THE AMERICANIZATION OF THE BRITISH NATIONAL HEALTH SERVICE

by David Mechanic

Prologue: Since the release of its much-discussed White Paper, Working for Patients, in 1989, the British government has been quietly going about the business of reforming its National Health Service (NHS). Three major changes proposed in that document, and implemented since then, are (1) to create an internal market to separate the financing of care from its provision; (2) to set hospitals up as self-governing trusts with budgetary autonomy and the ability to sell services to various purchasers; and (3) to establish general practitioners (GPs) as fundholders on behalf of their patients. The chief criticism of the reforms on the part of physicians and Labor Party liberals was that the NHS was being privatized and commercialized beyond recognition. Observers in the United States watched with interest as the British moved to “Americanize” their venerable NHS, in the words of David Mechanic. In this paper Mechanic, long a participant-observer of and commentator on the U.S. health care system, transfers his microscope to the British system, taking advantage of a year spent as visiting scholar at the London-based King’s Fund Institute to write a comparison of reform approaches, and results, in the two countries. Despite some differences in terminology, Mechanic writes, the British reforms “involved concepts that are familiar and taken for granted in the American context.” A native of New York City, Mechanic received his doctorate in sociology from Stanford University and spent many years on the faculty of the University of Wisconsin-Madison. In 1979 Mechanic moved to Rutgers University; in 1985 he established the university’s Institute for Health, Health Care Policy, and Aging Research, which he directs. Mechanic is the Rene’ Dubos Professor of Behavioral Sciences at Rutgers. He is a member of the Institute of Medicine and an elected member of the National Academy of Sciences.
Abstract: The core reform of the British National Health Service (NHS) was the establishment of a quasi market with a split between purchasers and providers. Health authorities and general practitioner (GP) fundholders were to be discriminating purchasers seeking more efficient and responsive services. This market orientation was embedded in a larger context of managerial, allocational, public health, and primary care changes. This paper reviews the background and dynamics of these modifications and offers an early assessment. There is evidence that the reforms have unleashed much energy, activity, and thoughtfulness about future health care, but it remains unclear whether the gains justify the increased administrative and other transaction costs and potential threats to equal access.

Both the United States and the United Kingdom have gone through protracted debates on reform of their health care systems in the past several years. In each instance, the debate focused on basic questions of how medical care should be organized to limit costs while maintaining quality and on the responsibilities of government, the private sector, and purchasers, providers, and patients. Although the United Kingdom set out on a new course and the debate in the United States stalemated, both systems of care continue to evolve in response to new challenges in science and technology, the aging of the national populations, increasing public expectations, and the demands of national and local politics.

There is much that differs greatly in the two countries, ranging from their systems of government and policy-making processes to the magnitude of their investments in health care services. The British National Health Service (NHS) is a system under the tight supervision of central government with predominantly a single source of revenue from national taxation. Medical care is universally available, and most care is free at the point of service. The general practitioner (GP) and health center, as the point of first contact, constitute a strong primary care system in which basic health services are readily accessible, but GP gatekeepers are the route to more expensive services such as specialty and hospital referral. Waiting lists are the central mechanism to fit services to demand, and waiting is most common for discretionary surgery. Although recent surveys show considerable public disquiet with developments in the NHS, particularly with perceived underfunding and conditions in hospital outpatient departments, the NHS commands great loyalty among the population.

It may seem curious to expect to learn from contrasts between systems as different as those of the United States and the United Kingdom. Yet, despite these differences, 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 budgets to meet them. Although not a central participant in either country, Alain Enthoven set the background for framing many of the issues in both nations with his concept of managed competition. His advocacy for an internal market in the NHS was widely
discussed in health policy circles and is acknowledged by former Prime Minister Margaret Thatcher to have been the background for the government’s reform considerations. Despite their very different starting points, the United States and the United Kingdom have been considering initiatives that could result in greater similarities than have ever been evident in the countries’ contrasting approaches to organizing health care services.

Background Of The British Reforms

Since its inception the NHS has undergone periodic reorganizations, but not in ways that greatly altered either medical dominance or the expectations of patients using the service. In the early 1980s considerable emphasis was put on improved management, and there was growing awareness that the needs-based formula for allocating funding to regions and districts and compensating areas for utilization across boundaries (the Resource Allocating Working Party formula, referred to as RA WP) was flawed. The allocation formula was modified to better take account of need as measured by mortality differences, age structure, and socioeconomic indicators; this process is continuing. In the 1980s a number of managerial initiatives were introduced in the hospital and community sectors, followed by efforts to monitor primary care more closely and to give greater emphasis to disease prevention and health promotion. Many of these ideas were implemented through a new contract for GPs introduced in April 1990. Thus, the later British reforms were embedded within processes of continuing operational changes affecting resource allocation, the organization of the Department of Health, institutional accountability, and GP contract provisions.

References to the British reforms usually relate to three changes that had greater ideological implications than the iterative modifications in operations and management had. First, these changes sought to separate the financing and purchasing of care from its provision, creating an internal market. Second, hospitals and other health care organizations publicly administered by the local health authority were allowed to become self-governing trusts, having more autonomy for their budgets and self-management and the authority to sell services to any health authority, other hospitals, or the private sector. Third, GPs with larger numbers of patients were allowed to take charge of part of the budget for their patients (approximately 25 percent) and to purchase services on their behalf from any provider.

Despite their unfamiliar descriptions, these reforms involve concepts that are familiar and taken for granted in the American context. The internal market, for example, is similar to public contracting for medical and social services as carried out by many state and local governments in
the United States. The British “trusts,” although they have less autonomy, resemble nonprofit provider organizations common in the United States. GP fundholding is basically a restricted or mini-health maintenance organization (HMO) in which providers are contractually responsible for purchasing necessary services for their enrollees. The details may vary a good bit, but it is not too far-fetched to suggest that the Thatcher reforms were to some degree an Americanization of the NHS.

Uncovering the forces and specific events leading to these changes is the historian’s task, but the general picture seems reasonably clear. In the 1970s and 1980s advancing technologies, an aging population, and increased patient expectations focused attention on resource shortages. Tensions were exacerbated by conflicts between the government and the medical profession and increased media attention to shortages, waiting lists, and other incidents that implied failure in maintaining NHS standards. The Labor Party made the NHS and evidence of resource shortages issues in the 1987 election, thereafter putting the Thatcher government on the defensive.\(^6\) No reasonable increment of increased funding by itself was likely to eliminate the rationing tensions. Chancellor of England Nigel Lawson, as chief financial officer of the country, was unwilling to yield to the irresistible pressures to increase NHS expenditures without a review of the inefficiencies and flaws in the NHS.\(^7\)

In January 1988 Prime Minister Thatcher set up a ministerial group, which she chaired. This small group of five members met frequently over most of the year; their efforts culminated in publication of the White Paper, \textit{Working for Patients}.\(^8\) The proposed reforms were strongly opposed by Labor and much of the medical profession, which alleged that the NHS was being privatized and commercialized. Commanding a majority in Parliament and in control of her party, the prime minister was able to legislate her program substantially intact. As the Labor Party prepares for the next election, it remains opposed to many aspects of these reforms, and especially to GP fundholding. It remains to be seen how firmly these changes are entrenched and how they might be modified if Labor prevails in the next election, an event seen as increasingly likely.

Americans familiar with state competitive contracting will appreciate how much the so-called internal market in the United Kingdom deviates from a truly competitive situation, especially considering that the constraints in the British context are greater than in most of our states. Julian Le Grand and his colleagues have described the British “internal market” as a “quasi market,” which departs from conventional markets in terms of both supply and demand. In quasi markets, organizations need not be private or seek profits. Nor is purchasing necessarily expressed in money terms.\(^9\) Although privatization was given consideration in early discussions of
reform within the Thatcher government, the eventual goal was more modest: making cost more salient for health professionals and patients.\textsuperscript{10}

\textbf{National Health Service: Reforms And Related Changes}

As noted above, the key feature of the British reforms was an effort to create a quasi market within the NHS with a separation between the purchasing of services and their provision. The District Health Authorities (DHAs), each encompassing about half a million people, receive an allocation from the central government. Although prior to the reforms the health districts were purchasers and providers of services, they now also are responsible for assessing need and purchasing services from hundreds of provider organizations that have become trusts and are independent of the health authorities. They also are permitted to purchase services from the private sector, although private purchasing is now very limited. Purchasing is allowed anywhere in the country as a means to encourage trusts to be more responsive providers and health districts to be more prudent buyers. The theory is, of course, that the competitiveness of the quasi market will result in improvements in efficiency and quality, or as the British put it, will provide more value for money.

\textbf{Fundholding.} GPs with larger practices are now allowed to apply to become fundholders, for which they receive an allocation for purchasing a defined set of elective, nonemergency services for their patients. Nonfundholders must refer patients to hospitals and specialists that have contracts with the local health authority.\textsuperscript{11} While nonfundholders are gatekeepers, they do not work within a budget. Fundholding services may be purchased from wherever the GP decides and from either public or private sources. Savings achieved may be reinvested in the practice or in new services, but not directly in GPs’ personal incomes. Some GPs resent the introduction of money into their relationships with patients, and some critics worry about the possibility that fundholders’ investments in their own practices can be turned into profit when they retire and transfer their practices. But, by any American standard, the profit incentives for fundholders are extraordinarily weak. Initially, the scheme was to apply to practices of 11,000 patients or more, but it was subsequently reduced to 9,000 patients, then 7,000, and more recently to 5,000.\textsuperscript{12} Fundholding now covers about half of the population, although such coverage varies greatly among geographical areas. The range of purchasing also has been extended, and experiments are now in place to examine a much broader capitation covering the entire spectrum of care.\textsuperscript{13} Fundholders are not at personal financial risk and are protected against excessive financial risk to their practices by a stop-loss for each patient, with additional costs incurred by the DHA.
Fundholding, initially seen as a small aspect of the quasi market, has gained considerable prominence in the United Kingdom, and the government has been extending the scheme. Fundholding greatly increases the bargaining power of GPs, who can take their contracts elsewhere should hospitals, medical consultants, or other agencies show a lack of responsiveness. Nonfundholders are largely restricted to those providers chosen by the local health authority. Fundholding also allows GPs to purchase a different mix of services. Although GP contracts are a small part of the income of any of the trusts, at the margins the income they provide can potentially affect the economic health or even the survival of these institutions.

Fundholding requires GP practices to engage in considerable contracting activities for which higher levels of practice management and informational capacity are required. The Department of Health has invested considerable funding in introducing managers into practices and upgrading computer systems. While some claim that the Department of Health gives preferential treatment to fundholders, others view the improvements in management and information systems as a prerequisite for high-quality primary care. Current data do not allow an accurate assessment of the extent to which early fundholders received preferential treatment or whether perceived improvements justify the added practice costs.

Community care. The three basic 1991 reforms were followed by a further initiative in community care that might be seen as an extension of the reforms. The 1991 community care initiative and later clarifications affecting the frail elderly, the mentally ill, and other persons with disabilities clearly distinguished between the responsibilities of the NHS in providing free health care to all and social care, which was to be provided on the basis of a means test. All responsibility for long-term care was given to local government, reducing some of the earlier flexibility in the NHS that allowed the transfer of patients from the health to the social security budget. The open-ended social security system and opportunities to cost-shift relieved pressures on both health and social services, but long-term care social security funding is now capped, with these monies transferred to local governments to distribute on a needs basis. Local authorities were instructed to reduce direct provision and purchase social services largely from the private sector. The reduction in funding flexibility and the budget cap led to charges that long-term care needs were being neglected. Studies by the Department of Health indicate serious continuing difficulties.

The community care initiative is a complex revision of services in which local government, in cooperation with the DHAs, develops and commissions services as a way of reducing fragmentation between these two sectors. Local government case managers are given new authority to assess need and to make disbursements for residential and home care on that basis. A major
policy motive was to reduce growing social security entitlements for residential care, shifting the emphasis to less expensive home care and making grants discretionary relative to assessed need. Community care is generally difficult, requiring cooperation from different sectors such as housing, social services, and medical care. Workers from each sector have their own culture and bureaucratic needs, and all function in a context of constrained resources. Also, it is not clear that case managers from local government have the capacity to integrate needed services. Everyone concedes that community care is problematic. The value of the reforms in this sector remains uncertain, and erosion of long-term care is of major concern to the affected groups.

Health promotion/disease prevention. Finally, as in the United States, efforts are being made to promote health through improved lifestyles and public education and practice. Focusing on behavioral change and environmental improvement, the government has set various objectives and priorities such as reducing smoking and lung cancer deaths and suicide in its publication, *The Health of the Nation*. The establishment of objectives is similar to the “year 2000 objectives” in the United States, although less elaborately developed. Both efforts share the same difficulty of developing a clear strategy for implementation. While over the longer run the British effort offers important potential, the challenge remains of translating rhetoric into viable programs that can realistically attain the goals envisioned.

Comparative Considerations

From the American side, there is much in the United Kingdom to emulate, particularly universal coverage, easily accessible and increasingly well developed primary care services, an impressive capacity to maintain a balance among various levels of care, and control of health care expenditures. But the NHS had become rather set in its ways, somewhat inefficient and unresponsive, and not particularly receptive to innovation or to patient preferences. Although it seemed to muddle through from year to year, periodically modifying its organizational and managerial structures, it has been a service very much dominated by the preferences and practice proclivities of the consultant specialists who controlled their turfs with an iron grip and were not particularly responsive to opportunities to carefully inspect the value of their practice choices. Most are hard working and conscientious but largely oblivious to issues of efficiency and the need to manage resources well. Global budgets impose financial constraints, but a need remains to allocate fairly within these limits. Innovations in the United States, such as outpatient and day surgery, professional peer review, health services evaluation, and practice guidelines, are slow to develop in a
system that goes along with the presumption that the consultant always knows best. Although the British government was ready to intrude when budgetary issues were at stake, it gave doctors a degree of freedom that U.S. physicians can regard with envy.

Rationing and queues. It should be no surprise that a service that invests so few of its national resources in health care, compared with the United States, would have fewer amenities and longer queues. Certainly the NHS rations the availability of technology—chronic renal dialysis being perhaps the best known and most highly publicized example—although the extent of rationing in this area has been greatly reduced in recent years. Here the result of rationing is clearly death; thus, this example served those who enjoy bashing the NHS. But, for the most part, the constraints on life-extending technology seem to be applied more to interventions such as coronary artery bypass surgery and uncertain cancer treatments for which there is at least an arguable case about the appropriate aggressiveness of intervention. Perhaps more serious are the extended waiting lists for discretionary services such as cataract, knee, and varicose vein surgery and hip replacements. Although people do not die from delays in receiving these treatments, their comfort and level of functioning may be severely limited. The Patients’ Charter, part of a national effort to improve the provision of public service, establishes maximum waiting times for various procedures. Despite some improvement, even these targets seem shockingly long to Americans. The quality of health systems must be judged by their capacity to promote health, reduce disability, and enhance quality of life and not solely by their ability to provide life-extending treatments. Indicators of improved functioning are likely to convey a great deal more about the quality of medical care than are mortality outcomes, which are largely a product of broader social and environmental factors.

Competition and decentralization. The direction of reform is never inevitable and depends much on culture, prior institutional and professional arrangements, dominant ideologies, and politics. During the 1980s both the United Kingdom and the United States followed a common ideology that extolled the virtues of competition in the marketplace and the efficiencies of privatization. In both countries, government, while advocating greater competition and decentralization of decision making, strengthened central control over financial arrangements and, in the United Kingdom, managerial control as well. Central government was prepared to leave micromanagement to the regions and local districts, but not without considerable advice and guidelines from the center. This allows the central government to have a hand in what goes on but also insulates it to some extent from embarrassment stemming from rationing problems or service failures.
The NHS remains largely intact, in the sense that it continues as a tax-funded, universal system, free to all at the point of service. Outside of major revolutions, health care systems evolve from what went before. Within these limits, it is fair to say that Prime Minister Thatcher put her distinctive stamp on Britain’s health care services, substantially shaking up the cozy understandings and power relationships that prevailed. At the very least, the reforms have forced all of the major participants to think more carefully about their roles and responsibilities and their connections with other parts of the health and social services systems. From a more optimistic standpoint, the separation of the roles of purchasers and providers of service offers the potential to introduce greater efficiencies and responsiveness to client populations. It will be uncertain for some time whether the large transaction costs of creating a quasi-market are justified by the results. Health districts and GP fundholders are now establishing service contracts with hospitals and other community caregivers to meet the needs of their patients. There is a great deal of learning required on the part of all parties as they modify their roles, and it will be some time before the outcomes sort out.

From theory to action: internal markets. The opportunity for the leadership of the political party in power to make policy in the British context allowed Prime Minister Thatcher to move forward aggressively despite broad opposition and fierce resistance from the medical profession. As the Thatcher government looked around for possible models, it seized on the idea of developing an internal market, but instead of testing the concept in demonstration projects as Enthoven had suggested, it imposed the idea on the entire country by fiat. Enthoven, focusing on efficiency, had argued for developing purchasing at the district level, but the government took a two-prong approach, giving purchasing authority to both the DHA's and the GP fundholders. Initial fundholders were given budgets based on their historical costs for purchasing a defined set of services and were held harmless for expenditures in any year exceeding $5,000 (approximately $8,000) per client. Theory would suggest difficulties with such small purchasing entities and an inclination toward risk selection, as some American commentators warned. Thus far, however, fundholding apparently has been one of the more successful of the new initiatives—energizing many GPs and encouraging provider responsiveness—although it is still early in the game.

There are good reasons why some of the perverse outcomes reasonably to be expected in the United States with such a scheme have not materialized in the British context. The first cohorts of GP fundholders were enthusiastic participants, largely motivated to improve care for their patients. Although savings could be invested in enhanced services in the practice,
they could not directly be used to increase GP remuneration. Moreover, with the funds based on historical costs, and with relatively stable practice populations, GPs were unlikely to experience any radical change in case-mix, and emergency services remained the responsibility of the DHAs. If case-mix was altered for unanticipated reasons, being held harmless for extra-large expenditures (a form of reinsurance) protected GPs from large losses. Historical costs vary quite a bit across GP practices for no apparent reason, and the obvious next step is to develop a risk-adjusted capitation formula that will allocate resources in a more equitable way. As more GPs enter fundholding status and as capitation schemes are introduced, it will be important to assess how the capacity of GPs to be independent purchasers develops and how national health objectives are sustained with the decentralization of purchasing responsibility.

While GP fundholding appears to have achieved some success, expanding the scope of fundholding to cover a wider array of health services might prove dangerous. There are indications that many GPs know too little about the potentialities of new specialized services to purchase them appropriately. Moreover, in some specialized areas, such as care for the severely mentally ill, appropriate services are not available in many localities and need to be developed on a geographic basis. Even if GPs are appropriately aware, the fragmentation of purchasing among many purchasers makes it less likely that the necessary service systems will be developed. There also is concern that GPs will divert resources intended for the severely mentally ill to patients who are less sick. Similar considerations apply to other highly specialized medical services.

While district purchasing has been very conservative, largely contracting with historical providers using block contracts, fundholding GPs have been more aggressive and innovative. GPs, who no longer fit the characterization put forth by Lord Moran (an eminent medical educator and Winston Churchill’s personal physician) as those who have fallen off the mobility ladder, nevertheless are treated by consultant physicians with less than full equality. Fundholding has given GPs more leverage in dealing with consultants and outpatient departments. They now have the wherewithal to take their business elsewhere should hospitals treat them and their patients discourteously or fail to provide a reasonable service. Studies of early fundholders show that they have had some success at reducing patient waiting times, getting consultants to see patients at GP premises, and generally improving the system’s responsiveness to patients. The assumption that the constrained available services provide a zero-sum situation in which improvements are bought only at the expense of nonfundholders has led to concerns about possible inequities resulting from fundholding schemes. As more GPs become fundholders, the risk of differential treat-
ment may abate somewhat, although monitoring of the situation would be prudent. Careful efforts to monitor the scheme thus far have not substantiated the fears and allegations, although the perception of growing inequalities persists.

Having studied general practice in the United Kingdom some thirty years ago, and having expressed skepticism of its capacity to keep pace with medical advances, I am impressed by how well the country seems to have fared since changes in remuneration and other conditions of service were introduced in 1966. One of the real strengths of the NHS is its primary care system, which provides easy access but controls admission to more expensive components of medical care. Single-handed practice has shrunk, and GPs increasingly work in small groups in collaboration with nurses, social workers, and other health personnel. Patient lists are substantially reduced from what they were thirty years ago, and GPs are given incentives to provide preventive care and to respond to other national priorities. GP remuneration has much improved relative to that of specialists, and GPs no longer express the sense of relative deprivation that so poisoned the practice atmosphere of the early 1960s. General practice is now successfully entrenched in the medical schools, and the Royal College of General Practice, which was just a fledgling organization thirty years ago, now plays a major role in encouraging a high standard of practice and in giving GPs a greater sense of esteem. The 1990 legislation that made it easier for patients to change GPs and that increased the capitation component of GP remuneration to 60 percent (to encourage competition for patients) represents another small facet of attempting to build a quasi marketplace that energizes provider responsiveness.

GP reactions. Many GPs, however, remain angry about their 1990 contract, which set increased expectations and required more practice monitoring and information. Some aspects of the contract provide additional fees for specific services and have not been controversial. But other requirements, such as annual checkups for patients over age seventy-five and having to provide more information to patients on the services they provide, are seen by some GPs as a waste of their time and practice resources. Also highly controversial are target payments for achieving particular levels of Pap smears and immunizations and health promotion “banding arrangements” in which remuneration is scaled to the proportion of one’s patients who are assessed for various health risks. Although the ideas underlying these incentives are apparent, they put new burdens on practitioners who already perceive themselves as overextended.

Large disparities in general practice costs still exist across geographical areas, comparable to the large utilization and cost variations found in the United States. These reflect differences in GPs’ attitudes, referral opportu-
nities, and other factors that are not yet fully understood. The expansion of fundholding makes salient the issue of adjusted capitation, although this remains an area that the British government will approach especially carefully, given the irritations already common among GPs.  

Resource distribution. In recent years the national government has made efforts to achieve greater equity among regions and districts in hospital services; resources have been withdrawn from inner London, an international center for medical education and research. The new purchasing arrangements have resulted in fewer referrals from outside London, leading to an inquiry into the future of health services in London. The resulting “Tomlinson Report” recommended closing or merging some of the most distinguished British hospitals, and this process is continuing despite years of controversy and rancor. London was greatly overbedded, but in the past few years there has been a large reduction of acute care beds. Strong differences of opinion persist on whether these reductions exceed reasonable levels, and the media almost daily feature stories about the difficulties in locating appropriate beds for emergency hospitalization of mentally ill patients, persons needing intensive care, and other groups. A 1992 King’s Fund report supported the conclusions of the Tomlinson inquiry, but more recently concern has been expressed about the pace of change. This later critique emphasizes the need for having new services in place before old ones are abolished, always having the capacity to deal with emergencies and crises, and achieving greater consensus and understanding as the changes proceed. There is little question that the shrinkage of resources has cast a pall over London medicine. Not surprisingly, most London physicians express hostility not only to the government but also to the reforms.

It is an open question as to whether the shrinkage of the London medical infrastructure has been too fast and too deep and whether the allocation formula on which this reduction is based is appropriately sensitive to the special circumstances of London. The extent to which the problem of acute bed availability reflects resource shortages or bad management remains controversial and unresolved. Whatever the merits of opposing views, the picture of the overall NHS reforms is soured by the developments that affect London and some other large cities. Yet these are the physicians whose voices are best known in the international community and who may substantially color how the British reforms are perceived from the outside.

Practice variations and quality control. Serious problems remain with the implementation of reforms, and dangers lie ahead. No reform can compensate for an underfinanced health service, and the NHS is greatly underfunded by the standards of most developed Western nations. Most of these nations are richer than the United Kingdom, but rising expectations for access to new technologies have no obvious link to gross domestic
product (GDP). For example, in the early 1990s rates of coronary artery bypass graft surgery and coronary angioplasty in the United Kingdom lagged behind those in most industrial countries. Rates per million population for these procedures have been approximately one-sixth of those in the United States. U.S. physicians may be doing far too many such procedures, although recent studies of appropriateness indicate that this excess may be exaggerated. Rates in the United Kingdom, however, are very low.

Variations in the use of such procedures among health districts in the United Kingdom are very large; clearly, too few are being done in many areas of the country. With purchasing fragmented among districts and GP fundholders, who can exercise great discretion, monitoring future performance will be difficult. This may be still a larger problem with less prestigious services, such as for the mentally ill or the disabled, whose needs may be even more poorly understood and neglected at the local level than they were before. With decentralization of purchasing, practice variations and differences in quality of service may become larger. As the reforms proceed, it will be essential to distinguish rhetoric from results. The declaration of goals and aims may be quite different from the allocation of resources. In an interesting study of 100 commissioning authority plans for 1993-1994, Sharon Redmayne, Rudolf Klein, and Patricia Day found relatively stable purchasing patterns despite many new aspirational priorities. In tracing the subsequent allocation of new developmental funding, they found that 58 percent of the total went to acute care relative to acute care’s 51 percent proportion of the NHS budget. Mental health, the most commonly endorsed aspirational priority, received only 8 percent of priority expenditures, which is only two-thirds of its share of the overall NHS budget.

However one may regard the direction of NHS reforms and the particular initiatives, the energy in new directions is incontestable. The NHS may not feel a great deal different for the typical patient, but the reforms have initiated a process of examination and local involvement that has brought new enthusiasm to many participants. Thus far, health districts, encouraged by the Department of Health to move slowly, have been extremely conservative, only modifying preexisting service arrangements at the margins, but the potential for more radical shifts as they gain confidence and expertise is evident. Whether the efforts and new administrative expenses are justified by the results remains to be seen. In the short run, however, the new potential has shaken many entrenched routines.

Lessons From Abroad?

One might chalk up the varying success of the Thatcher and Clinton governments in reforming health care to differences in determination,
political skill, or, more likely, the very different governmental structures in the United Kingdom and the United States. The founding fathers of the United States did not establish a framework that makes it easy to concentrate power or to achieve major shifts in carrying out government’s business. Nevertheless, the different outcomes in the two countries are instructive and offer some insights about the increasing difficulties of formulating coherent public policies.

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Thatcher was not deterred, however, and persisted with her agenda on the basis of ideology, with little evidence that the quasi market could really work. Skeptics might argue that her goal was to divert attention and responsibility from the failure to adequately finance the NHS by decentralizing many decisions to disperse responsibility and to make it difficult to monitor events. Interestingly enough, even left-wing British health care experts now view the reforms as having positive potential.

In accepting many aspects of Enthoven’s conception of an internal market, the British government disregarded his reasonable advice to test the theory in selected regions and to work out administrative details. Instead, the reforms were put in place nationally with only the vaguest concept of how they were to be implemented or of the actual costs involved in the elaborate contracting that would become commonplace. Goals and implementation plans were repeatedly modified, and the government directed purchasers to move slowly in modifying preexisting relationships. In a sense, after a major ideological victory, the choice was made to implement social policy by muddling through, amending the process in response to both experience and politics. This process continues now, and implementation of the reforms is still evolving. It is assisted by the flexible legislative framework of the NHS that allows much modification without detailed legislation.

U.S. economists and health services researchers who follow British events were not shy in warning the British about all the ways in which the reforms would not work. The researchers were quick to observe that practices of 11,000 patients were far too small to become purchasers or to assume the risks of possible patient selection. Ironically, there has been no evidence that this constitutes a major problem in the United Kingdom, and the size criterion for a fundholding practice decreased to 7,000 patients and is now 5,000 patients. Indeed, the idea of fundholding itself, which was seen as too inconsequential and inefficient to be pursued, has turned out to be one of the more interesting innovations that has invigorated many GPs and has begun to change the insensitivity of some consultants.
It is naive to anticipate that approaches to reform or their substance are transferable from one culture and political context to another. Countries certainly get ideas from one another and insights as to what works in varying contexts and why. A recent review of reform in seventeen countries in the Organization for Economic Cooperation and Development (OECD) concluded that there was considerable convergence among these countries in reform initiatives, although these ideas were modified to fit local conditions. One lesson, perhaps, from the recent experience of the NHS is that governments not only need a vision, but also a pragmatic willingness to muddle through a bit, to allow reforms to evolve in iterations that build on experience. Although the Thatcher government knew what it wanted to achieve, unlike the Clinton administration, it left most of the details to be worked out over time. Health care reform, whether British or American, can be solved only in stages. As Rudolf Klein, one of the most astute observers of the British scene, recently noted:

There may be much to be learnt from the experience of different countries about the balance of advantages and disadvantages of trying to introduce carefully crafted new models, with every detail worked out, as against designing framework institutions which evolve over time. A comparison of the experiences of the United States and the United Kingdom might suggest that the advantage lies on the side of designing flexible framework institutions. Or it might simply demonstrate that different models of change are contingent on the political institutions in which the health care systems are embedded.

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NOTES

2. A.C. Enthoven, Reflections on the Management of the National Health Service (London: Nuffield Provincial Hospital Trust, 1985); and M. Thatcher, The Downing Street Years (London: HarperCollins, 1993), 607. Although it is clear that Enthoven's analysis was background to reform considerations, these reforms, particularly the internal market, were part of a broader trend to reduce the role of government and increase competition and responsiveness in education, social services, and housing as well as in health care. Thus, the reforms in their more general sense constituted part of a coherent and pragmatic ideology.
7. Ibid., 612-619. While Margaret Thatcher confirms Nigel Lawson's resistance to
increasing NHS expenditures, she gives his role less importance in initiating the review and developing the reforms. See Thatcher, *The Downing Street Years*, 607-617.


11. Prior to the reforms, GPs could refer patients to any NHS facility, although most referrals were to hospitals and other services within the district. Nonfundholders now have fewer choices for referral than they had before the reforms.


17. Department of Health, *Implementing Caring for People: Community Care Packages for Older People* (Lancashire: Health Publications Unit, 1994).


21. Frankel and West, *Rationing and Rationality in the National Health Service*.


24. Lawson, in *The View from No. 11*, offers an alternative view: “There was much criticism when the White Paper was published that the Government was being characteristically doctrinaire and arrogant in imposing its reforms without even having a series of pilot projects first. I found this very puzzling. No hospital was obliged to become an NHS Trust Hospital: those that did, volunteered to do so. Similarly, no doctors were obliged to become fundholders: those that did, volunteered to do so. This seemed to me to be the best possible form of pilot project, with the guinea pigs volunteering for their role rather than having it unwillingly thrust upon them” (618).

25. Ibid. Lawson notes: “My own idea had been that the review should be confined entirely to the hospital service. . . I felt it would be politically prudent to leave the reform of general practice until later, after the reform of the hospital service had been completed. Margaret, however, having initially been too nervous to do anything at all, once she accepted the idea, characteristically decided to go the whole hog, and reform everything at once” (615).

28. Ibid.
33. Here again, Lawson’s *View from No. 11* is revealing. He notes that “the general practitioner came face to face with the public all the time, and the political cost of alienating them could be very high” (615).