

From Managed Competition to Managed Cooperation: Theory and Lessons from the British Experience

DONALD W. LIGHT

*University of Medicine and Dentistry of New Jersey;
University of Manchester, United Kingdom*

THE TRANSFORMATION OF THE BRITISH NATIONAL Health Service from an integrated system of government finance and provision to one of competitive contracting is a leading example of an international trend (Organisation for Economic Cooperation and Development 1992; Chernichovsky 1995). Because it started so early (1989) and adopted the Big Bang approach (Klein 1995) of transforming the entire system rapidly, whereas other countries deliberated over partial experiments, the British case holds important policy lessons for employers, states, business health coalitions, and many nations contemplating competition as the way to “contain costs, increase efficiency, satisfy consumers and providers, achieve equity and improve the quality of health care” (Chernichovsky 1995, 339–40). For the British experience allows us to gain insights into what happens if the basic safeguards are in place (as they are in many countries that are exploring the option of competition, although not in the United States) against bias selection, deselection, undertreatment, access barriers, cost shifting, and product substitution, so that real competition over price, service, and quality can occur (Enthoven 1988, 1993). For the countries in Europe, Asia, and Latin America that have installed these safeguards,

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the British experience provides insights into the likely problems and benefits of competition. For the United States, the British experience raises questions about how much is being saved by competition per se and how much only appears saved through the cost shifting and risk selection that are possible because the basic safeguards are lacking. Indeed, leading economists told *The New York Times* in 1994 that savings from managed competition "are illusory for the country as a whole [and] would disappear if everybody had managed-care coverage" (Freudenheim 1994).

A number of excellent articles have recently appeared on the British reforms, and they have familiarized readers with many of their features (Maynard 1994; Mechanic 1995; Klein 1995; Ham 1996). However, they only sporadically attempt to draw policy lessons, as Klein did when he noted that the underlying political structure is critical, or Ham, when he concluded that purchasing needs to take into account both population and patient perspectives. Most of these writings however, quickly become immersed in the idiosyncratic details of the reforms, whereas, in this article, I will distill from my observations and participation in the reforms since their inception a set of *adaptable* policy lessons for other systems, with the goal of extrapolating the implications of one system's experience for the benefit of others. This requires comparative experience by which to judge which aspects of a system have relevance elsewhere and how much local context can be left behind. Perhaps the task is impossible. British observers are so aware of the unique history of the NHS and its internal variations that generalization seems impossible, especially to other systems. Yet, from a comparative perspective, the British system is homogeneous, while a system like the one in France could be regarded as somewhat diverse and the American system would represent the farthest extreme of diversity. Thus the British experience with introducing competition is a relatively promising basis for extrapolating adaptable policy lessons. At least it is worth a try.

The lessons here rest on a basic assessment that differs sharply from those found in other accounts. In a five-part series published as the reforms began, I maintained that the NHS was seriously underfunded and predicted that the competitive strategy would significantly increase management and information costs while concurrently increasing expectations and demand (Light 1990a,b,c,d,e). I held that little competition would take place in a system of tight budgets and taut supply. Rather, competition would replace a service ethos with a commercial

one and would motivate local hospitals or specialty teams to behave like monopolists. More basically, competition is ill suited to health care for reasons currently overlooked but long known by an earlier generation of economists, whose writings on this topic are all summarized by Light (1993): see Arrow (1963); Boulding (1958, 255); Buchanan (1960, 400–1); Ginzberg (1954); Klarman (1965); Samuelson (1955, 122); and Stigler (1952, 219–20). Health care is often *emergent* as diagnosis and treatment unfold. Clinical decisions are *contingent* on what is found and how the patient reacts. Cases are highly *variable*, and the course of treatment is *uncertain*. These qualities mean that no clear product, with clear property rights, can be defined and its price set, as can be done for hotel rooms or computers. Put another way, health care has a large gray area in which services and products can be manipulated by the provider/seller, or by a contractor of services, so as to appear cheaper by treating less illness or by treating illness less.

But these are not the only deviations of health care from the requirements for a market that benefits customers and purchasers. There is great *information asymmetry* because the clinician knows so much more than anyone else. *Information is expensive*, not free. Even worse from a market perspective, the seller/clinician is the patient's trusted advisor. Thus, a competitive perspective recasts the heart of the fiduciary doctor–patient relationship as a core conflict of interest. Finally, there are few buyers and few sellers, and the barriers to entry and exit are high. In short, hardly any basic requirements for ensuring that competition benefits society are in place, which amounts to what economists call “market failure.” Market failure, however, is not like engine failure, where the car grinds to a halt at the side of the road. Rather, it unleashes the powerful forces of uninhibited self-interest that are not bound by any requirements to be socially useful.

A careful attempt to solve these massive problems and dangers of market failure in health care is Enthoven's theory of managed competition. In its most complete and candid rendition (1988), the theory requires extensive regulations and strong management of the market as a whole because “without carefully drawn rules and without active collective management on the demand side, the medical plans would be free to pursue profits or survival using numerous competitive strategies that would destroy equity and efficiency and that individual consumers would be powerless to counteract” (Enthoven 1988, 27). The requirements include community-rated universal insurance for a single com-

prehensive package of needed services delivered by integrated health plans (like HMOs), with extensive reporting on, and monitoring of, quality, productivity, and prices. Consumers would then choose among plans, making tradeoffs in price and quality. But Enthoven's theory, although it represents a great improvement over unmanaged competition, involves significant costs and leads to oligopolies as the leading competitors corner the market (Light 1995b).

Notwithstanding the theoretical danger that purchasers could end up with more costs and less control than before, Enthoven (1985) strongly advocated managed competition as the solution to the rising costs of the NHS that were creating political heat for Prime Minister Margaret Thatcher. This solution was based on a diagnosis that salaries, fixed wages, strong unions, and set budgets created "perverse incentives" that worked against making services more productive or efficient; the result would only be more work for the same pay or out of the same budget. Moreover, these perverse incentives in combination created "gridlock."

This analysis struck me as persuasive, yet contrary to the facts, and therefore more a theoretical caricature than a realistic diagnosis (Light and May 1993). Specifically, during the 1980s, when perverse incentives and gridlock supposedly prevailed, the NHS reduced the average length of stay for all acute cases by 28 percent, increased the number of cases handled per bed by 46.8 percent, reduced its acute-care beds by 17 percent, and at the same time kept the occupancy rate near the optimal 85 percent (National Association of Health Authorities and Trusts 1990). NHS managers and clinicians actually *decreased* the average cost per acute inpatient case by 10 percent, after adjusting for inflation. They also reduced the average cost of geriatric cases by 25 percent. Meantime, the NHS poured more money into primary care and increased the number of general practitioners (GPs) by 18 percent.

Clearly, Enthoven's narrowly economic diagnosis of salaries and fixed budgets creating perverse incentives and gridlock, even if it contained some truth, overlooked powerful sociological, institutional, and professional forces that significantly increased efficiency and productivity. These are not unrelated to the motives and organizational culture that made HMOs the models of cost-effective health for the current era, before that era began. In fact, it is questionable that any other system matched this record of the NHS in its prereform decade. For the NHS can be regarded as one giant managed care system that had already accomplished most of the efficiencies now being achieved by American

managed care systems through roughly similar means: tight, careful control over the availability and distribution of specialty teams, service, and facilities; a strong, broad foundation of primary care that controlled access to specialty services and coordinated them; a mixture of capitation, salary, and unit budgets for physicians; volume discounts on systemwide purchases; and tight budgets. For these reasons, it did not make sense to me to use "dictated competition," or the Big Bang effort (Klein 1995), to transform the NHS overnight from an administered delivery system into an internal network of competitive contracts. It was more realistic to be aware that health care is inherently rife with "inefficiencies," but that the NHS had fewer than most. What inefficiencies it had were more sociological than economic, embedded in institutional rules, the organization of work, and the professional and organizational culture, so that competition would be a cruder way to ferret them out, with higher transaction costs (Williamson 1975), than targeted managerial approaches (Light 1991a,b).

Contrary to these observations and achievements, however, the Thatcher administration felt it faced a budgetary crisis and wanted to apply market discipline to the NHS, as it had to many other sectors of society. In doing so, Mrs. Thatcher started with most of the safeguards stipulated by Enthoven for managed competition, which were lacking in the United States, and thus her reforms were most likely to produce greater efficiency and value for the money spent: universal health coverage, independent of age, health condition, or risk; equitable financing; equitable access and distribution; and a systemwide infrastructure that could be mobilized to sponsor or manage the markets, provide market information, track quality, and track value (Light 1995b). Thus, whereas a policy of true managed competition would aim to correct the distortions of largely unmanaged market competition in the United States, managed competition in the United Kingdom was used to introduce market forces into a highly managed system that was among the cheapest, most comprehensive, and equitable in the West.

For adaptable policy lessons, the reader needs only a brief sketch of the NHS that Mrs. Thatcher wanted to transform through managed competition. It provided, through three separate budgets, a comprehensive range of primary through quaternary services, plus home-care and community-care services, as well as some long-term institutional care. The main budget for hospital and community health care was allocated to regional, and thence to district, health authorities that

administered the services. Specialists and those in training grades received salaries through this main budget. A separate, national GP contract paid for primary care through GPs as independent contractors; they received about 60 percent of their practice income through capitation and the rest through a complicated formula to pay for operating expenses. GPs received substantially more in proportion to the number of socially and economically deprived patients they served (Jarman 1993). Finally, some of the health-related social services were paid through local or municipal councils and were means tested. This system was financed largely through income taxes and was usually free at the point of delivery. Cost controls consisted principally of tight budgets; stringent control over equipment, facilities, and personnel; a strong primary-care base; and waiting lists for elective procedures. Private supplementary insurance had risen to about 12 percent of the population, largely as a perquisite for managers, and it was highly selective in both who and what it covered. The NHS served a population about one-fifth the size of that in the United States, and it spent about one-fifteenth of the money while covering nearly everybody for nearly all medical services.

Mrs. Thatcher's goal was to squeeze out what conservatives regarded as extensive inefficiencies in the NHS. She aimed to create a purchaser-provider split by transforming health authorities from administrators into purchasers and hospitals and community care units into sellers or "trusts," a status change that gave them quasi-independent powers to run their own affairs. The reforms seemed aimed particularly at the consultants (the senior specialists) and their seemingly impregnable fiefdoms (Light 1992a). To make doubly sure that they could be brought to account, a parallel scheme was developed to give larger GP practices the funds to purchase specialty services as well, thus allocating to the underdog GPs the power to control the purses of senior specialists.

With this brief sketch, which previous articles have filled out, I will attempt to extrapolate five positive and six negative lessons from the British experience with managed competition. These lessons are based on extensive field work over the past seven years, opportunities to participate in several major developments of the reforms, and a score of reports and articles with which readers are unlikely to be familiar. The lessons constitute the second half of a report to the Physician Payment Review Commission, the first half of which consists of lessons to be learned from the British experiences before 1948, in an era of private insurance mixed with public programs, public and private hospitals,

and significant maldistributions—not unlike the situation in the United States during the 1990s (Light 1995a).

Essentially I will argue that although the British have improved on Enthoven's model of managed competition in several ways, they have repeatedly discovered that even managed competition seriously threatens the safeguards against inequalities on which it rests. Competition is also highly disruptive. In the computer or restaurant business, it may drive firms into bankruptcy, eliminate jobs, and shut down facilities, perhaps resulting in better value and service; but in medicine such events can easily disrupt services, fragment care, and increase overall costs. As a result, a responsible, moral state or employer or purchasing cooperative that cares for its people, especially when they are suffering, will find itself struggling against competitors' efforts to segment markets and shed unprofitable patients or services. A moral purchaser can then end up with the worst of both worlds: higher costs, more regulations, increased demands, and constant tendencies toward greater inequality, dislocation, and fragmentation. What the British are realizing is that most of the benefits come from purchasing and most of the costs come from competitive contracting. If, then, purchases are made jointly via what might be called "managed cooperation," information can be shared rather than hidden, thereby engendering and rewarding trust and promoting collaboration in meeting the health needs of communities (Light 1993, 1994). After going through the wrenching experience of imposing a purchaser-provider split, the British are now moving toward purchaser-provider partnerships. This will work if the purchasers are large, clearly sophisticated, and in control.

Five Lessons from Designing Managed Competition British Style

1. Have Supply-Side Competition within a Fixed Budget

Theoretically, competition should not work within a budget limit, and Alain Enthoven has repeatedly emphasized that his concept should not be subject to budget limits. The economic expression of preferences, as buying and selling take place, results in a natural total that theory says would be distorted by a budget limit. But British leaders did not dare (and Treasury would not allow them) to drop the central feature that has

held NHS expenditures in check. Why not create markets of competitive contracts among doctors and hospitals within budget limits? The British called the resulting design "the internal market." Since firms outside the NHS hold contracts too, a more accurate term is "supply-side competition," with budgets set at the appropriate macrolevel to cover all residents in a geographic area. Literally speaking, this is a "single payer" structure, but not in the sense in which that term is used to mean the entire Canadian system. An areawide business health coalition, for example, approximates a "single payer" for its population of employees (Robinson 1996). One might call the resulting design "single-payer managed competition" (Chernichovsky 1995).

2. Allocate Funds Based on Needs: Choose Services Based on Effectiveness

The shift from an administrative to a purchasing model has three significant implications. First, purchasing and markets make more visible the ways in which allocations deviate from the health needs of populations and create a demand to level the playing field. In most countries, budgets are inequitable, reflecting the past priorities and special interests, especially of hospitals and specialists. Even with limited resources, most countries reflect a heavy bias toward hospital-based services. But the logic of the market calls for a level playing field of budgets allocated on a risk-adjusted basis. The British have been reducing past regional inequities for years, a slow process because reallocations involve substantial losses to historically overfunded authorities or units of service. At the small-scale level of primary care practices, the variations in budgets from years of differences by social class, politics, and area are still greater and more inequitable (Bloor and Maynard 1995). In response, the NHS is edging toward reducing these inequities: first, as health authorities devise their own ways to allocate funds more equitably; and, second, as national efforts to address the problem mature (Healthcare Financial Management Association 1993, 6–10; Appleby et al. 1994). However, developing a risk-adjusted formula for highly variable small populations may be impossible; Majeed (1996) maintains that the only way to do so is through practice-based needs assessments.

Second, a focus on purchasing leads to rethinking old treatment patterns to find the most cost-effective ones. Within the first two years of the reforms, the British started using the term “commissioning” to connote the notion that purchasing authorities should do more than purchase existing services “off the shelf.” Rather, they should seek new, more cost-effective configurations of services across specialty and organizational lines and move upstream to prevention, health education, self-management of chronic problems, and reduction of illnesses whose source lies in local environments. For a health care system that has built itself up around hospitals, major academic centers, and the elaboration of subspecialized medicine, the implications of needs-based health care commissioning are more radical than Enthoven’s model of managed competition. The center of *medical* care becomes the periphery of *health* care. Whereas British planners see these implications clearly and emphasize prevention, the entrenched interests of hospitals and specialists combine with a tight budget and patient demand for specialized services to impede change.

This search for value has prompted, as it did in the United States, a long, research-based effort to define what effectiveness means to different people under varying circumstances, to figure out how to measure it, and then to experiment with different approaches. The British call it “evidence-based medicine.” The larger point here is that needs-adjusted limited purchasing for a stable population aligns priorities and incentives in fundamentally new ways, aside from managed competition itself, that echo the seminal writing of Archie Cochrane (1972), a prominent champion of social medicine. His thinking can be distilled into a Cochrane Test for Effective and Efficient Health Care Systems, which asks to what extent does a health care system:

1. Determine the relative effectiveness of interventions?
2. Make more effective interventions available to all and drop less effective ones?
3. Minimize ill-timed interventions?
4. Treat people at the most cost-effective time?
5. Treat people in the most cost-effective place?
6. Focus on preventions that are effective?
7. Focus on diagnostics that affect treatment?

The better part of efficiency, Cochrane emphasized, is effectiveness; for how can a system be efficient if no one knows what works and what does not? There should be no restrictions on the search for what works best: when, where, and how (Light 1991c). If cerebral vasodilators for dementia do not work, delicense them. If osteopathic manipulative theory is more effective for some kinds of back pain than drugs or surgery, use it.

A third implication of the shift to purchasing by a single corporate or governmental payer should be a long-term approach toward maintaining the health, well-being, and functioning of a population. This implication differs profoundly from an annual competition among private insurers for the healthiest subscribers (Reinhardt 1982; Light 1992b; Stone 1993a; Woolhandler and Himmelstein 1994). Even in a single-payer system, however, there are serious dangers that a strategy of competition will delegate to the sellers the collection of performance data, the allocation of facilities and capital, and therefore the ability to create inequities, by setting the criteria for and the barriers to access. Put another way, there is a basic tension between the decentralization that often accompanies competition and the overall goals of equity, access, and efficiency. What is good for a given provider may not be best for the overall payer. Pollock (1995a) argues persuasively that the large-scale payer must set criteria for equity and access, institute a common database, establish standards of quality, and retain a good deal of control over the allocation of capital and facilities. Otherwise it will not be informed about what it is getting for its money and/or inequities will pervade the system. The strongest business health purchasing groups, after floundering on the shoals of weak purchasing, have reached similar conclusions (Robinson 1996). The NHS reforms also ignored these requirements of effective purchasing, and focused instead during the formative years on pitting providers and sellers against one another in annual contracts.

Finally, "needs" are shaped by the ten rights listed in the Patient's Charter, an important set of safeguards that frame the market reforms (fig. 1). The government has increasingly focused its funding priorities on them, particularly the ninth right, thereby substantially reducing waiting times for elective procedures (J. Yates 1997: personal correspondence with tables). The number of people waiting for more than a year has dropped from 223,311, or 25.5 percent, in March 1989, to 14,993, or 1.4 percent in September 1996. All urgent cases are treated immediately, and 57 percent of elective general surgery is done within eight weeks (Harley 1995).

Patients are assured of ten rights:

1. to receive health care on the basis of clinical need, regardless of ability to pay
2. to be registered with a general practitioner (GP)
3. to receive emergency medical care at any time, either through a GP or through the emergency ambulance service and hospital accident and emergency department
4. to be referred to a consultant, who is acceptable to the patient, when a GP thinks this necessary and to be referred for a second opinion if the patient and GP agree this is desirable
5. to be given a clear explanation of any treatment proposed, including any risks and alternatives
6. to have access to health records and to know that those working for the NHS are under a legal duty to keep their contents confidential
7. to choose whether or not to take part in medical research or medical student training
8. to be given detailed information on local health services, including quality standards and maximum waiting times
9. to be guaranteed admission for treatment by a specific date no later than two years from the day when a patient is placed on a waiting list
10. to have any complaint about NHS services investigated and to receive a full and prompt written reply from the chief executive or general manager

FIG. 1. The Patient's Charter.

3. Have Professional Agents Compete at the "Wholesale" Level

Although the Enthoven model of managed competition focuses on "retail" consumer-patients choosing among health plans by price, quality, and the fruits of efficiency, a good argument can be made that the complex, esoteric, and contingent nature of health care calls for professional agents to compare alternate services and to buy the best services in volume for groups of consumer-patients. In fact, many purchasing decisions in the United States are made at the wholesale level, although the professionals who do so have not been as well trained as their counterparts in the United Kingdom.

The British version of managed competition uses a wholesale approach, in which professional agents for patients negotiate bulk con-

tracts with provider groups. There are two classes of buyers' agents: the district health authorities (DHAs) and the GP fundholders. Fundholding is a program by which qualified GP practices can receive the budget for purchasing a specific list of low- and mid-risk specialty and hospital services, prescriptions, home health care, community services, dietetic and chiropody services, and services for people with many outpatient mental health problems and learning disabilities (Glennerster et al. 1994, 76; Ham 1994, 20).

The rationale for relying on a wholesale approach that uses buyers' agents is supported by evidence indicating that British patients are a long way from being informed, smart buyers. Results of surveys show how few Britishers even know what the transformation of budgets, incentives, organization, and power are about, or have any idea of their impact on care (Mahon, Wilkin, and Whitehouse 1994; Jones, Lester, and West 1994). Nor do most patients have much interest in traveling beyond their local area in search of better care (Mahon, Wilkin, and Whitehouse 1994, 118–21). Extensive American research shows that people often cannot evaluate how well their choices meet their preferences, do not choose even when they have the opportunity to do so, and make choices that not only serve them less effectively but can even do them harm (Rice 1997, 29–50). These and other limits to retail patient consumerism (Stone 1993b) are not addressed by advocates of consumer competition.

The basic problem with the British version of the wholesale market is that it establishes two fundamentally different systems of buyers' agents: DHAs, which are responsible for commissioning all services for a whole population; and GP fundholders, which are responsible for purchasing some services for their sick patients (Saltman 1995). Moreover, the budgets for fundholders are taken out of the overall allocation to health authorities, leaving them with partial budgets and uncoordinated contracting. Who, then, should commission what, and on what basis? Ham (1996) has addressed this issue, but it remains unresolved. Thus, the British have laced their own lesson with conflicts, which may be resolved by giving the funds to large GP groups (total fundholding) or by firmly subordinating GP fundholding to DHAs.

4. Set Up Comprehensive, Local Primary Managed Care Practices

The Thatcher Administration considerably increased the range and specificity of primary care practitioners' responsibilities, while removing

oversight from their control (Day 1992). In addition, it offered—increasingly pressured—larger practices to become purchasers of selected services. Because GP fundholding aimed to break down what seemed like the impenetrable fiefdoms of consultants by having doctors control the pursestrings of other doctors, thus splitting ranks of the powerful British Medical Association (Scheffler 1992; Day 1992), its list of fund-held services is not especially coherent. GP fundholding has a number of design flaws that need not trouble those interested in learning how to make primary care more comprehensive and effective (Audit Commission 1996; Royal College of Physicians 1996; Light 1995c). But the *design* idea of creating comprehensive primary care through a subcontract to primary care groups deserves consideration by other countries or purchasing groups. Let us call this more generic policy idea *primary managed care*, or PMC (Fry et al. 1995).

Essentially, PMC creates GP-administered mini-HMOs, subcontracted as a clinically coherent range of home, community, and office-based services (fig. 2). It addresses a number of frustrations and wishes of GPs that are pertinent to strengthening primary care in other systems. Physicians expressed their preferences for how these services should be run:

1. They wished to hold funds in order to coordinate services and improve the quality of the services for their patients.

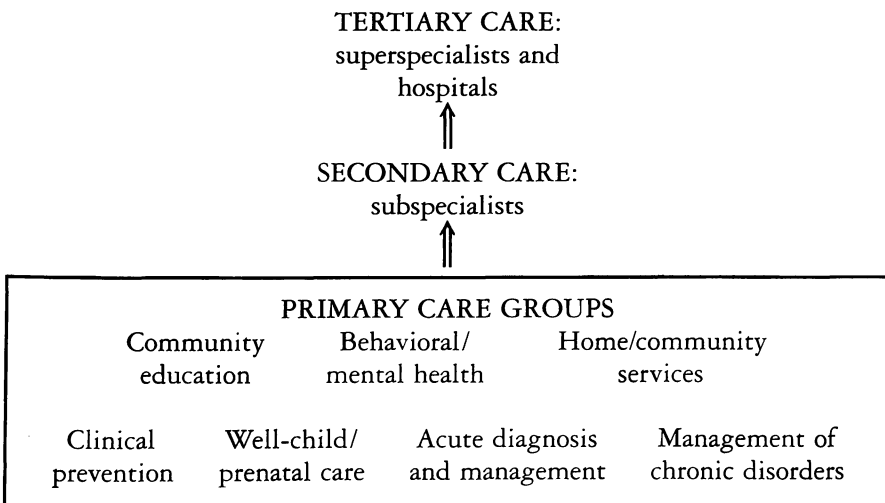


FIG. 2. A model of community-based primary managed care.

2. They wanted to select the specialists and hospitals with which to work on behalf of their patients.
3. They wanted to develop a better on-site constellation of services.
4. They wanted to have the budget to develop their own comprehensive primary-care service (Glennester et al. 1994, 83–6).

GP fundholding practices, or PMC, have some distinct advantages over American-style, full-service HMOs and “managed care”: They are small, local, and personal. They are run by the GPs themselves, who provide *clinically* managed care and are directly accountable to patients (Fry et al. 1995). They allow GPs to make their patient services more comprehensive.

The concept of PMC is ideally suited to meeting the major challenges of the 1990s. It provides a base for prevention and health promotion. It coordinates the growing portion of short-stay and ambulatory specialty procedures. It reflects the shift from institutions to community and home care. PMC practices develop shared care and the management of chronic illness, coordinating health care with other local services.

GP fundholding is based on three principles that Americans could well apply to their own system (Fry et al. 1995). One is to design a comprehensive, primary-care contract and give it to clinicians. If applied in the United States, such a contract would give patients and the system a foundation of *clinically* managed care rather than “MBA managed care,” and would offer them more choice in small cities, large towns, and even semirural areas than the few large managed-care systems that characterize U.S. reforms. British-style fundholding also brings GPs into the center of the NHS. Their responsibilities now extend to other segments of the health care system, requiring them to interact with others more than they were used to under just their independent national contract.

The second principle is to pass on enough risk to motivate people, but not so much risk that they can make or lose large sums. This contrasts with the American tendency to pass on as much risk as possible to providers, forcing them to cut services, raise barriers to access, avoid sicker patients if possible, and join large corporate entities with deep pockets who can bear the risk.

The third principle is to keep practices nonprofit. Surpluses must be plowed back into the practice. Fundholders tried to start personal, for-

profit corporations to which they referred their own patients, but, unlike the United States, these were quickly outlawed. Instead, use of surpluses must be reviewed and approved. This too minimizes the conflict of interest inherent in providers receiving capped prepayments. The British are concerned about the ability of fundholders to fatten their pensions by upgrading their offices, which become an important asset that they sell in retirement; comparatively speaking, this seems like a minor and indirect form of personal profit that enhances the practice in the years before retirement.

Both PMC and fundholding profoundly change the organization and power structure of medicine, giving GPs financial control over some specialty and hospital services. They create incentives for the primary care team to perform minor operations, specialty procedures, and tests whenever possible. GPs are demanding that specialists work more closely with them and respond more readily both to their needs and to those of their patients (Glennerster, Matsaganis, and Owens 1992; Farmer 1993, 62–3). GPs are also more committed to developing good ways to care for the disabled and people with chronic problems so that they can reduce hospital admissions and specialty consultations.

Despite these design advantages, the imperfect implementation of GP fundholding has created serious hazards that can serve as warnings to others (Light 1995c). It eliminates the purchaser–provider split that is the foundation of managed competition and the NHS reforms. In the minds of some, this is a fundamental flaw. It can easily compromise the commitment of GPs to their patients, especially those needing purchased specialty services (Black 1992). Conflicts of interest are inherent, although proper design can minimize them. In addition, fundholding budgets vary by more than threefold per capita and are inherently difficult to equalize (Day 1992; Majeed 1996). The overall organization and funding of specialty services can also become fragmented, as different fundholders make purchases on their own that are not coordinated with others' purchasing decisions. The whole thrust of a "primary-care-led NHS" threatens to devalue the seriously ill and the specialty services they need (Royal College of Physicians 1996).

So far, fundholding decisions are uncontrolled, and no quality checks have been installed, although the situation is changing as internal and external accountability increases. Systematic evaluation has been minimal (Dixon and Glennerster 1995), confined to single studies or commissioned studies without controls; finally, in 1995 an external body

carried out a more comprehensive review (Audit Commission 1996). The success of fundholding is "running on anecdotes," as one senior official put it. Decentralized services and administration are inherently more costly, even if they have other clinical and political advantages (Audit Commission 1996). Deploying specialty services out to local practices in some instances costs more, although in other instances it costs less (Black et al. 1996). A number of the GPs feel swamped with managerial work, and overall stress is high (Light 1995c). GPs vary greatly in their managerial competence, and none was trained for the job. Inevitably, some practices are not well run, and as fundholding spreads from early leaders to rank-and-file practices, quality is likely to decline. Even by 1995, the Audit Commission (1996) found that only a small minority of practices realized the potential of fundholding to increase value and quality. More seriously, GP fundholding creates strong pressures on financially strapped hospitals and specialty teams to compromise in setting priorities based on clinical need by creating a two-tier system in which patients who are "sponsored" by fundholders get priority over those who are not (Samuel 1992; Fisher 1993).

In the NHS, fundholding is assuming various forms: multifund consortia; a Newcastle hospital that has bought out GP practices and integrates primary care into secondary care; various soft- and hard-wired forms of integration with health authority commissioning; and total fundholding of all services (Light 1995c; Department of Health 1996; May et al. 1997). The GP contract, a mainstay of the national system for 50 years, may be reallocated to district commissioning authorities as part of a broader effort to develop comprehensive primary care services and integrate them with other levels of care. The pros and cons of these many developments exceed the capacity of this essay.

5. Use Local, Nonprofit, Community-Based Services

Although Mrs. Thatcher wanted to create a level playing field for private, for-profit providers and hospitals, the limited-risk, primary-care contracts and the emphasis on using NHS resources when possible have kept managed competition largely local and nonprofit. For-profit medicine has not won much of the main business in acute care. In 1991–92, Appleby and colleagues (1994, 51–2) found that only 0.5 percent of

purchasers' contracting partners were from the private sector. In 1992–93, the private contractors accounted for only 0.04 percent of providers' contracts. Although the role of for-profit practices is likely to increase, the question is whether they will win bids by competing for the more profitable cases, leaving the NHS with a heavier mix of chronic and very costly cases. In the U.S. market and elsewhere, for-profits, even the most advanced American examples, have proved to cost more (Hsiao 1994; Woolhandler and Himmelstein 1997). Moreover, their primary goal of maximizing profits and revenues can seriously distort the distribution, access, and equity of services (Pollock 1993, 1995a, b).

Six Negative Lessons from Implementing Managed Competition

The British have had more experience with managed competition than any of the nations that are considering its systematic implementation. Managed competition has been costly and disruptive. Many of the improvements attributed to it are continuations of earlier trends, and most innovations (like GP fundholding) have significant drawbacks. Six lessons are drawn here from studies, observations, and interviews conducted over the past several years.

Problem 1: Lack of Good Market Information or Effective Purchasers

Competition is only as effective as the purchasers and the information they have collected. When people think of competition, they think of "competitors," that is, sellers. But it is sophisticated buyers that cause markets to increase value for money. Just how sophisticated is reflected in Robinson's (1996) account of how much the Pacific Business Group on Health has had to do in order to overcome the natural advantages of providers and to obtain comparative data on productivity, quality, and cost-effectiveness. Such a project is not only extremely complex and expensive; it also requires a sustained determination to carry it out.

Mrs. Thatcher started with weak buyers and poor market information, and both stayed weak for years. Surveys in 1991 and 1992 of NHS managers found high agreement that the "information required was

limited, non-existent, inaccurate, or late" (Appleby et al. 1994, 34–5). Eighty percent of the purchasers surveyed said they had difficulty obtaining comparable cost data in 1991. Sixty-five percent said they also lacked data on patient flows. Over 70 percent of providers/sellers surveyed also said that obtaining cost data was a problem (Appleby et al. 1994, 42–3). As a result, health authorities had no choice but to purchase largely by means of block contracts with hospitals and units, hardly what advocates of competition had in mind. By 1992–93, 88 percent of all contracts were still block contracts, and only 10 percent had enough information to be based on costs per procedure (Appleby et al. 1994, 40).

Information technology (IT), all agree, was badly handled (National Health Service 1996). In the name of "market freedom," the government allowed provider units to choose their computer systems and software, with the result that neither systems nor data were compatible across markets, making comparative marketing information impossible. Large sums were also wasted on management systems that did not work. As of 1995, the majority of trust hospitals still lacked the information necessary to assess their cost-effectiveness and thus to make competition a viable enterprise (Health Services Management Unit 1996).

These problems are echoed in the purchasing plans of health authorities (and presumably those of GP fundholders): there are no common requirements for reporting. "It is clearly absurd," write Patricia Day and Rudolf Klein six years into the reforms, "that strategy documents do not present figures in a standard, comparable form and that it is therefore impossible to compare the resource allocation policies of different purchasers, let alone identify national trends in spending priorities" (in Redmayne 1996, 9).

Closely related to the lesson of the importance of starting with good market information and effective purchasers, if competition is to improve value for money, is the need for good information on quality. The British immediately perceived this and made "medical audit" part of the reforms. However, an independent assessment of audit concluded that medical audit, which is done by clinicians of their own work, is largely "an extension of the profession's current self-management arrangements" (Kerrison, Packwood, and Buxton 1994, 157). This overstates the case because half of the funds go to audits requested by the purchasers, who define what aspects of medicine are to be audited (mainly the technical areas) and by what measures. Yet the research team found that no vision or guidelines exist to inform these decisions. Also, the

amount and quality of data at most sites are wholly inadequate. The results of audit are not linked to purchasing, and clinicians do not generally emphasize resource use as an important focus of medical audit.

In the last two years the government has realized the importance of strong purchasers and good information, but only after top talent left the health authorities to head up the major sellers (the large hospital trusts), regional health authorities were dissolved, and the parties on both sides of the market were allowed to choose their own software and data systems. The NHS Executive is now trying to establish beachheads of comparable data and sound purchasing.

*Problem 2: Allowed Little Competition
in Order to Avoid Political Embarrassment
and Preserve Equity*

The British experience with managed competition is sobering for any employer, state government, purchasing cooperative, or nation that, unlike the United States, really believes in equity and has limited funds. Very quickly the British government feared that competition would unleash powerful forces that could disrupt services, bankrupt hospitals, and create two-tiered services. From the start, the government controlled markets and competition tightly in a manner that might be called “dictated competition,” which is perhaps a contradiction in economic theory but not in politics.

Mrs. Thatcher announced in effect that, on a certain day, hospitals and specialists in one of the world’s largest welfare organizations would compete for their budgets rather than receive them. Ironically, however, politically dictated competition meant that actual competition was minimized. Ministers, the Management Executive, and the Department of Health, collectively referred to by some NHS employees and policy critics as “the Kremlin,” issued hundreds of orders, directives, executive letters, and advisories that specified the terms of the competition.

First came a practice year of “shadow purchasing,” in which the provider units and their administrative offices were required to provide the same services from the same sources based on nearly identical budgets, while making up pretend, or “shadow,” contracts for practice. Next, the government required that the first year of real contracts must go largely to the same hospitals and other providers for nearly identical

services in order to ensure a “steady state” and a “smooth take-off” as the health service was transformed from an administered service to an internal market. There followed hundreds of pages of terms, guidelines, and prohibitions from the Management Executive and the Department of Health. All of this meant that a huge restructuring took place with hardly a patient or a ball being dropped. But it also meant that the competing parties settled into stable, barely competitive relationships before the real contracting began.

The government also realized from the poor business plans of the first self-governing trust hospitals, and from the inability of health authorities to purchase, that the reform to which it was committed could quickly become a disaster (Light 1991b). To preempt this possibility, the government took a number of actions to minimize the very competition it was boldly promising. It quickly reined in the ability of trust hospitals to borrow money and imposed the following performance requirements in order to discourage them from taking risks that might lead to failure: Trust hospitals had to earn a 6 percent return on assets in use; they had to stay within their external financing limit; they had to set prices equal to average costs; they were not permitted to cross-subsidize between services; they were told to make no capital investment that could not be recovered from contract income; they could not dispose of their surpluses; and they were required to obtain most of their income from contracts with NHS authorities and fundholders (Bartlett and LeGrand 1994). Trusts cannot go bankrupt, although they can be closed. Bartlett and LeGrand concluded that “the independence and autonomy available to trusts is highly circumscribed, and the incentives to improve performance, which might be expected to be associated with an ability to retain financial surpluses earned through improved management performance, are eliminated” (1994, 56). They also concluded that the financial success of better-performing trusts was largely an artifact of their greater financial strength and lower costs *before* they became trusts. Strong initial performance was largely the result of one-time declines in real estate values that gave hospitals operating returns significantly above the 6 percent requirement.

By December 1990, hardly before real contracting began, the Secretary of State for Health admitted that the government had been carried away in its application of standard business competition to health care. A sea change took place behind the scenes, one evident by 1991–92 in language changes. “Buyers” became “purchasers” and then “commission-

ers." "Sellers" became "providers," thereby acknowledging their distinct and central role in medicine. "Budgets" became "funds" or "amounts." NHS contracting was placed outside contract law so that an "NHS contract is an administrative arrangement which is probably not enforceable in the courts, which may be imposed on parties in the absence of mutual consent, and which is subject to special dispute settlement procedures" (Hughes, McHale, and Griffiths 1996, 158). Most important, "marketing" faded into time-honored "needs assessment." Ever since, the government has found itself in the awkward position of setting up the structure for a potentially highly competitive market, while denying to an anxious public and a suspicious press that any such thing was happening (Butler 1994, 23).

All of these efforts at damage control ironically mean that competition leads to more control and more regulations than an administered system. To ensure this control, the secretary of state for health appointed politically loyal chairs and many of the nonexecutive members of all health authority and trust boards, who in turn appointed the chief executives and senior officers. Opinions differ, but I believe this politicized the NHS. For example, even low-level staff personnel in the second and third years explained in confidential interviews that they felt they must either report "doctored" data, showing the success of the reforms so that their superiors would have their expectations confirmed by "facts," or suffer criticism for turning in "bad" reports. "It is widely acknowledged that the 1991 reforms strengthened the chain of command from Secretary of State to the DHA" (Hughes, McHale, and Griffiths 1996, 174). "[T]he service has become more centralised over the last five (or perhaps more) years as politicians tightened their grip in order to try and control the flow of 'bad news' stories which affected the political climate" (J. Appleby 1996: personal correspondence, p. 1).

The tight, fail-safe restrictions on competition have restricted what commissioning authorities can do. Appleby (1996: personal correspondence, p. 2) writes: "The financial rules governing trusts have meant that purchasers have found it very difficult to change the pattern of services," and their prices must include 6 percent return on assets, or if they do not, they must make it up in what they charge to other buyers. Systematic evidence shows that commissioning authorities initially altered past funding patterns only at the margins and often at variance with their declared priorities (Klein and Redmayne 1992, 17). They were able to free up less than 1 percent of their budgets for purchasing

decisions, and ironically they moved more money toward acute services and away from community services. On the whole, they handled "priority overload" by distributing the money to many small initiatives (Klein 1993, 73). This national study found "no agreement as to what should be included in a purchasing plan" (Klein 1993, 6). Some had detailed analyses of demographics and needs, while other plans plunged into the details of contracts with providers. Time pressures and lack of good data made this almost inevitable. Subsequent studies of purchasing plans (Redmayne, Klein, and Day 1993; Redmayne 1996, 40, 54-7) have found modest improvements in this picture.

In theory, purchasing could quickly become more aggressive. The tight restrictions on profits, losses, and cost shifting also mean that trusts are very sensitive to small changes in prices, so that if purchasing authorities shopped and negotiated more aggressively, they could leverage large changes (Dawson 1995, 23; Propper 1996, 318). However, fears of rebellion by GPs, of dislocations in service, and of political heat hold purchasers back (Redmayne 1996, 54-7).

Likewise, providers could use their natural monopolistic advantages more aggressively. Competition introduces, and even imposes, a commercial ethos that can turn local hospitals and specialty teams into monopolists. Several factors abet monopolistic behavior by providers: their natural control of information, decisions, resources, services, and the hearts of patients; the weakness of buyers, as discussed above; the disinclination of patients to travel very far so that de facto markets are small; and forms of collegial behavior that economists call "collusion."

So far, entrepreneurial exploitation by British doctors has been minimal, in part because the government has severely restricted such behavior and in part because the cultural shift to a commercial ethos takes many years; it has been taking place in the United States since the end of World War II (Starr 1982). The dangers of commercialism, however, may well increase. GPs have now been given a strong economic stake in a wide array of services. Consultants (chiefs of services) have had to become small businessmen, and they increasingly market their services to a wider range of purchasers. Despite policies designed to minimize failure, increasing numbers of trusts are losing money. They have only begun to exercise their powers over staff mix, compensation, and contracts to corner valued market niches. Trust hospitals have also only begun to move into primary and community care, and the danger is that a given community-based service almost always costs more when run by a hospital. Yet as hospitals lose money and grow increasingly desperate,

they can use their financial and political clout to create hospital-run integrated services that cost even more than before.

Just how paradoxical are the problems posed by competition for public policy is the subject of an analysis by Diane Dawson, a health economist at the universities of Cambridge and York. As she notes with wry humor, government policy reflects “a preference for competitive structure and competitive behavior except where they prefer a less competitive solution” (1995, 2). The law prohibits actions against the public interest, which is “whatever the current Minister says it is,” and differences between ministers have caused “a policy in disarray.” The government wants to maintain sufficient capacity to ensure that purchasers can switch providers and to minimize barriers of entry, but it then works against both. It does not want trusts to lose money, so it imposes break-even rules on revenue and expenditure targets. These rules, however, effectively prevent a unit from entering a new market because initial losses are likely. Units are not even allowed to build up excess profits, nor will the Treasury allow units to raise capital to take market share away from another trust (Dawson 1995, 15–18). One might call this “fail-safe competition.” Although the government talks about mergers to increase efficiency and quality, Dawson shows that no evidence exists on how economies of scale increase either. As a result, market reconfigurations have been characterized by “the shotgun merger,” with the government taking the role of the father holding the 12-gauge. Efficiency is enhanced in the short term by increasing production, but this poses another dilemma for the government: whether “to maintain some excess capacity (lower activity for the funds available) in order to maintain competitive pressure on providers” or to maximize use (Dawson 1995, 11). This leads to a profound policy insight: greater efficiency reduces the chances for competition, and any politician will choose to maximize care, even if it means minimizing competition. This choice makes perfect sense in a system dedicated to ensuring that public monies are spent to maximize services equitably and to minimize disruptions to services.

To summarize, the government’s decisions to dictate competition, to make managers accountable to political leaders, and to eliminate most competition because of its potential to cause political damage raise serious doubts about the wisdom of introducing managed competition in the first place. The government’s conservative requirements for a practice year and for “steady state” contracts were responsible and sensible, but they greatly limited competition. With minimal failure and

exit, there cannot be much competition, and in most national health care systems that are trying to contain costs, new competitors do not often enter the system either. Moreover, in national systems with a history of tight budgets and taut supply or choice, little can change. If there is barely enough money to do a job, and everyone is being used to the hilt, especially without new entrants or with few providers exiting from the scene, there is little room for maneuver.

Since managed competition began, the British have had to add funds to pay for more managers, more consultants, more data, more marketing, more consumer pressures, more consumer complaints, and increased demand. Even had the British saved money, competition has historically been an engine of economic *growth*, not restraint. This is an obvious lesson of history that policy makers and consulting firms throughout the world studiously ignore as they advocate competition to save money in health care. For while competition may decrease expenditures in the short run, in the long run it strongly rewards the creation of new products, new markets, and economic growth. Adam Smith's famous book was about increasing wealth and was not entitled "The Efficiency and Cost Containment of Nations."

*Problem 3: Created New Dislocations,
Inefficiencies, and Costs*

Even though it is supposed to save money overall, competition in health care has created new inefficiencies, costs, and dislocations. Some of the dislocations are good in the sense that they show the market is working. Perhaps the largest and most successful have been the decisions by purchasers in communities outside of London to buy specialty services nearby rather than send patients to the very expensive, major academic hospitals in London. This has certainly highlighted the inefficiencies, waste, and oversupply of academic medical centers; but the size and scope of dislocations are regarded as so great that the government is essentially administering the situation in an old-style state planning mode of closing or consolidating facilities by administrative fiat. Thus any government, employer, or large buyer has to ask itself the basic question, *How much dislocation and outcry is it willing to tolerate?* Behind this question is a paradox of dictated competition—tension between center and periphery embodied in policies designed to foster local initiatives—that requires separate treatments.

Annual contracting has caused numerous dislocations and disruptions. It basically destabilizes provider institutions and groups, even though, as we have seen, not much changes, because they are highly sensitive to small changes. It has broken up some working relationships between GPs and specialists and fostered others. Clinically, the contracts also reduce choice. Even though one of the most widely promoted reasons for the reforms was to let "money follow patients," competitive contracting has meant the reverse: patients follow money. Finally, annual contracts consume months of administrative time, so that staff of both purchasers and providers have hardly caught up with their other work before they must turn once again to the next round of contracts (Hughes, McHale, and Griffiths 1996, 160).

The dislocations caused by inequality, even though modest by international standards, seem more evident. For example, the large, covert differences in how much GPs use hospital and specialty services per capita (Day 1992) are now locked into explicit fundholding budgets, giving richly funded practices much more purchasing power and all fundholders more money than non-fundholding GPs. The dislocations are exacerbated by the generous enticements offered to persuade reluctant practices to join the fundholding program. All large or generous budgets come out of the health authorities' district budgets, leaving less for services to patients of non-fundholders. At the district level, there is national concern that the allocation formula is "shifting funds to affluent counties at the expense of inner cities" (H. Hunter 1996).

The dual and uncoordinated purchasing systems of fundholders and health authorities have caused further dislocations in the planning and coordination of services. One has many fundholders buying their fraction of surgical, subspecialty, hospital, and diagnostic services as they choose; health authorities buying those services for the practices left over; and both entities buying fractions of similar services from providers in other districts, with contracts changing annually.

In addition to dislocation, managed competition has produced new inefficiencies and increased costs. Early on Scheffler (1992, 183) concluded: "There is little doubt that the NHS reforms will increase the percent of GNP spent on health care." A British-American team observed that "the most salient lesson of all from the US is that transactions costs soar in a developed market system . . ." (Hughes et al. 1995, 292). Figure 3 lists some of the new inefficiencies that competition may generate in health care, implying that the savings must more than make up for these new costs. First, because the British had few itemized costs

Managerialism

Managerial power vs. clinical responsibility
 Bossing instead of facilitating
 Front-office overstaffing

Datamania

Forms, data, accounting beyond what can be digested and used
 "Accountability" as an end

Disruptions and inefficiencies of underused losers and overused winners

Ethos of commercialism replaces ethos of service

Gaming
 Favorable selection
 Cost-shifting
 Service dilution

FIG. 3. New inefficiencies of medical markets.

or prices beforehand, millions went into constructing the basic market itself: defining what the "products" were, determining costs, setting prices, gathering market information, contracting, and monitoring. These one-time costs pertain to many countries, but not to the United States. Second are the ongoing costs of gathering detailed information on every aspect of clinical work and contracting to be sure of obtaining the best value for the money. Although this information is inherently valuable, there is a greater chance that multiple, uncoordinated, poorly designed data systems will be established by competing parties to monitor and evaluate each other than would be the case under a system based on trust and cooperation. Whether these investments generate more savings than their costs is the central question, yet no solid data have been gathered to settle it either way.

A third new cost is management itself, which stems from the destabilization of institutions and providers that results when their revenues are placed at risk. In any competitive market, fear of losing part of one's business seems to be more prevalent than the expectation of winning. In either case, many institutions believe that hiring the best management team possible will assure success. This produces a "management arms race." As a result, the number of managers, their compensation, and their power increase. The sheer pace of the reforms, and the frequency with which the rules—and even the structure—of managed competition have changed, has increased the need for management teams and has driven up their cost. The number of managers in the NHS has approximately tripled, largely to handle the complex and relentless re-

quirements of contracting. The increased number is due partly to the reclassification of supervising nurses as “managers”; this has been a principal way for them to make more money. Managerial salaries have been rising two to three times faster than doctors’ or nurses’ salaries. Although by American standards the proportion and cost of managers in the NHS are low, their relative rate of increase is notable. Since 1995, under pressure from increased expenditures, the NHS Executive has ordered significant reductions in managerial positions. This strikes me as penny-wise and pound-foolish because, in order to achieve significant savings through contracting, clinical services for serious, costly disorders and high risks will have to be reconfigured. Such reconfigurations, however, require strong, talented management teams and integrated data systems (Shortell et al. 1996).

Fourth, the costs of competition were pushed up by the new freedoms and power granted to qualified hospitals to act as “self-governing trusts.” Such status gave those deeply entrenched institutions, which already consumed a large percentage of the national budget, more powers and incentives to persist and grow, just when the nation needed to move its health care system away from dependence on them and to reallocate the large sums locked up in hospital-based services.

A fifth cost, ironically, results when winners win and losers lose. Winning institutions find themselves swamped with more business than they can handle. Their quality and efficiency tend to decline. Meanwhile, losers become still more inefficient as their unused capacity rises. Health care failures do not shut down quickly, or at all; instead, they drag on through the system for years, adding to everyone’s costs. In short, winning and losing do not per se produce efficiencies if markets clear slowly and the costs of losing institutions have to be carried (Light 1991a).

Problem 4: Fostered Massive Rationing by Eroding Coverage

While debates rage about rationing NHS services like removal of tattoos, warts, or varicose veins, a more fundamental rationing has occurred through the declassification or erosion of NHS coverage for geriatric and psychiatric long-term care and the restructuring of budgets for health-related social services (Pollock 1995a). As the central NHS was being transformed from an administered public service to an interlocking

network of competitive contracts in 1990, an act was passed that closed a loophole through which social security had been paying for long-term institutional care and that capped public spending on long-stay care by transferring that part of the budget to local or municipal authorities, whose services are means tested. What had been free NHS care for the elderly and physically and mentally disabled would now become free only for the poor. "The government recognized early on that one consequence of capping the social security budget and devolving funding would be rationing" (Pollock 1995a, 1583). This budget transfer, moreover, was made transitional, diminishing for four years to zero. Local authorities might possibly (if they had the political will) raise local taxes to make up funding shortfalls, but the conservative government has capped the amount they can raise in local taxes. Localities are thus forced to bill these hapless patients for their long-term care. To ensure that they are doing so, the government deducts a portion of its allocation to local authorities on the assumption that they are levying charges; if they are not, they are penalized. Pollock (1995a, 1581) reports: "In 1970, 28% of all elderly people receiving long term care outside their homes received free NHS care; by 1992 this figure had fallen to 12%. Around 40,000 couples had to sell their homes to pay for nursing home care last year alone."

As the NHS reduces admissions and length of stay, it is "shifting the boundaries of care by, for example, substituting elements of acute care it once provided free in hospital with care increasingly paid for in and by the community" (Pollock 1995a, 1583). Despite a rhetorical emphasis on health and prevention, the National Health Service could more aptly be called the National Sick Service today than ten years ago. The aging of the population and the increasing use of home-based care mean that rationing will increase because the role of social services provided outside the NHS by local authorities is increasing. Moreover, social care budgeting, unlike health care budgeting, is not earmarked or circumscribed, so it must compete for funds with other local services. The size of these budgets and the ability of towns to raise additional funds varies greatly.

In general, competition seems to have this narrowing effect, of dropping coverage for what are not regarded as core services. Although, in theory, competition can apply to as broad a domain as one likes, in the United States we see similar tendencies, as competing provider groups focus on just their part of the service continuum and as delivery systems squeeze out the cross-subsidies that once paid for

professional education, clinical research, charity care, and social services. The question to be asked, in each case, of policies for competition is to what extent the larger goal, or effect, is reduced coverage rather than greater efficiency?

Finally, a major de facto erosion of coverage and increased rationing in the United Kingdom is occurring as private health insurance spreads. Unlike Canada or the Netherlands, British law permits unfair competition between the NHS and private insurers to occur on an unlevel playing field by allowing insurers to choose the disorders, procedures, and people it wants to cover and leaving the rest to the NHS. Naturally, insurers choose disorders and procedures that have definable costs, and they market to healthier groups. This leaves the NHS to ration among the less affluent and the sicker, especially those with serious and costly disorders. As a rule of thumb, this policy has produced about a 30-fold difference in access to elective surgery: two days versus two months, or three days versus three months (Yates 1995). As private insurance grows for the managerial and middle classes through laws that favor it, adequate funding for a universal service becomes increasingly difficult to justify. "Those who 'go private' will be less and less content to pay for an NHS they think they can do without" (Coote and Hunter 1996).

In the meantime, since the private work is done by NHS-trained and NHS-employed specialists, who control which patients they care for on the NHS and which ones they see in their private practice, the private insurance has a corrosive effect on the practice of medicine. This trend too is abetted by the government, which has created an arrangement whereby specialists can give up as little as 9 percent of their salary in return for doing all the private work they want, even during normal working hours (Yates 1995; Light 1996). Moreover, surgeons and other consultants control who waits, for how long, and for what procedures, a clear conflict of interest that the reformers have left untouched. The macro effects are erosion of coverage, rationing behind closed doors, and reduced support for the NHS.

Problem 5: Privatized Public Assets and Services

Behind the growth of private insurance and privatized two-tiered access to surgical and other valued services are laws introduced under the Thatcher Administration to provide tax exemptions, and even rebates, for the private insurance premiums of people over 65 (Butler 1997, 5).

This practice is widely regarded among American health economists as a principal force in driving up health care costs, and it means that British taxpayers subsidize an upper tier of privatized services. Moreover, the privatized services may be much more expensive. For example, private policies leave patients with serious psychotic and organic disorders to the NHS while covering depression, other neuroses, anorexia nervosa, and substance abuse. But although patients with these latter disorders are usually treated inexpensively on an outpatient basis in the NHS, they are hospitalized at much greater cost under private insurance (Shah 1997).

In the public budgets of the NHS, competitive bidding by private contractors began in the 1980s for nonclinical services like cleaning, catering, laundry, and transport. A complex literature does not clarify whether money was saved, aside from rehiring NHS workers through outside contractors, at lower wages and with fewer benefits. Contracting with the private sector for clinical services is growing, and the basic question is whether private contracts win because they are selecting the cases that are economically more clear-cut and paying marginal costs, leaving the NHS to cope with complex and chronic cases and to pay all the hidden costs of the overall system. Given the lack of good market data, no one can really tell, but Pollock (1995b, 684) reports that many owners of private residential homes make a gross profit of 30 percent per bed.

A much larger privatization occurred in 1982 when an amendment allowed social security benefits to pay for the private institutional care of the elderly and of people with serious psychiatric, physical, and learning disabilities. Cash-strapped NHS authorities and rate-capped local authorities encouraged patients to use this new revenue stream. Between 1982 and 1993, 148,000 of these NHS beds and 40,000 places supported by local authorities closed. As the new rules allowed social security to pay for these services privately, the number of places in the private and voluntary sector grew by 122,000 (Pollock 1995a, 1580). This double move simultaneously privatized health care and moved it off the NHS books. Then in 1993 the social security payments were capped, transferred to local authorities, and reduced during the four-year transitional block grant described above.

Further de facto privatization of de jure public institutions has occurred by making hospitals and community services into trusts. As Pollock (1995a, 1582) points out, "The remit of trust boards is to manage their trust effectively and to make a return on their capital

stock,' not, one notes, to improve patient care or give satisfaction to the community." They are no longer controlled by health authorities. Their "business activities are protected from scrutiny either by the public or by health authorities" (Pollock 1995b, 683). Privatization has been further accelerated by the private financing initiative (PFI), which enables investors to buy or build NHS facilities with long-term, noncompetitive leases and to enter into contracts with the NHS in which the profits are built in. PFI is a way to "save money" on current capital expenditures through loans that cost substantially more over the long run (Pollock 1995b; Dawson and Maynard 1996; Butler 1997). It is the principal device by which officials are making increases in the budget appear to be small (British Medical Association 1996, table 1). As emerged during the sale of nonprofit hospitals in the United States, the question is the extent to which policies for competition are a vehicle for using taxpayers' money to benefit private companies with no commensurate benefit to the public (Fox and Isenberg 1996).

Besides services and public assets, accountability is being privatized, as independent agents are given public money and allowed discretion in how to spend it. The lack of standards for measuring eligibility, service, and quality, and the absence of data sets by which to document them, mean increased privatization of access and services and greater inequalities (Pollock 1995a, b).

Problem 6: Substituted Ideological Conviction for Evaluation

The ideology of competition promises to depoliticize cost containment (Enthoven 1985), but the decision to introduce market reforms was itself highly politicized and did not involve assessing how the remarkable efficiency gains of the 1980s were achieved nor how competition would actually improve value for money (May 1993; Webster 1993). Underfunding was the chief culprit. Beds and services routinely had to be closed. Despite costly technological advances, rising expectations, and the burdens of aging, funding slowed during the 1980s compared with previous decades (Robinson and Judge 1987). The Thatcher Administration was repeatedly attacked in the late 1980s for letting desperately ill patients wait for treatment, or even die (Butler 1994). An editorial in the *British Medical Journal* declared the NHS to be in terminal decline (Smith 1988). Managed competition substituted ideology for realistic evaluation.

The British government's response to these dangers has been to announce Success by Declaration. This has involved three notable policies. One required that no senior officer speak critically of official actions or engage serious criticism realistically, which in effect produces a blackout of realistic exchange about real problems that need solving. This "we can do no wrong" posture greatly limits what can be done to repair a decision that is not working.

The second way in which the government made it difficult to measure performance objectively was that it commissioned virtually no independent evaluations, it minimized data collected on the performance of providers or units, and it issued misleading reports of increased productivity (Radical Statistics Health Group 1992; 1995). As recently as December 1994, the *British Medical Journal* published details of suppressed data, obstruction of access to other data, use of the Official Secrets Act to block information about services, gag clauses in trust contracts prohibiting doctors from voicing criticisms of the quality of medicine they observed, and political control of health care professionals (Smith 1994). The problem persists (Birley 1996), and the traditional inspection role of the Health Advisory Service is being brought to an end (Agnew 1996).

The devolution of management has increasingly fragmented national data, a point that raises basic questions about the relation between markets and measured quality or efficiency. All the senior health economists and health service researchers confirm this situation (see essays in Light and May [1993] and in Robinson and LeGrand [1994]). Most of the studies I have cited are small scale and limited, but little else is available.

Finally, consumer and citizen involvement has been minimal. Of course, consumerism appears to be one of the basic platforms of the market reforms; the key document is entitled *Working for Patients* (Secretaries of State for Health 1989). Yet working "for" patients largely means doctors and managers deciding what is good for them. There is no independent monitoring or assessment of the consumer rights bestowed on patients as part of the reforms (McIver and Martin 1996). Although recent years have witnessed many consultation exercises in the community, the reformed NHS stands in contrast to other, similar primary-care-based systems that are run by community councils (Boерна, deJong, and Mulder 1994; Simard 1995; Kokko 1995).

More profoundly, the reforms were not anchored in a vision of where the NHS wanted to go and a strategic plan for getting there, but they

rather arose out of a belief in competition as an end in itself. After summarizing the central elements of the reforms, Butler (1994, 19) asks, "Yet what was it all for? What were the goals or purposes or objectives of the white paper? . . . What was the theory underlying the Government's belief in the capacity of the internal market to enhance the efficient use of resources?"

These six problems, or negative lessons, suggest that the underfunding that the government tried to blame on inefficiencies, which market reforms were to eliminate, still remains; only now there are new expenses and dislocations (Lyll 1997). After holding steady at about 6 percent GDP during the 1980s, health care expenditures have risen to 7 percent during the reforms (Organisation for Economic Co-operation and Development 1993; British Medical Association 1996). The lesson to be learned is that if one cannot have good competition in health care that produces lower prices, better services, and greater value without sacrificing equity, then don't have it at all. According to two prominent researchers, the reforms have produced "the emergence of low-trust relationships, a range of perverse incentives (i.e., cost shifting, gaming, goal displacement, adverse selection), high transaction costs, irreversibility" (D. Hunter 1996; Coote and Hunter 1996). The last repercussion is the most sobering. Despite increased funding, two-thirds of the health authorities and many trusts are in deficit (Chadda 1996); yet 77 percent of the population name health care as a top priority for more spending, and 61 percent say they are willing to pay more taxes to do so (Jowell et al. 1996).

From the six negative lessons we have learned that, contrary to the image of an invisible hand sorting out the problems of health care, competition in health care requires a strong, guiding hand. Its tendencies to highlight inequalities and to create political embarrassment mean that a nation interested in avoiding both may trumpet the virtues of competition while allowing little of it to take place. Market reforms also spur consumerism and demand. They accentuate the natural advantages that belong to providers and packagers of services in health care and reward them for maximizing their advantages over the purchasers. These observations imply that although the competition strategy in the United States may initially save money as its huge overprovision is squeezed out, eventually the result will be greater costs, dislocations, and inequities as the relatively unmanaged markets expand and the entire system gets locked in by corporations focused on maximizing quarterly returns to investors.

From Managed Competition to Managed Cooperation

By the second year of managed competition, many hospital executives and purchasers began to express in interviews their frustrations with the dislocations and costs of competitive contracting, especially in markets that the central market managers were constantly altering. Competitive contracting took a lot of time and seemed to get in the way of providing health care. It turned partners into adversaries, pitted one part of the system against another, led to closed-door negotiations and private pricing, and created high transaction costs. Yet, paradoxically, "the development and regulation of the market in its first four years have depended on the very structures that it aimed to dismantle" (Hughes, McHale, and Griffiths 1996, 177). Wasn't the point of needs-based purchasing to *work together* to figure out how best to spend a limited budget to help people with their health problems? Didn't this mean that the act of purchasing—or even better, of commissioning—was what really mattered? Purchasers began to advocate *joint commissioning* between the primary-care GP budget and the health authority budget for hospital and community health care (Ham and Heginbotham 1991; Light 1994). Purchasers found that it made more sense to work cooperatively in providing care to patients with chronic conditions. Top administrators began to form joint commissioning authorities, even though they were illegal, because each partner was required to purchase in its own domain. Senior managers developed elaborate informal procedures and accounting mechanisms to meet the legal requirements to keep budgets separate while breaching them in practice. The NHS Executive quickly caught on and announced that "partnerships and long-term agreements" were the new order of the day (Mawhinney 1995, 19). Parliament hastily rewrote the law to make these practices legal. Now official, unified health authorities are drawing GP fundholders into various forms of cooperative purchasing. In the fall of 1996 the NHS Executive revealed that "'competition theory' was to be unceremoniously junked and replaced with renewed emphasis on collaboration" (Disappearing Continents 1996).

Purchasing or commissioning promotes accountability, value for money, and a structured process of reflecting on what one is doing that administering services does not do. If commissioning is done as *managed cooperation* between purchasers and providers, parties come together over a

common, needs-based budget and think through more cost-effective ways to reconfigure their services and reallocate funds. There is the sense that almost all the benefits of the health care reforms stem from the act of purchasing, and almost all the hazards, inequities, and cost run-ups come from competitive contracting. This conclusion may seem strange, even contradictory; for how can one purchase without competition resulting? Certainly some contestability is inherent in purchasing, but the policy refocus makes a great difference. Cooperative purchasing between parties or enterprises that have a common goal (like maximizing the health of a people) is similar to the Japanese style of competition in which protected entities (like health authorities) have long-term relationships with the best producers they can find, and work mutually with them to improve service and product (Best 1990; Johnson 1995; Lazonick 1991). Cooperative and regulated purchasing focuses on maximizing production, in this case of health for entire communities and society. Laissez-faire competition tends to be short term, unplanned, and corrosive to the shared values that underpin care for the sick (Soros 1997). Cooperative purchasing is long term, planned, and involves partnerships with the suppliers or providers. A critic might reasonably point out that this shift from purchaser-provider split to purchaser-provider partnership takes one full circle back to a state-administered system. Three differences, however, distinguish managed cooperation: the purchasers are in charge, the relationships are contractual, and the parties search together for greater value.

Joint commissioning and managed cooperation have revolutionary implications: the end of the GP contract as primary care is integrated into the rest of the NHS; the reconfiguration of secondary services into local facilities; large redistributions of funds to attain risk-adjusted equity; major redistributions of power; and the integration of services around populations with chronic problems (Light 1992c; Malcolm, Alp and Bryson 1994; Redmayne 1996). However, they are complex concepts, which are now being defined and are still unproved. The leaders of authorities that oversee hospitals and community care have different values and come to joint commissioning with different backgrounds from those overseeing primary care. Further, senior figures in hospital, community, and primary care come to the table with significant differences, which need to be worked out (Ham and Shapiro 1995). Still more fundamental are differences in the goals of purchasing. "The dilemma here is that health authorities and fundholders offer a starkly contrasting

approach to purchasing. . . . In simple terms, the choice is between needs-based purchasing for large populations and demand-based purchasing for small populations" (Ham and Spurgeon 1992, 32). Reconciling the patient-centered focus of GP fundholders on patients at the local level with areawide joint commissioning has become a priority and may be accomplished either by enlarging fundholding to include the entire budget, by bringing GPs into commissioning, or by creating local comprehensive commissioning authorities (Smith 1996; Light 1994, 1995c). Missing from joint commissioning and managed cooperation, however, is managing the waiting lists, a clear function of purchasers, not consultants, that should be coordinated through areawide appointment centers (Light 1990e).

Joint commissioning also refers to joining the budgets for primary care and for hospital and community care with the budget for community care services that are now part of the local or municipal budget for social services. Such a move would make sense in terms of addressing the social and practical needs of people with chronic disorders and in terms of moving upstream to reduce health problems by reducing crime and violence, providing safe and adequate housing, and generating more jobs. For these same reasons, some of the leading health policy analysts in the United States are warning against current competition and advocating cooperation: "The ultimate goal for health care's stakeholders is to create healthy customers and communities. . . . Only if all parties agree to cooperate in reducing demand and optimizing resources can America provide affordable health care to its 250 million residents" (Coile 1995, 7). All the national hospital associations now advocate comprehensive community care networks as the vision for the future (American Hospital Association 1994; but see Light 1997). But in the United Kingdom, if not the United States and many other countries, this kind of joint commissioning poses the real danger of becoming the conduit for shifting still more services from the NHS, where they are available free to everyone as "health" services, over to local budgets, where they are available only as "welfare" services (Pollock 1995a).

The Americanization of the NHS?

A prominent overview of the NHS reforms proposes that they are Americanizing the NHS in five ways (Mechanic 1995): First, "both countries

emphasize the role of market forces and competition in seeking new arrangements that are better suited to address the growing tensions between population demands and needs and the capacity of public budget to meet them" (p. 52). Second, the internal market is like American public contracting. Third, creating trusts makes hospitals like nonprofits. Fourth, GP fundholding creates mini-HMOs. And fifth, "as in the United States, efforts are being made to promote health . . ." (p. 57). At the same time, eight other ways are mentioned in which the NHS remains substantially different from the American system, leaving it unclear what one is to conclude.

Let me conclude by suggesting that the NHS is not becoming very Americanized in these ways, but rather in darker ways that are a cause for concern by the new British government and many other nations involved in forms of managed competition. To review the five ways, we have seen that the British did not allow market forces much play for good reasons, and they are moving away from them at the same time that U.S. policy makers are letting them rip through health care services with increasing ferocity. The internal market is somewhat like public contracting in the United States, but the difference is that, in the United Kingdom, it applies to everyone and has risk adjustments for the deprived as well as extensive safeguards against discrimination and cost shifting. Trust status does move NHS hospitals a bit toward being like American nonprofits, which raises all the same questions now current in the United States about the meaning of "nonprofit" and whether nonprofits serve any public purpose at all. Is trust status a way station on the road to NHS hospitals becoming for-profit? GP fundholding would be like mini-HMOs if HMOs bore little risk, could not lose money, could not make profits, and had to operate within the framework of a comprehensive budget that covered all services for an entire area population. The national campaign to promote health in Great Britain is not so much American as it is a derivative of WHO's Health for All many years later, without the central principles of reducing social inequalities and promoting community participation (Radical Statistics Health Group 1991).

To say that so fundamentally different a system as that of the United Kingdom is becoming like ours has an ethnocentric ring, but, if anything, the NHS *is* becoming Americanized in five quite different ways: using tax breaks to drive up expenditures on health care by providing discounts on health insurance at taxpayers' expense; fostering two-tier

access to vital services through public law; transferring public property to investors at favorable rates; using public money to pay for private services with generous built-in profits; and shrinking NHS services for persons with chronic problems, just when the number of people suffering from these problems is increasing rapidly. These five trends serve to hold down current public expenditures by increasing future ones and by shifting costs to people's household budgets. In the United Kingdom and elsewhere, market reforms to produce efficiency and savings represent a major import of U.S. public policy. Evidence that either goal has been achieved is mixed, but the reforms provide a rationalization for privatization and class discrimination behind the scenes. Hsiao (1994) reports the same effect in several other health care systems. The question is whether the new government in the United Kingdom will allow these trends and their legal underpinnings to continue. So far, neither party, nor the press, is discussing them seriously.

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Address correspondence to: Professor Donald W. Light, University of Medicine and Dentistry of New Jersey—SOM, 40 East Laurel Road, PCC 218, Stratford, New Jersey 08084.