions to industry groups, especially the pharmaceutical industry, which forced legislators to prohibit Medicare from negotiating prices with drug companies (Oberlander, 2012 forthcoming).

Cost Control: The Problem "Free Choice" is Meant to Fix

Each of the free-choice reforms passed in a political environment where cost growth was understood to be the major problem in health policy. Until the late

[4] This is the same idea that Representative Paul Ryan pushed so hard in 2011, and that Republicans are still pushing through the deficit/debt ceiling debates.

1960s, growth in medical expenditures had been perceived as a *good* thing, indicative of scientific and technological progress and increased social welfare. But in the first three years after Medicare and Medicaid passed, large increases in health spending generated cries of alarm. Public medical expenditures no longer dressed demurely in plain cotton statistical tables; now they rushed across the public stage in purple velvet adverbs: "staggering," "spiraling," "runaway," "chaotic" "galloping" and "crippling," to name a few (Hackey, forthcoming 2012, chap. 2). President Richard Nixon was the first to use the "cost crisis" metaphor in a speech in 1969 (Hackey 2012 forthcoming). Also in 1969, the chair of the Senate Finance Committee declared Medicare a "runaway program," (Oberlander 2003b: 1103). Soon, health policy discourse had converted medical care expenditure from a source of national satisfaction and pride into a "monster" that that was choking the public sector ("an unsustainable burden on the federal budget") and would soon devour the GNP (Oberlander 1112). Other versions of the crisis in the early 1990s cast health care as an impending "catastrophe," a system about to "collapse." President Bill Clinton, speaking in 1992, made health care costs Public Enemy Number One: "If we're not going to control health care costs, you can forget about controlling the deficit, forget about America being competitive in manufacturing, and forget about restoring our health" (Hackey, forthcoming 2012, chap. 2).

Milton Friedman, the intellectual father of neoliberalism, offered a diagnosis of the health policy problem that, predictably, traced it to the lack of competitive free markets among suppliers. In his 1962 book, *Capitalism and Freedom*, he proposed doing away with medical licensure, permitting anyone to sell their services as a healer, and allowing people to seek care from anyone they choose. Although Friedman's solution never gained traction in political discourse or public opinion, his larger lesson on the paramount efficiency of free markets came to dominate debates about health insurance—despite the obvious facts that competitive insurance plans were leaving ever more Americans uninsured.

Meanwhile, policy discourse was influenced almost to the point of capture by a man whose name is hardly known outside academia, Alain Enthoven (Enthoven 1980; Enthoven and Kronick, 1989a; 1989 b; 1991). Enthoven and his frequent co-author, Richard Kronick, diagnosed the cost problem as faulty incentives: "Our health care system has more incentives to spend than not to spend." The fee-for-service reimbursement system "pays providers for doing more, whether or not more is appropriate." Health insurance removes any incentive for consumers to be "cost conscious." And last, "free choice of provider insurance"—i.e. insurance plans that allow policyholders to use any doctor or hospital they want—"blocks cost-consciousness on the demand side by depriving the insurer of bargaining power." In other words, if patients can choose their providers, and if their insurers have to pay their claims, insurers can't bargain with providers *beforehand* for better rates (all quotes in this paragraph from Enthoven and Kronick 1991: 2532).

Enthoven's solution—the one conservatives persistently push for Medicare—was "a set of public policies and institutions designed to give everyone access to a subsidized but responsible choice of efficient, managed care (HMO, preferred provider insurance plans, etc.). . . .We propose *cost-conscious informed consumer* . . .

choice of managed care so that plans competing to serve such purchasers will have strong *incentives to give value for money*" (Enthoven and Kronick 1991: 2533, emphases added).

Free Choice as a Governing Technology

Enthoven's concept of consumers accords perfectly with Foucault's *homo economicus*—a person eminently manipulable by price signals in his environment. In almost Foucauldian language, Enthoven and Kronick wrote: "Presented with an opportunity to make an economically responsible choice, people will choose value for money." Further, *homo economicus'* psyche can be used as a technology of governing: "the dynamic created by these individual choices will give providers strong incentives to render high quality, economical care. *We believe providers will respond to these incentives*" (Enthoven and Kronick 1991: 2532, emphasis added).

The illusory nature of free choice becomes apparent when we examine the institutional forms it takes. Enthoven and Kronick acknowledged, "The market for health insurance does not naturally produce results that are fair or efficient. It is plagued by problems of biased risk selection, market segmentation, inadequate information, etc. In fact, *the market for health insurance cannot work at the individual level* (Enthoven and Kronick 1991: 2534, emphasis added)." Instead, large organizations such as employers or "public sponsors" (e.g. Medicare) "must act as intelligent, active, collective purchasing agents and manage a process of informed cost-conscious consumer choice of managed care plans . . ." p. 2534-35).

Here we come to a fundamental paradox: in this so-called "consumer choice" paradigm, individual free choice has disappeared, to be "managed" by "collective purchasing agents" who are more "intelligent" than individuals. Indeed, in each of the Medicare consumer choice reforms, the federal agency responsible for Medicare takes the role of "collective purchasing agent," setting forth criteria for insurance plans to participate, certifying plans, publicizing them to Medicare beneficiaries, and even, specifying criteria for how the plans must *publicize themselves* to beneficiaries.

Nevertheless, conservatives consistently sold the new privatized versions of Medicare with free choice rhetoric. The 1997 Balanced Budget Act packaged the new program in a brilliant rhetorical flourish. The title "Medicare + Choice" was an arithmetic formula any second-grader could interpret; the plus sign is the first mathematical symbol children learn. The plus sign was followed by the word "choice," as though traditional Medicare did not include any choice and the new program (as any seven-year old could tell) gave you more.

The rhetoric and practice of consumer choice disguises how much individual choices will be constrained the moment the beneficiary chooses a managed care plan. Managed care is *intended and designed* to restrict individuals' choices of providers, and in turn, to restrict providers' ability to supply services by limiting reimbursement. First, most of the new managed care plans limited their beneficiaries to a small network of doctors and hospitals under contract with their insurer, in contrast to the standard Medicare, where consumers had complete freedom to use almost any

doctor and hospital in the country. Second, in standard Medicare, patients do not need a primary care doctor referral to consult a specialist. In most managed care plans, they do, and one of the ways managed care plans control their costs is by restricting specialist consultations. Thus, if beneficiaries chose to enroll in a managed care insurance option, they *lost* some control over their choice of doctors and hospitals.

Third, among the types of managed care plans, some gave patients more freedom to use any provider inside or outside the insurer's network. However, plans that allowed patients to go "out of network" made them pay extra for the privilege. Relative to traditional Medicare, then, these "point of service" plans restricted choice of providers by *charging people for choice*—hardly an expansion of choice, and effectively a contraction for low-income beneficiaries.

Fourth, under Medicare + Choice, beneficiaries were allowed to switch their choice of plan only once a year, during a specified "open enrollment" plan. Under the previous 1982 TEFRA rules, enrollees in managed care plans could give notice at anytime, and it would take effect on the first of the next month. Relative to the old TEFRA rules, then, Medicare + Choice expanded the *kinds* of plans that Medicare enrollees could join, but limited their freedom to *change* plans. In some sense, the managed care options within Medicare are more of a trap than an opportunity, because once enrolled, beneficiaries are not allowed to switch plans for one year, until the next open enrollment period. "Free choice" is thus a choice with long duration—painfully long for patients who find that their plans refuse to authorize doctors, tests and treatments they would like to choose.

According to neoliberal theory, consumer choice initiates a chain reaction of beneficial behavioral responses and can therefore be used to govern other actors' behavior besides that of patients and consumers. Consumers choose insurance plans on the basis of good information about the plans' efficiency, that is, their ability to deliver better services at lowest cost. Medicare sets its payment rates to encourage insurance plans to behave efficiently—the more cost-conscious they are in paying for members' medical care, the more new members they will attract and the more profit they will make. Insurance plans use their revenues (Medicare payments on behalf of beneficiaries who choose each plan) as bargaining clout to recruit doctors and hospitals as providers, and importantly, to force providers to accept the insurers' oversight and rules.

In theory and in political rhetoric, the virtuous circle starts with patients. The system is "consumer driven." In practice, much of insurers', hospitals' and doctors' behavior has already been determined by Medicare policies and incentives, before (and after) patients make their choices. Once in managed care, patients have no clout over either their insurers or their providers. They're at the mercy of insurers' coverage decisions. The only way free choice can work as a disciplinary tool is if managed care plans *must* increase the quality and quantity of care patients receive in order to attract enrollees. But managed care plans can game the system so as to maximize their revenues *without* delivering better care, and once patients find out how restrictive managed care plans are, they are not free to leave until the next open enrollment period.

Growing the Private Sector

As in the Danish case, there are good reasons to think that free choice of insurance plans for Medicare beneficiaries was in large part a strategy for empowering and enriching the private sector. In the U.S., private insurers' main competitive strategy has always been cream-skimming—selecting healthy people as policy holders and refusing to insure sick and potentially high medical care users. Insurers write policies that exclude pre-existing conditions. They refuse to renew policies of people who develop major illnesses and disabilities. And they can find ways to deny payment for specific claims, especially, for new and costly treatments or tests (Stone 1993). Given this well-known history of the private health insurance industry, the idea that competition would drive insurers to deliver better services for less mone was shaky at best.

And indeed, notwithstanding all the rhetoric about how markets necessarily produce efficiency, legislators, lobbyists and other politicians who shaped Medicare's managed competition rules well understood how insurers could evade the pressures to deliver better care. Both the 1982 and the 1997 legislation included numerous prohibitions on risk-selection and cream-skimming. For example, in the 1982 TEFRA, HMOs were required to hold an open enrollment period of at least 30 days, and "must accept beneficiaries in the order in which they apply up to the limits of its capacity . . . ." So far, so good, but then came the loophole as a big as a barn door: ". . . unless to do so would lead to . . . an enrolled population unrepresentative of the population served by the HMO" (Congressional Research Service 1997: 51). HMOs could use the "unrepresentative" excuse to reject people, and who would know?

By 1997, insurers' risk selection had been highly publicized and labled as "discrimination." Several states were making laws and regulations to prohibit these practices. Not surprisingly, the Balanced Budget Act included much more specific non-discrimination requirements than TEFRA, but it included the same giant loophole. Insurance plans were not permitted to deny enrollment on the basis of physical and mental illnesses, medical history, past use of medical care, insurance claims experience, genetic testing information, or disability. However, "these provisions do not apply if they will result in enrollment substantially misrepresentative of the Medicare population in the service area" (Congressional Research Service 1997: 55). Plans were also forbidden to "disenroll" members on account of their health status or medical care use. That such prohibitions were even included in the law reveals that legislators knew the practices were occurring. For all the black ink, however, the escape-hatch phrase "unrepresentative of the population" and the difficulty of policing enrollment and disenrollment meant that the rules against cream-skimming were bound to be ineffectual.

Although managed care plans were technically prohibited from rejecting applicants on account of their health status, they still benefited from positive risk selection. They tended to draw healthier and younger beneficiaries, who didn't need much medical care and so could accept managed care restrictions. Managed care plans could design their marketing campaigns and benefit packages to attract healthier beneficiaries—for example, by offering discounts on fitness club memberships. In

plans sponsored by doctors, doctors could steer their healthier patients to join while counseling their sicker patients to stay in traditional medical care (Congressional Budget Office, 1997: 31). Hence, private insurers could use (or benefit from) cream-skimming to enhance profit without making much effort to provide quality care at lower cost.

Even before the Medicare + Choice provisions went into effect, the Congressional Budget Office and several other studies estimated that because of favorable risk selection, Medicare was paying at least 5 percent more for its enrollees in managed care plans than it would have paid had they remained in traditional fee-for-service Medicare (Congressional Budget Office 1997: 29; Weissman et al. 2005: 482). With this knowledge in hand, the Balanced Budget Act built in a key provision for adjusting payment according to the health risks of plan members ("health based risk adjustment"). Predictably, however, the managed care industry was able to delay its implementation for several years. When plans realized the government was serious about using risk adjustment to help Medicare save money, they lobbied hard against any risk adjustment, and many withdrew from Medicare and/or eliminated the extra benefits they had used to induce beneficiaries to join (Weissman et al. 2005: 488-91).

Medicare's payment formulas also dilute the disciplinary power of managed competition. Similar to the Danish payment system, the capitation (per beneficiary) payments often include increments for things besides medical care that traditional Medicare subsidizes—especially medical education, charity care, and contributions to care of low-income beneficiaries (Congressional Research Service 1997: 52). Many managed care plans don't provide these "extras," so the payment formulas give them bonuses that they don't need to earn by being efficient. Because rural areas were unattractive business environments for managed care plans and many rural areas lacked even one such plan, the payment rates for rural areas were set higher than rates for treating Medicare patients in the fee-for-service sector (Congressional Budget Office 1997: 29). Here, too, managed care companies had zero incentive to be more efficient.

We conclude the American case by posing the question, "Who governs whom?" As Jonathan Oberlander notes, by the mid-1990s when Medicare reform was up for debate, managed care had taken off in the private sector. By 1995, well over 150 million Americans were enrolled in some form of managed care (Oberlander 2003 b: 114). Numerous, well-capitalized managed care plans were now a powerful constituency for opening Medicare's coffers to the private sector, and a powerful lobby for ensuring that any new program rules would be highly favorable to them. In the face of insurers' ability to organize as trade associations, garner major corporate contributions to legislators' election campaigns, and influence the drafting of laws and regulations, neoliberalism's ideal type of market competition dissolves into a very different kind of struggle.

Two Worlds of Free Choice

Neoliberal ideas about competition, market and choice clearly influenced both the Danish and American health reforms. Now we ask, what lessons can be learned from the introduction of consumer choice in vastly different health systems? In this section, we compare the two countries' choice reforms on three key dimensions and draw some conclusions about the nature of neoliberal ideas in theory and practice. First, we compare how free choice was articulated as an instrumental solution to diametrically opposite problems. Second, we consider whether the free choice reforms did in fact "work." Did they solve the problems they were meant to address and did they change the way health was governed in a more efficient direction? Finally, we look in more detail at how both the meaning and exercise of free choice was constrained in both cases, often because there was an underlying ambiguity as to whether freedom is mainly an instrumental value or a value in itself.

Freedom is the Solution – What Was the Problem?

In both countries, the political impetus for free choice reform came not from consumers, citizens, patients, or anything that could be called grassroots or a social movement, but rather, from political elites. These elites presented free choice as "good for" citizens because choice enlarged their "rights" or "freedom," and because free choice would make the health care system more efficient and therefore provide citizens with more and better services. The top-down political origin of both reforms highlights the use of free choice rhetoric and reforms as governing technologies. In both countries, political elites used "free choice" as a political appeal to open up the public sector to private providers. "Free choice" served as a discursive sledgehammer to break health care monopolies—in Denmark, the monopoly of public hospitals, and in the United States, the federal government monopoly on insuring the elderly.

Both countries also introduced consumer choice reforms with the intention to solve specific problems in the public sector by opening its borders to the private sector. But here we note a striking difference. In Denmark, the problem was that demand continually exceeded supply and thereby generated unacceptable waiting times for treatment in public hospitals. The powerful image of the 'lethal waiting list' served to increase public support for using private hospitals to *expand the supply of health services*. By giving patients access to free choice when their home hospital could not deliver, the government was able to push public hospitals to produce more while at the same time giving business opportunities to the private sector.

In the United States, the problem was defined as excessive demand, some of it provider-induced. Policy makers therefore sought to *contract the supply of health services*, first, by limiting the range of providers available to beneficiaries, second, by moving large numbers of patients from fee-for-service to managed care plans, and third, by allowing private insurers to review and refuse to pay for physicians' recommended treatment.

Common to these two opposite objectives, expanding or contracting the supply of medical services, is the underlying principle that free choice was meant to *control the supply of health services*. In other words, free choice is really more about

controlling the health care sector than it is about giving patients rights or expanding individual freedom. Yet ironically (or cynically perhaps), elites sold free choice reforms by claiming to take citizens' side vis-à-vis the health system.

Governing Through Consumer Choice – Does it Work?

In both countries, policymakers aimed to restructure the incentives facing providers and make them act differently based on a new configuration of incentives. Both reforms were designed to harness the energy of consumer decision-making to put pressure on health care providers. In Denmark, patient freedom to use the exit option and the requirement that their home hospital must pay for their care wherever they received it combined into a strong financial incentive for hospital administrators to reduce their waiting times.

The U.S. Medicare program incorporated distinct financial incentives on different actors—beneficiaries, insurers, and health care providers. First, Medicare beneficiaries could theoretically gain more benefits at lower premiums by choosing a managed care option. Second, private insurers could make a financial profit from enrolling Medicare beneficiaries if they succeeded in being more efficient, that is, providing the required benefits at lower costs than fee-for-service providers in the Medicare program. And third, to the extent that beneficiaries chose and remained locked into managed care insurance options, managed care administrators could use their purchasing power to exert downward pressure on doctors' and hospitals' supply of services; in other words, Medicare enrollees' decisions could indirectly restrain doctors and hospitals.

This, at least, was the theory behind using free choice reforms as governing technologies in both countries. Did the reforms work as promised? The Danish reform did live up to its promise of shorter waiting times (Olesen 2010: 117), although the *perceived* reduction of waiting times by far exceeds the actual change. Waiting times had actually already dropped significantly before the reform, especially for life-threatening conditions, but the perception of a long waiting list remained intact. The 2002 reform replaced a messy picture of different waiting times for different procedures with a simple, guaranteed maximum of two months, which created the perception that the waiting list problem had been immediately solved.

In the U.S., the Medicare + Choice program did not live up to its promise, and in fact, was widely considered a political and policy disaster (Oberlander 2012, and personal communication 2011). In the first five years, more managed care plans *withdrew* from Medicare than joined. Many plans cut back their benefits rather than delivering enhanced benefits to Medicare enrollees. The number of Medicare beneficiaries choosing to enroll in Medicare plans declined, rather than growing as projected by reform advocates and government agencies (Oberlander 2003a: 194-5).

Both cases illustrate how program rules and payment formulas diluted the capacity free choice reforms to make insurers and providers more efficient. Payment formulas were often designed to be so lucrative that private insurers and providers had no need to be efficient in order to make a profit. In Denmark, the payment formulas did goose the public hospitals to be more efficient. However, when the pub-

lic and private sectors are considered as a whole, it's not clear whether the entirety is more efficient, because the free choice reform had no mechanism to control the efficiency of private hospitals. Of course, as neoliberal rhetoric goes, greater efficiency would be achieved through the market mechanism, but in a situation with a limited supply of private providers and systematic overpayment of them by public funds, these ideal market conditions were far from satisfied. Last, we should stress that while Danes did get quicker access to health care on average, this does not necessarily indicate higher efficiency if overall health costs rise at the same time. It was not "more for less," but "more for more," so to speak, which raises a critical question: could waiting times have been reduced simply by increasing funds to the public system?

In the United States, despite the failure of Medicare + Choice, advocates of free market competition never gave up. To attract private insurers to participate, the authors of the 2003 Medicare Modernization Act, with the help of industry lobbyists, wrote payment formulas that often paid managed care plans *more* than the cost of providing care to beneficiaries in the traditional fee-for-service plan. In 2006, only three years later, Medicare was paying 12 percent more to private plans than it cost to cover them in traditional Medicare—compared to the 5 percent excess cost for managed care that obtained pre-1997 (Oberlander 2012).

Scholars of neoliberalism have tended to emphasize either the goal of increasing free markets and private enterprise, or the goal of governing individual and organizational behavior. Our study illuminates how the two goals sometimes work against each other. In both countries, concessions and policy rules meant to strengthen the private sector actually weakened or undermined the effectiveness of consumer choice as a disciplinary tool.

The Ambiguity of Freedom

Political ideals are always ambiguous and politics always involves struggles over competing interpretations. In neoliberalism, freedom has multiple meanings and plays dual roles as both means and ends.

First, there is the issue who actually gets more freedom from free choice policies, and what kinds of freedom do they get? In Denmark, the 2002 free choice reform definitely expanded patients' range of choices among various providers, albeit only for the limited group of citizens whose waiting time at their home hospital for non-acute care exceeded the guaranteed maximum. The expanded freedom was real, but highly conditional. On the other hand, if hospitals were able to provide services within the guaranteed waiting time, patients gained no freedom to use a private hospital.[5]

In the United States, the new consumer choice model arguably *constrained* Medicare beneficiaries' range of choices for the things most people care about—which doctors and hospitals they use, and what tests and treatments they can

[5] A patient can always use the original (1993) free choice among *public* hospitals, but despite fewer conditions, this type of free choice has never been used to a large extent.

have through their insurance. The only choice added in "Medicare + Choice" was a choice of insurance plans, and that choice was limited to plans certified by Medicare. Once beneficiaries chose a managed care plan, those plans would likely limit their choices of doctors, hospitals, tests and treatments compared with the traditional Medicare plan.

One lesson of this comparison, then, is that what type of freedom "free choice" policies create depends on the type of insurance system into which "free choice" is introduced. In a national health insurance system like Denmark's, where everyone has free and equal access to health care and is subject to the same rules, giving citizens a choice of *providers* enhances their control over their actual medical care. The Danish free choice reform does not compromise free and equal access, at least in the short run. In the long run, because the reform contributed to creating a larger private sector, and because other reforms stimulated the growth of private supplementary insurance, the free choice ideal will probably generate greater inequality of access and less freedom of choice for some citizens than others. In a system without universal and fairly homogeneous insurance, as in the United States, consumer choice of *insurance plans* only widens differences in access to medical care and can often constrain patients' choices. Free choice in a system with unequal access can lead to more inequality.

Another question arising from our study is how much advocates of consumer choice care about choice as an intrinsic value versus how much they regard it as an instrument to reach certain governmental goals. Proponents of free choice often argue that freedom "*is* good" and "*does* good" at the same time. For the most part, Danish policymakers stressed the instrumental value, where free choice was introduced to solve the problem of waiting times, although it is clear from Fogh Rasmussen's ideas about cultural struggle that he also sees freedom of choice as an intrinsic value, an appreciation for which he hopes to cultivate in Danes.

In the United States, policymakers stressed both the instrumental and intrinsic value of free choice. They emphasized how free choice reforms would give patients incentives to restrain their purchase of medical care, and thereby restrain the total cost of care on the government's budget. Advocates also sold free choice politically as an end in itself, emphasizing that people have a right to participate in markets and make their own decisions. Yet, for all the ideological commitment of Medicare free-choice advocates to the *idea* of consumer freedom, the *policies* they put in place clearly restricted consumers' choices in several ways. It is hard not to speculate that the rhetoric of free choice was also a political cover that enabled legislators to vote for these reforms without losing the votes of elderly constituents, who understood that traditional Medicare gave them greater freedom to control their medical care.

Perhaps the ambiguity between freedom as an instrumental or intrinsic value is one of the reasons why neoliberal ideas and technologies are able to integrate themselves into a wide range of policy sectors across a wide range of political systems facing a wide range of different problems. Our guess is that the success of neoliberal ideas in penetrating the heartland of the welfare state – access to health care – is partly due to this polymorphous character of freedom of choice. It can serve as a universal fix to whatever problems a system is experiencing and offer citizens "more"

of everything. It can take away substantive benefits and freedoms, while playing on the high note of empowering the individual.

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