

Risks and Benefits of Comparative Studies: Notes from Another Shore

RUDOLF KLEIN

University of Bath, England

ONE OF THE CHARACTERISTICS OF THE *MILBANK Quarterly* under the editorship of David Willis was its intellectual cosmopolitanism. On the one hand, Europeans like myself were given an opportunity to display their wares to an American audience, once we had survived the ordeal of being edited more rigorously and more intensely than ever before. For being edited by David Willis *was* an ordeal, one that left the author feeling both exhausted and exhilarated. No one has ever been more intolerant, surely, of either intellectual or verbal sloppiness; no one, too, has had such a willingness to invest his own time and ideas in improving other people's work; no one could be so inexorably and innocently exasperating, yet leave his authors with a sense of total gratitude. On the other hand, the *Quarterly* has consistently, over the years of his editorship, put the issues of American health care into an international context. In doing so, it has provided its readers with an antidote to the dangers of ethnocentric overexplanation: the temptation to explain all the health care problems of one's country in terms of its own very special institutions and circumstances. It has thereby illuminated the question of what is—and is not—so very special about the United States, and delineated more precisely the nature and limits of American exceptionalism.

For if we are to understand what is special to the United States, or

any other country, there is no alternative to adopting a comparative approach. In what follows, I shall therefore elaborate on this theme, without in any sense attempting to review the field or the literature comprehensively. This has been done elsewhere (Atteveld, Broeders, and Lapré 1987). Nor shall I analyze the advantages and disadvantages of different strategies of comparison, a topic that has already received ample attention (Marmor 1983). Instead, I shall concentrate on a sub-species of comparative studies: the literature generated by the enduring fascination with each other's systems demonstrated by American and British students of health care over the decades. It is, in a sense, a perverse intellectual love affair. No two countries could be more different in terms of their geography, wealth, and political institutions; only a common language unites them, creating the illusion that understanding words must necessarily lead to comprehension of meaning. In what follows, I shall therefore reflect on this experience, before drawing out some general implications for comparative studies—and concluding, however tentatively, with some speculations about convergence in policy outcomes.

A One-Way Traffic in Ideas?

In the 1950s when Britain was beginning to realize that it was no longer an imperial or world power, the Prime Minister—Harold Macmillan—described its future role as being Greece to America's Rome. By this he meant, buttering up the national ego, that Britain would provide the intellectual drive, while the United States would supply the brute power. In fact, as the health services literature confirms, things have turned out rather differently. Perhaps the most significant aspect of the trans-Atlantic traffic in ideas is also the most simple and obvious: there is an intellectual imbalance of trade in favor of the United States, with Britain running a large deficit. A series of American scholars have, over the decades, made a remarkable contribution to our understanding of the origins and dynamics of Britain's National Health Service (NHS) (among them Eckstein 1958, 1960; Fox 1986; Marmor and Thomas 1972) as well as illuminating specific policy issues and options (Enthoven 1985; Fox 1978). There is no similar reciprocal literature of British scholars writing about the United States. Both quantitatively and

qualitatively, the health care literature on the two countries speaks with a strong American accent.

Perhaps this is neither surprising nor significant. The imbalance could well be a function of the difference in the size and resources of the two academic communities. Much the same comment could, in all probability, be made about most other areas of scholarship. If comparative studies in all fields are, in part at least, the product of academic tourism, it is not after all astonishing that publications reflect the general scale and direction of the tourist trade. Add linguistic accessibility as an additional factor drawing American scholars to Britain, and it may be that further reflection on the imbalance in trade is redundant. The health care literature may simply be one more example of American dominance in the international marketplace of intellectual goods and cultural phenomena.

The puzzle revives, however, if we take account of the content of the literature. The authors I have mentioned contributed to an understanding of the British situation precisely because they were driven chiefly by disciplinary curiosity, by a desire to comprehend the dynamics of health care systems. Yet, in other cases, the driving force—as in so much of the comparative literature—was not so much the desire for understanding, but rather the search for arguments to use in domestic policy debates. In other words, the British experience was viewed as a laboratory for experimenting with a particular formula for financing and organizing health care, from which it would be possible to draw lessons for the United States about the applicability or otherwise of the model being tried out.

The “what can we learn from Britain’s experience” literature produced some distinguished work, but its focus shifted in line with the domestic concerns of the United States. If one knew nothing about the evolving U.S. debate on health care, it would be possible to reconstruct it to a large degree by looking at what American scholars were writing about the National Health Service in different epochs, always allowing for the lag between research and publication. Thus, in the still optimistic early 1970s, when radical reform of the American health care system seemed a distinct possibility, the focus was on the achievement of equity in Britain (Anderson 1972). In the pessimistic 1980s, when the American obsession was with cost containment above all other issues, the interest in the NHS shifted to its ability to ration scarce resources

(Aaron and Schwartz 1984). When planning and consumerism were on the U.S. agenda in the 1970s, these were the issues that interested American scholars working in Britain (Rodwin 1984). When attention shifted to such problems as malpractice suits and defensive medicine, again they were the topics that brought American scholars across the Atlantic (Rosenthal 1987). Similarly, the growing interest in health promotion in the 1980s produced an Anglo-American comparative study (Leichter 1991). In many of the studies cited, Britain was paired with Sweden, logically enough given that the two countries have the same model of universal, tax-financed health care, if with significant variations in the organization of the delivery system.

The interest in the NHS was, however, not just driven by an intellectual desire to seek illumination in the search for solutions to America's health care problems. It was also impelled by a determination to find political texts for sermons, that is, to use the experience of the NHS as evidence that particular solutions would or would not work in the United States. The resulting literature would suggest that selective perception is the original sin of comparative studies. For those in the United States who opposed anything remotely resembling "socialized medicine," Britain's waiting lists could be held out as dire warning of things to come if America moved in the direction of a national health service. In particular, the NHS provided a rich text for public choice economists, eager to demonstrate the dangers inherent in state bureaucracies: it meant, they argued, an underfinanced system employing underpaid doctors in undercapitalized hospitals (Buchanan 1965; Lindsay 1980). Conversely, those pushing for some system of national insurance in the United States tended to fasten on to the NHS's successes—notably its ability to provide a universal service with reasonable equity and remarkable parsimony—as evidence of the advantages of such a system. Both views caught important insights, if at times also perpetuating myths (British doctors, for example, are not underpaid by local standards). Neither interpretation caught the complex reality.

Looking at the much sparser British literature on the United States, there is no such neat symmetry. American experience provides a simple text. It demonstrates the dreadfulness of leaving health care to the marketplace and thus, by implication, underlines Britain's triumphant good sense in creating the NHS. America's failure was thus taken as proof of Britain's success: a conclusion flattering to national self-esteem, if somewhat lacking in logic. The classic, and best known, text

expounding this view is, of course, Titmuss's *The Gift Relationship* (1970): an eloquent disquisition on the advantages of a health care system based on altruism and mutual help, freely given, over one where financial considerations corrupt even the blood supply. It was a book that had, and continues to have, considerable resonance in Britain, despite evidence that its analysis of the American situation is in many respects inaccurate and misleading (Drake, Finkelstein, and Sapolsky 1982): a reminder, once again, that much of the comparative literature represents a search for evidence that will bolster stereotypes resistant to both argument and evidence. The point would emerge even more strongly from any more general analysis of the British health care literature, let alone political debate. The evocation of American experience is used to make the flesh creep. The assumption is that any development that can be presented as an invasion of American ideas or practices will automatically be rejected with horror. Indeed, as I will discuss below, this was very much the reaction in the 1980s when American ideas were filtering through, albeit selectively, and even influencing government policy. American ideas were widely perceived as tainted by their source, rooted as they were in a health care system that excluded the poor and revolved around the profit motive.

What conclusions, if any, can we draw from this rather brutal and summary review of the Anglo-American comparative literature? It is, of course, a caricature, and meant as such. It leaves out many valuable studies that have examined details of the two systems. However, it does indicate, I think, that comparative studies can distort as well as illuminate; that they bring risks as well as benefits. The fault line does not run simply between discipline- or curiosity-driven and policy-concern-driven studies. There is no inherent reason why an interest in policy issues—or even a strong bias toward a preferred policy solution—should necessarily lead to selective perceptions, and there are plenty of scholarly studies to prove the point. However, it is clear that the temptations are stronger in the latter case; so is susceptibility to the occupational disease of comparativists, which is a highly developed capacity to find what they were looking for.

This is not to argue against comparative studies; far from it. Comparisons are essential if one is to achieve an understanding of one's own national health care system. Logically, as argued at the start, it is impossible to make a statement about cause and effect within a national system without checking it out against the experience of another coun-

try. So, for example, it could be said—looking only at Britain—that rationing is the inevitable price to be paid for a parsimonious national health care service operating with a capped budget. If I then look at the United States, however, I would discover that rationing is also apparent there—albeit in a different form, by exclusion from the system of coverage—even though there is no national health service, no capped budget, and spending levels are twice as high as in Britain. I might therefore be tempted to conclude that rationing is inevitable in all health care systems—a conclusion that, however, then requires to be tested against the experience of yet more countries. The necessity of comparative studies therefore hardly needs laboring. What my perhaps somewhat mischievous caricature of the Anglo-American comparative literature suggests, however, is that we should pay more attention to those characteristics of comparative studies calculated to enhance understanding, as distinct from buttressing preconceived notions. These are twofold, as I shall argue in the next section. First, comparative studies have to be explicit about the criteria being used: the spheres of analysis, as it were. Second, analysis has to be anchored in an understanding of the specific historical origins of national institutions, and of their economic, social, and political context.

Spheres of Analysis

If one of the driving forces behind comparative studies is the attempt to understand the advantages and disadvantages of different systems—perhaps even to devise, with the aid of intellectual and institutional transplants, the perfect health system—then it is clearly crucial to have clearly defined and agreed currency of evaluation. The point is so obvious that it would scarcely require mention were it not for the fact that it is usually ignored. In a sense, we take our criteria of evaluation for granted most of the time. They can probably be summed up in terms of the three *Es*: equity, economy, and effectiveness. These are the kind of generally accepted, common-sense, assumptions that seem to underlie much of the comparative literature, with only a rarely felt need to make them explicit—and, by making them explicit, set them out for critical scrutiny of what they mean, and how they are interrelated.

Yet, to take the last point first, it is clear, from even the most superficial run through the comparative literature, that the relative weight

attached to the three criteria has shifted over time, and appears to be strongly related to changes in the economic and political environment. As already noted, the comparative literature of the 1960s and the early 1970s was largely shaped by a concern about equity, with strong emphasis on comprehensive coverage of the population and the rational planning of services as necessary (if not sufficient) conditions. It was a literature that accurately reflected the optimistic assumptions of an era in which continued economic growth was taken for granted in the Western world—and with it, the continued expansion of the welfare state. Conversely, the decade of economic turmoil that followed the oil shock to the world economy in the mid-1970s led to a rather different focus, reflecting the more pessimistic (or realistic, depending on one's point of view) assumptions about likely economy growth and the role of the welfare state. The emphasis was very much on comparing the performance of different health care systems in terms of their ability to contain costs.

In this, the role of the Organisation for Economic Co-operation and Development (OECD) is of particular interest. As part of its more general interest in economic management and public expenditure, OECD published a series of comparative analyses of health care systems (OECD 1977, 1985, 1987), which not only helped to set the terms of debate, by focusing on cost-containment issues, but also encouraged scholars generally to use its currency of evaluation by supplying the necessary statistics. All scholars interested in comparative health studies are deeply indebted to OECD for its heroic efforts in pulling together disparate national data and providing accessible and (reasonably) accurate time series. OECD data have informed countless comparative studies and policy arguments (see, e.g., Maxwell 1981 and Pfaff 1990). However, by generating these data OECD was, of course, also subtly helping to shape the nature of comparative inquiries by focusing on health inputs: spending levels, the number of beds, manpower figures, and so on. This is not to imply deliberate intent or to suggest that a conspiracy of economists and statisticians were trying to dictate the terms of comparative studies. There was no need for a conspiracy. The economic stringencies of the period were, in any case, leading to an inflation in the influence of economists in the field of health care research (Fox 1990). Rather, it is to argue that the focus and methods of those engaged in comparative studies are inevitably influenced by the nature of the available data. It is a general point: witness the epidemic use of public ex-

penditure statistics in the comparative literature on the development of the welfare state (such data have the further advantage, apart from their easy availability, of not requiring the chore of learning foreign languages). It applies with special force, however, to comparative health care studies, perhaps because of the famine of other data, notably about the impact of different types of health care systems on the populations being served.

It is a gap that the OECD reports have recognized from the start. Indeed successive reports have attempted ever more strenuously to fill it, particularly in the late 1980s when the emphasis switched from economy to effectiveness. Thus, the latest report (OECD 1990) reviews evidence on international differences in medical care practices and in health service utilization. Yet, in doing so, it underlines the problematic nature of the comparative task. In part this springs from the sketchiness of much of the data, and the difficulty (and expense) of generating comparable cross-country information. The most ambitious attempt to do so on the basis of population surveys in seven countries (Kohn and White 1976) remains a monument to the dangers and frustrations of the enterprise. It has never made the contribution to the comparative health care debate that might have been expected from its scale, cost, and sophistication, largely, I suspect, because the complexity of the data defies easy comprehension and yields few direct policy conclusions. There are, of course, more successful examples of international information collection (i.e., Glaser 1970 and 1978). In any case, the real difficulty of comparison may derive less from the inadequacy of information than from the deficiencies in our conceptual framework for using and evaluating it, to return to my argument at the start of this section.

Consider the 1990 OECD report, which seeks to pull together a variety of evidence from different sources. This suggests, for example, that the United States has (by international standards) a poor record in the birth control of technological innovation. Similarly, it shows that the American rate for certain procedures, notably hysterectomy, is far above most other Western countries—although Canada and New Zealand are not far behind. Conversely, it demonstrates that, predictably, Britain tends to come out at the parsimonious end of the spectrum. All of this simply confirms that a country that spends twice as much as another is likely to provide rather more in the way of medical activity. How much of that extra activity is superfluous, in the sense of yielding no benefit

to the patient, is a different question to which we have no satisfactory or complete answer. We do know (because we have the appropriate statistics) that there is little link between health service spending and mortality; we do not, however, know (because we lack the relevant statistics) whether different levels or patterns of spending affect the quality of life of the population concerned—although this may be a much more important criterion. Indeed we do not even know the extent to which particular phenomena or outcomes are inherent to specific health care systems in a causal sense. Wide variations in practice *within* the United States—and other countries, even Britain (Ham 1988)—suggest that it is all too easy to be overly deterministic in assuming that system characteristics are necessarily the decisive factors. The fact that large variations in practice patterns seem to be general across health care systems might suggest that other factors—such as the culture of the medical profession and the uncertain nature of medical knowledge—are equally important. This is to come back, once more, to one of the most valuable functions of comparative studies, which is to guard against ethnocentrism in explanation by identifying similarities in different systems (Fox 1986; Marmor and Thomas 1972).

To sum up the argument so far, the source of the confusion (in which we all share) is that much comparative health care research is data rather than question driven. This may well be the inevitable result of the costs of collecting comparable data in different countries; of necessity we are forced to make the best of what is available, even though the information is usually generated by national concerns and by specific disciplinary or clinical interests, rather than asking what we would need to know in order to answer specific questions. Hence, the difficulty of comparing different systems in terms of all three dimensions—economy, equity, and effectiveness—and exploring the relationships and tradeoffs among them. The assumption of the 1990s seems, increasingly, to be that assuring effectiveness—by eliminating unnecessary, redundant, or low-yield forms of treatment—is a necessary condition for reconciling the demands of economy and equity. The question remains, is it a sufficient condition, in the absence of full knowledge about which medical interventions are actually effective?

Moreover, when moving into the learning or prescriptive mode of comparison, does it make sense to compare health care systems in isolation from the societies that have created them? How transferable is experience? There is, for example, some evidence that political support

for state welfare programs, including health, depends in large measure on the extent to which the middle classes benefit from them (Baldwin 1990; Goodin and Le Grand 1987). This, in turn, implies that some degree of inequity may be a necessary condition if national health care systems are to flourish: if the system is perceived to be mainly redistributive, it may lack political support—although the extent to which this limiting condition applies will vary in different political systems. Thus, Sweden has a higher tolerance of explicit redistributive policies than, say, the United States.

In the next section, therefore, I will address the question of the extent to which it is useful to compare health care systems without also comparing the way they have been shaped, over the decades, by their political, social, and economic environments. Such understanding, it is argued, is a necessary condition for the transfer of experience or ideas. In other words, the two modes of comparative studies—those of understanding and of prescription—may be complementary rather than antithetical. If prescription does not rest on the kind of research produced by discipline- or curiosity-led research, then it is likely to offer quack remedies.

Learning from What Experience?

At this stage in the argument it may be useful to return to the starting point of this paper: the American fascination with Britain's National Health Service. While proposals for a comprehensive system of national health insurance were still on the political agenda in the United States, in the 1960s and early 1970s, there was a steady procession of scholars, health professionals, and politicians who came to inspect the NHS as a possible model for imitation; in their wake they brought their opponents, who came in search of evidence to use against the import of the British system. Both parties seemed, however, to share the view that the British model was in some sense exportable. From the British perspective, this always seemed a puzzling assumption. Indeed, it seemed positively perverse for Americans to be looking for inspiration for reform in a country that differed so radically in a number of highly relevant respects.

The NHS, like the British welfare state generally, is the product of

a tradition of bureaucratic paternalism and a monument to professional rationality (Fox 1986; Klein 1983). It is a tradition going back to Chadwick's 1834 Poor Law Report, which was nurtured by the Webbs and which informed many of the post-1945 reforms. It is the product, moreover, of what, until recently at least, has been a homogeneous society—divided by class rather than by race—and of a highly centralized political system in which governments are virtually guaranteed automatic majorities for their policies in parliament. Britain, too, is a small country—it would fit into California with something left to spare—where it has always appeared to make sense to talk about national policies, national standards, and national services, although in recent years the Scots have increasingly begun to question this inherited piece of wisdom. Thus, long before we begin to examine the institutional characteristics of the NHS, it should be obvious that its foundations rest on peculiarly British soil. Even if the institutions could be exported, the soil could not.

Yet in practice the NHS has always depended on—and exploited—an inherited legacy of attitudes, and it may well be that it is the gradual depletion of this legacy that accounts for the growing sense of crisis and the search for new solutions in the 1980s (Day and Klein 1989). The point hardly needs laboring. One of the triumphs of the NHS, it is conventionally held, is that it manages to provide a comprehensive service both reasonably equitably and extremely parsimoniously. What is much more rarely recognized is the extent to which this achievement depends on the public's acceptance of the medical profession's definition of needs: political decisions about resources are, in effect, disguised as clinical decisions. In return for conceding an extraordinary degree of clinical autonomy to the medical profession, the state in fact delegated to it the responsibility for rationing—and thus made it socially acceptable. It is precisely this implicit contract or bargain that is now in question, given the recent changes in the NHS introduced by the Conservative government (Klein 1990). In turn, the public's acceptance of rationing decisions by doctors may well reflect deep-rooted attitudes of deference to professional expertise. These, however, are gradually being dissipated: witness the semantic revolution in public debate that is transforming patients (those to whom things are done, essentially a passive concept) into consumers (those who go out to buy things for themselves, essentially an active concept). To the extent that Britain is

becoming more like the United States, so in fact there may be scope for convergence, a point to which we shall return in the next and final section.

Even this short, and overly simple, account should underline the importance of putting health care institutions into their context: the exportability of systems (or parts of them) depends crucially on the comparability of the societies concerned. Note the emphasis on the comparability of the societies, rather than of the health care institutions themselves. By the 1980s it was becoming clear that the United States was unlikely to adopt anything like a national health service, that Britain's NHS offered an inadequate and implausible model. Attention in the American comparative literature switched to Germany (e.g., Light 1985; Wysong and Abel 1990) and Canada (e.g., Barer, Evans, and Labelle 1988; Marmor and Mashaw 1990) as possible models: countries with a federal political system, pluralistic health care systems based on insurance and fee-for-service payments to physicians that yet manage to contain costs. Indeed, these offer far more plausible models than Britain's NHS. It is still worth noting, however, the political limitations on their possible import into the United States. Consider, in particular, the case of Germany. Its example may appear particularly seductive in American eyes because of its success in containing spending. Yet this success depends less on the finance and organization of the health care system (precisely those characteristics that might, in theory, be transferable) than on the willingness of the medical profession to administer the cost-containment policies themselves (Iglehart 1991a,b). It draws on a century-old tradition of corporative policy making in Germany (Stone 1980) that is quite incompatible with America's political culture and institutions (Morone 1990), and is thus not exportable.

All of this would suggest that comparative studies should not be in the export-import business—selling ready-to-install models—but that they can extend national ideas about what is possible. They may be at their most useful when they prompt questions about how a particular approach to health care organization or finance could be translated, conceptually and practically, into a different context. The point is neatly illustrated by the transformation in the Anglo-American traffic in ideas that took place in the 1980s. From having been virtually a one-way stream of traffic in the previous decades, this became very much more of a two-way flow, with American ideas actually influencing British policy. On the face of it, this was a perverse and paradoxical devel-

opment: the most successful health care system in the advanced industrial countries (at least in terms of economy, and perhaps also equity) importing ideas from the least successful. In conclusion, therefore, we briefly examine this reversal in the intellectual terms of trade in order to explore its implications.

Reversing the Roles

When in 1989 Mrs. Thatcher's government announced sweeping changes in the NHS, based on the notion of creating an internal market and introducing general practitioners in the role of budget holders (Day and Klein 1989), the predominant reaction was one of outrage and horror. Not only was the very idea of introducing competition into the NHS sacrilegious: an insult, as it were, to the memory of the founding fathers and their faith. Perhaps worse still, it was American in origin, and there was no shortage of American scholars to point out that competition had not been very successful in solving America's own health care problems (Light 1990). Britain seemed about to become a case study in the folly of learning too eagerly and too naively from the experience of other countries: a warning against importing foreign ideas.

In the event, it seems set to become a case study of a very different kind—of the sea change that ideas may undergo while crossing the Atlantic, and the way in which they develop in a new kind of habitat. For the direct influence of American ideas about the organization of the national health care system was limited. True, the notion of an internal market clearly reflected the proposals by Enthoven (1985) in a much discussed analysis of the British situation. However, the reason why the idea of competition found resonance was that it fitted neatly into the ideology of the government and followed the logic of the diagnosis made by the policy makers themselves. This ran along the following lines. The NHS had proved its worth. It ensured financial control and enjoyed great political popularity. However, there was a rising demand (largely orchestrated by the medical profession) for extra funds. If this was to be resisted, as it was by a government anxious to limit the rise in public spending, then something had to be done to squeeze more productivity out of the system. Moreover, the NHS was notoriously insensitive to consumer demands. Again, then, something had to be

done—within the existing framework—to compel providers to take more heed of consumer preferences.

The logic of this line of reasoning led to the interest in competition—among both hospitals and general practitioners—as a way of introducing incentives to efficiency and responsiveness into an overrigid, provider-dominated system, a line of reasoning that Sweden now appears to be following as well (Saltman 1990). Moreover, the government had already applied much the same kind of logic to the education system several years before the NHS reforms; school budgets now depend on the number of pupils they can attract.

If the government wanted to look for tools to improve efficiency, where better to look than the United States? The NHS had been largely able to ignore questions of microefficiency for 40 years precisely because of its success in controlling total costs. It was parsimoniously effective in general, even though wasteful in detail. Conversely, the United States had desperately searched for ways of promoting microefficiency in the doomed hope that this would control total costs. It was wasteful in total even though striving for efficiency in detail. In the process, however, the United States had developed information systems, review processes, and managerial skills whose sophistication and quality dazzled the British visitors who, increasingly through the 1980s, flocked to America in search of tools and ideas.

The paradox is, then, perhaps not as perverse as it may seem. Competition in the British context will have a very different meaning from what it has in its country of origin. It will be limited in scale and scope. It will, above all, be contained within a rigid framework of regulation and financial control. It will therefore serve mainly to provide incentives to individual producer units and to give greater transparency to what the NHS actually does. The main result of the internal market so far has been to give visibility to the great inequalities in both performance and pricing of health authorities. There has not been a transplant of American policies; rather, some ideas from America have become naturalized and, in taking out British citizenship, have adapted to and become absorbed in the native health care culture.

Just conceivably, a similar process may be taking place in the United States. The United States appears to be moving hesitantly and falteringly toward embracing the key principle of the NHS, and indeed of all health care systems that have been successful in controlling their costs: a central, capped budget. This is the theme that appears to be

emerging increasingly from the babble of competing proposals that, even from across the Atlantic, now suggests that health care reform is back on the U.S. political agenda. There are many variations of this theme (e.g., Aaron 1991; Marmor and Mashaw 1990), but widespread agreement on the need for a single payer. The United States may thus be moving toward adopting a framework of financial regulation within which competition can flourish, just as Britain has introduced an element of competition within the already existing framework of regulation. The U.S. system of regulation will be very different from Britain's, just as competition means something very different in the context of the NHS. However, there may be convergence—not so much in the institutions as in the ideas that shape those institutions—for which those engaged in comparative studies can, perhaps, take at least some of the credit.

Having reached this speculative conclusion, I can just imagine David Willis taking on the editorial role. An interesting argument, he might gently suggest, but where is the evidence? For every assertion made, could not some counterassertion be found in the literature? Had you quite made up your mind, he might even ask, whether you were attempting to write a polemical essay or a scholarly review of the field? Several drafts later, there would emerge an exhausted author and a much more coherent article. Thus, this paper's most lasting contribution to the literature on health care may be as a demonstration of what happens when David Willis is not around to do the editing.

References

- Aaron, H.J. 1991. *Serious and Unstable Condition*. Washington: Brookings Institution.
- Aaron, H.J., and W.B. Schwartz. 1984. *The Painful Prescription*. Washington: Brookings Institution.
- Anderson, O.W. 1972. *Health Care: Can there be Equity?* New York: John Wiley.
- Atteveld, van L., C. Broeders, and R. Lapré. 1987. International Comparative Research in Health Care. A Study of the Literature. *Health Policy* 8:105–36.
- Baldwin, P. 1990. *The Politics of Social Solidarity*. Cambridge: Cambridge University Press.
- Barer, L.M., R.G. Evans, and R.J. Labelle. 1988. Fee Controls as Cost

- Control: Tales from the Frozen North. *Milbank Quarterly* 66(1):1-64.
- Buchanan, J.M. 1965. *The Inconsistencies of the National Health Service*. London: Institute of Economic Affairs.
- Day, P., and R. Klein. 1989. The Politics of Modernization: Britain's National Health Service in the 1980s. *Milbank Quarterly* 67(1):1-33.
- Drake, A.W., S.N. Finkelstein, and H.M. Sapolsky. 1982. *The American Blood Supply*. Cambridge, Mass.: MIT Press.
- Eckstein, H. 1958. *The English Health Service*. Cambridge, Mass.: Harvard University Press.
- . 1960. *Pressure Group Politics*. London: Allen & Unwin.
- Enthoven, A.C. 1985. Reflections on the Management of the National Health Service. London: Nuffield Provincial Hospitals Trust.
- Fox, D.M. 1986. *Health Policies and Health Politics*. Princeton, N.J.: Princeton University Press.
- . 1990. Health Policy and the Politics of Research in the United States. *Journal of Health Politics, Policy and Law* 15(3): 481-99.
- Fox, P.D. 1978. Managing Health Resources: English style. In *By Guess or by What?*, ed. G. McLachlan. London: Nuffield Provincial Hospitals Trust.
- Glaser, W.A. 1970. *Paying the Doctor*. Baltimore: Johns Hopkins University Press.
- . 1978. *Health Insurance Bargaining*. New York: John Wiley.
- Goodin, R.E., and J. Le Grand. 1987. *Not Only the Poor*. London: Allen & Unwin.
- Ham, C. Ed. 1988. *Health Care Variations*. London: King's Fund Institute.
- Iglehart, J. 1991a. Germany's Health Care System: Part 1. *New England Journal of Medicine* 324(7):503-8.
- . 1991b. Germany's Health Care System: Part 2. *New England Journal of Medicine* 324(24):1750-6.
- Klein, R. 1983. *The Politics of the National Health Service*. London: Longman.
- . 1990. The Political Price of Successful Cost Containment. In *Health Care in the '90s: A Global View of Delivery and Financing*. Los Angeles, Calif.: Blue Cross of California.
- Kohn, R., and K.L. White. 1976. *Health Care: An International Study*. London: Oxford University Press.
- Leichter, H.M. 1991. *Free to Be Foolish*. Princeton, N.J.: Princeton University Press.

- Light, D.W. 1985. Values and Structure in the German Health Care Systems. *Milbank Memorial Fund Quarterly/Health and Society* 63(4):615-47.
- . 1990. Learning from Their Mistakes? *Health Service Journal* 100(5221):1470-2.
- Lindsay, C.M. 1980. *National Health Issues: The British Experience*. Santa Monica, Calif.: Hoffman-LaRoche.
- Marmor, T.R. 1983. *Political Analysis and American Medical Care*. Cambridge: Cambridge University Press.
- Marmor, T.R., and D. Thomas. 1972. Doctors, Politics and Pay Disputes: "Pressure Group Politics" Revisited. *British Journal of Political Science* 2:421-42.
- Marmor, T.R., and J.L. Mashaw. 1990. Canada's Health Insurance and Ours: The Real Lessons, the Big Choices. *American Prospect* 3:18-29.
- Maxwell, R.J. 1981. *Health and Wealth*. Lexington, Mass.: Lexington Books.
- Morone, J.A. 1990. American Political Culture and the Search for Lessons from Abroad. *Journal of Health Politics, Policy and Law* 15(1):129-144.
- Organisation for Economic Co-operation and Development. 1977. *Public Expenditure on Health*. Paris.
- . 1985. *Measuring Health Care, 1960-1983*. Paris.
- . 1987. *Financing and Delivering Health Care*. Paris.
- . 1990. *Health Care Systems in Transition*. Paris.
- Pfaff, M. 1990. Differences in Health Care Spending Across Countries. *Journal of Health Politics, Policy and Law* 15(1):1-68.
- Rodwin, V.G. 1984. *The Health Care Planning Predicament*. Berkeley, Calif.: University of California Press.
- Rosenthal, M.M. 1987. *Dealing with Medical Malpractice*. London: Tavistock.
- Saltman, R.B. 1990. Competition and Reform in the Swedish Health System. *Milbank Quarterly* 68(4):597-618.
- Stone, D.A. 1980. *The Limits of Professional Power*. Chicago: University of Chicago Press.
- Titmuss, R.M. 1970. *The Gift Relationship*. London: Allen & Unwin.
- Wysong, J.A., and T. Abel. 1990. Universal Health Insurance and High-risk Groups in West Germany: Implications for U.S. Health Policy. *Milbank Quarterly* 68(4):527-60.

Address correspondence to: Professor Rudolf Klein, Centre for the Analysis of Social Policy, University of Bath, Claverton Down, Bath BA2 7AY, England.