Competition, Cooperation, Or Control? Tales From The British National Health Service

In the battle between market competition and central control in Britain's health care system, control won. Will Labour's new version of the market prevail?

by Julian Le Grand

PROLOGUE: In July 1998 the British National Health Service (NHS) marked its fiftieth anniversary. The NHS brought together in one organization, for the first time, hospital, physician, and community health services—and also posed administrative and fiscal challenges that continue to plague it.

Britain undertook the latest in a series of reforms after the New Labour party assumed power in 1997. This latest reform, which represents a "third way" between the poles of liberal and conservative, focuses more on collaboration and less on the competitive principles of the previous internal-market reforms of Britain's Conservative government. In this paper Julian Le Grand discusses "the evidence concerning the internal market's effectiveness," building on a paper published in *Health Affairs* last July (Rudolf Klein, "Why Britain Is Reorganizing Its National Health Service—Yet Again"). Following Le Grand's paper is a series of Perspectives, focusing both on the NHS reforms and on another endeavor under way in Britain: an attempt to address inequalities in health, based on a study of the social determinants of health and poverty. This discussion has implications for other health care systems as they seek to improve their citizens' health in an era of cost constraints.

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ABSTRACT: The British National Health Service (NHS) recently underwent a massive social experiment, inspired in large part by the ideas of U.S. experts. This involved the creation of an internal or quasi-market, separating purchaser from provider and encouraging competition among providers. After reviewing the evidence concerning the impact of this experiment, I conclude that the impact in fact was minimal, partly because of the retention of central government control and partly because the experiment was based on an inadequate understanding of professional and managerial motivations. The paper draws out general lessons of the experiment for other market-oriented health care systems and examines whether the lessons are reflected in the new batch of NHS reforms initiated by the recently elected Labour Government.

THE BRITISH NATIONAL HEALTH SERVICE (NHS) has just undergone a massive social experiment. Inspired in large part by the ideas of American experts, especially Alain Enthoven, in 1991 Prime Minister Margaret Thatcher's Conservative government replaced the state bureaucracy of the NHS by an internal or quasi-market in health care: a market in which the state provides the finances but in which competition exists between independent suppliers to provide the service.[1] This system was controversial from its inception, and the Labour government of Tony Blair that took office in May 1997 is now replacing it with a system that, in theory at least, will rely more on cooperation than on competition.

Did the market experiment fulfill the expectations of its proposers? Or did it fail in the ways that its critics predicted? And are there more general lessons that can be learned by other countries—especially the United States, whence came much of the inspiration for the ideas in the first place?

Rudolf Klein recently set out in this journal the history of the experiment and offered his own interpretation of the events that led to its (partial) demise.[2] Rather than covering too much of the same ground, I concentrate first on discussing the evidence concerning the internal market's effectiveness and then add some further thoughts concerning that market's operations that complement Klein's analyses. The paper continues with some reflections on the lessons that could be learned by other countries from the experiment and concludes with a few observations on Labour's changes.

Introduction Of The Quasi-Market

Under Prime Minister Thatcher's reforms, a quasi-market in secondary health services was introduced where, in contrast to the old single-bureaucracy system, "purchasers" were separated from "providers" of health services. As under the old system, purchasers were funded by government from general taxation. Providers became quasi-independent entities, managing their own budgets and

financing them from contracts with purchasers. There was therefore the potential for competition between providers, with hospitals and other secondary care suppliers competing for contracts.

There were two kinds of purchasers. One was a district health authority, allocated a budget to purchase secondary care based on the size and characteristics of the district's population. The other was the general practice (GP) fundholder: a GP practice with a patient list over a certain size that was given a budget from which to purchase a more limited range of secondary treatments on behalf of its patients (usually elective surgery).[3] GPs could volunteer to become fundholders; those who did so received a budget based on their past referral activity for the treatment concerned.[4] The budget was deducted from the budget received by the health authority in which the fundholder was situated. Fundholders (but not health authorities) could keep any surplus they made on their budget, provided that it was spent on services or facilities of benefit to patients.

On the provider side, hospitals and the providers of other services became independent "trusts," although still nominally within the NHS. These providers contracted with health authorities and GP fundholders to provide services and had certain freedoms of action concerning pay, skill-mix, and service delivery. However, they had to conform to central guidelines concerning pricing and investment, and they could not retain any surpluses they might generate.

This quasi-market had similarities to more conventional market-oriented systems. GP fundholders were similar to U.S. health maintenance organizations (HMOs) that use primary care practitioners to manage care and that contract for secondary care with a variety of hospitals. Trusts were not dissimilar to U.S. nonprofit hospitals, in that they were independent but not privately owned and hence had no requirement to distribute any profits to private owners or shareholders. Most important, at least in theory, American-style competition had replaced Soviet-style command and control.

These similarities, however obvious, should not be overplayed. Unlike in the United States, funding remained firmly in the hands of government, with state finance still accounting for well over 90 percent of all health care spending. Most patients could not choose their own purchaser (patients of GP fundholders could change physicians if they wished, although few did, but no one could change his or her health authority except by moving). Thus little competition existed between purchasing agents for clients. Trusts, although nominally independent, remained publicly owned. And, as we shall see, both purchasers and providers still had their freedom severely curtailed by the central government.

Evidence On How The Quasi-Market Worked

The first point to make about the evidence concerning the working of the quasi-market is that there is not very much of it, and what there is, with one or two exceptions, is not very helpful. This is for two reasons. First, the Conservative government was against sponsoring its own evaluative studies, suspecting (with some justification) that those who called for experimentation and evaluation when the internal market was proposed intended to brake and perhaps even to derail the reforms. Moreover, unlike in the United States, few independent foundations or research institutions had sufficient resources to undertake the kind of large-scale evaluation that a macro-reform of this kind needed. Second, evaluating systemwide changes of this kind was fraught with methodological difficulties: confounding factors, time lags, measurement problems, and so on.

Despite these obstacles, some work has been done. Its conclusions may be summarized under three broad headings: efficiency, equity, and choice and responsiveness.[5]

■ **Efficiency.** The only indicator of overall efficiency for the NHS as a whole is based on the cost-weighted activity index (CWAI), obtained by aggregating activities such as outpatient attendances and inpatient spells, weighted by their cost. The CWAI is a crude indicator of health service output; it takes no account of quality or case-mix differences, for instance, let alone of effectiveness in terms of health gain. However, an index of the CWAI showed an annual rate of growth of 2.3 percent from 1980–1981 to 1990–1991, but 4.1 percent for the postreform period 1991–1992 to 1995–1996. Dividing this by the changes in real resources over the same two periods gives a crude measure of the average annual change in productive efficiency: 2 percent after reform, compared with 1.5 percent before.[6]

At a more micro level, some improvements in the quality of treatment could be mostly attributed to fundholding. Fundholders provided more outreach services than nonfundholders did. Also, fundholders obtained quicker admission for their patients and, generally, better response from providers.[7] Fundholders also kept down prescription costs relative to those of nonfundholders and were better able to generate surpluses than health authorities were.[8] Whether these improvements outweighed any associated increases in costs (and thereby led to an increase in efficiency, properly defined) is not known. There is controversy as to whether fundholders' relative success derived from their being more generously funded than health authorities; however, evidence suggests that this was not so.[9]

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The NHS traditionally has had remarkably low administrative costs. However, the introduction of contracting, and of the accounting procedures necessary to make contracting work, prompted this level to increase from around 8 percent in 1991–1992 to 11 percent in 1995–1996.[10] Administrative and clerical staff increased by 15 percent from 1990 to 1995, and general and senior managers increased by 133 percent.[11] However, it is important to note that management costs are included in the overall measure of the costs of resources going into the NHS. Hence, because activity increased more rapidly than did resources overall, any cost-inflationary impact from the increase in these costs was more than outweighed by other positive factors contributing to greater efficiencies.

■ **Equity.** The principal equity issue that worried many analysts, including U.S. observers, at the start of the internal market was the danger of "cream-skimming": the deliberate selection of patients, both by hospitals and by fundholding practices, who were easier or less costly to treat, in order to protect budgets.[12] However, there is no evidence that this was a problem, on either the purchaser or the provider side. Given that several parts of the internal market apparently offered incentives for cream-skimming, it is not immediately obvious why it failed to materialize. In the case of GP fundholders, perhaps the most obvious candidates for engaging in this practice, its absence may have been because there was an "insurance" scheme by which fundholders were not liable for the extra costs associated with very expensive patients—a fact that greatly reduced any incentive they may have had to exclude such patients from their lists.

■ **Choice and responsiveness.** The evidence suggests that choice for patients did not increase under the internal market. For instance, a study of the reforms' impact on choices offered to patients for cataract surgery found no increase in choice of either procedure or provider for patients of both fundholders and non-fundholders; indeed, if anything, choice for both purchasers and patients seemed to have been reduced. However, there was a limited increase in the amount of information given to patients.[13]

Fundholders appeared more successful than other forms of purchasers were in obtaining responsiveness from providers. However, there was little evidence of increased choice for their patients.[14]

■ **Little change overall?** Perhaps the most striking conclusion to arise from the evidence is how little overall measurable change there seems to have been. Indeed, in some areas where major

changes were expected, there were none. For instance, there seems to have been no difference between fundholders and nonfundholders in referral rates for elective surgery, despite the fact that one set of GPs was making referrals from a fixed budget for which they were responsible, and the other set was not.[15] In general, it is hard not to agree with Klein that "the outcome was less catastrophic than its opponents feared and less radical than its proponents hoped."[16]

This apparent absence of obvious change attributable to the internal market may be because there indeed was little change. Or it may be because there was change, but the studies concerned either focused on the wrong indicators or focused on the right indicators, but their deficiencies of technique were such that they could not pick up the relevant changes in those indicators.

It is clear that in some unmeasurable ways the NHS has changed fundamentally since the 1991 internal market reforms. Most analysts sense that there has been a considerable degree of cultural change involving health authorities and fundholding and nonfundholding practices, especially in terms of extra attention being paid to the concerns of GPs of all types and an alteration in GPs' standing within the system, if not always in their coercive power. Several analysts have shown the numerous ways in which new partnerships are developing between groups of practices and with health authorities.[17] It would now be unthinkable not to involve GPs and, increasingly, other primary care professionals in local commissioning processes in one way or another. Also, there seems to have been a considerable (and praiseworthy) increase in cost-consciousness throughout the NHS. Finally, there appears to be a wide, but not total, agreement that separately identifying the purchaser role from that of the provider has proved to be broadly successful and should remain in some form. At the very least, the contracting process probably has forced some greater clarity into the interchange between purchasers and providers as to what should be provided, for whom, to what standard, and at what price.

But why did these changes not result in more demonstrable impacts in the areas that we have investigated? The failure of studies to discern what changes did occur seems unlikely to be the whole explanation. Although the problems with the published evidence are legion, there do seem to have been a sufficient number of competent studies that would have picked up changes and differences, had they been large enough. So what went wrong?

Incentives And Constraints

The explanation probably lies with the way in which the internal market was implemented. Here there does seem to be a ready eco-

nomic answer: The incentives were too weak and the constraints were too strong. Put another way, the motivations for change were relatively weak, especially when compared with the pressures for stability from outside.

For markets of any kind to work, in the sense of achieving efficiency and equity, a number of conditions must be met.[18] In particular, agents must be motivated and free to respond to the relevant market signals. Yet most of the key actors in the NHS internal market, for a variety of reasons, had little direct incentive to move in the direction indicated by market developments. Also, both the actors and the market signals themselves were heavily constrained by central government intervention. So health authorities could not keep or invest any surplus they generated, leaving them with the sole incentive to spend up to their budget. The investment and, even more significantly, the pricing policies of trusts were strictly controlled; as a consequence, the opportunities for competition between them were highly restricted.

Further, many trusts' incomes were heavily dependent on their local health authority. Hence, authorities could not switch providers easily without destabilizing them. Also, because both central and local politicians were acutely sensitive to the political costs if a local hospital were to close, authorities often were instructed by the central government to bail out trusts in financial difficulties. As a result, for many trusts budget constraints became viewed as "soft" rather than "hard." Again, this had implications for competition. Trusts not only had limited opportunities to compete with one another, they had little incentive to do so—they could not keep any surpluses if they succeeded and would be bailed out if they failed. More generally, both health authorities and trusts were not really treated as independent but were viewed more as partially decentralized instruments of central government policy. They were certainly not, in any sense, free-market agents.

All of this is reinforced by the evidence concerning the relative performance of health authorities and the one agent not mentioned above: GP fundholders. Health authorities had little incentive to develop a surplus on their budgets, since it would simply disappear at year's end. At the same time, they were subject to a stream of governmental directives concerning priorities, waiting lists, and so on. They also were under considerable pressure, both from central government and from local interests, not to destabilize local providers by any abrupt changes in their purchasing strategies. It thus is hardly surprising that many of them concentrated on simply keeping the system going while trying to meet central priorities.

In contrast, GP fundholders could retain their surpluses and use

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them to improve their facilities. Equally significantly, they were less constrained than health authorities were; they were subject to a weak accountability regime and, being relatively small, could switch their purchasing without massively destabilizing providers. Instead, they represented an attractive source of marginal income to trusts. They had both more opportunity and more capacity to be innovative. It is no coincidence that the area where it has been easiest to detect some significant changes is where the incentives were strongest and the constraints the weakest.

Knaves Or Knights?

There is a more fundamental explanation for the failure of the internal market to have the impact its proponents hoped for. This concerns the principal motivations of the actors involved. For markets to work effectively, individuals need to be primarily motivated by the furtherance of their own interests, narrowly defined. In David Hume's terminology, service providers should be "knaves."[19] They should seize all profit-generating opportunities regardless of the impact on the service provided or the people using that service; they should act ruthlessly to cut down competitors; and they should only cooperate when it is in their direct self-interest to do so.

However, in practice, those working in the NHS—whether doctors, nurses, managers, or ancillary staff—often did not see themselves in this light. Rather, they felt that they were engaged in the provision of a public service, with provider relationships (both with each other and with their patients) based more on considerations of mutual trust than on adversarial competition. Bending Hume's terminology slightly, they were more "knights" than knaves.[20]

Researchers found that contracting had less impact than was expected in part because of the difficulty of specifying the content of services with sufficient clarity for contracting without threatening the relations of trust, professional discretion, and long-term cooperation on which the effective production of many services had largely depended.[21] Others found that relationships between purchasers and providers continued to develop alongside the formal contracting process as much as through it.[22] And, although we have noted that GP fundholders were the most potent engines of change, this reflected the activities of only a minority; the majority remained fairly passive with respect to the opportunities offered by the internal market and were certainly not entrepreneurial.[23]

So it may be that knightly motivations undermined the knavishness that would have been necessary for the quasi-market to work. It also may be that the incentives to be a knave that were implicit in the quasi-market structure also undermined existing knightly motivations, turning knights into knaves. Although perhaps morally distasteful, this might not have mattered from the point of view of the efficient operation of the market if any newly created knaves had been able to respond properly to market signals. However, as we have seen, these signals were often flawed or nonexistent.

Lessons For Other Systems

At least three lessons emerge from the British internal market experience. First, putting budgets for purchasing secondary care under the control of family practitioners can work in terms of improving hospitals' responsiveness, encouraging innovation, and improving efficient resource use. Depending on the services purchased, the population for which they are purchasing need not be very large: Some GP practices purchasing elective surgery had patient lists of only 5,000, and some of the "Total Purchasing Pilots" (TPPs, or fundholders purchasing all secondary care, including accident and emergency) had lists as small as 20,000. Nor need the budget be risk-adjusted, provided that there is some stop-loss insurance system for catastrophic expenditures (as there was for the small GP fundholders, although not for TPPs).

Second, incentives to encourage dramatic behavior change by health professionals or managers must be greater than those offered under the British internal market. Nor should they be undermined by continuous central government directives and by pressure to rescue failures.

Third, any incentive structure for health professionals and other staff needs to take account of both "knightly" and "knavish" motivations. Given that, as Kenneth Arrow pointed out more than thirty years ago (in my paraphrasing), a measure of knightly behavior is necessary to overcome possible problems that might arise from market failures in health care markets, care should be taken not to undermine that behavior by overly simplistic performance-incentive schemes.[24] What is needed are "robust" incentive structures, which appeal to both the knight and the knave. Although not easy, these are not impossible to find. Indeed, the incentive structure for GP fundholders had elements of this robustness, for their surpluses could be used for improving their own facilities, which not only improved services for patients (thus attracting the knight) but also increased the value of their own property (thus appealing to the knave).

What Next For The NHS?

In December 1997 the Labour government published a White Paper proposing the abolition of the internal market and its replacement by a new set of organizational structures.[25] Do the new proposals suggest that the lessons of the internal market have been learned?

The changes may be summarized as follows. (1) The purchaser/provider split is to remain, but with an emphasis on cooperative relationships, not competitive ones. However, as a last resort, purchasers can switch their purchasing away from their current providers. (2) Purchasers are to become primary care groups (PCGs), led by GPs. All GPs will be required to join PCGs. PCGs, already being formed, cover populations that vary in size from around 30,000 to 250,000. PCGs will be able to retain surpluses from their budgets, surpluses that can be spent on services or facilities of benefit to patients. The current trusts will remain and also will be able to retain surpluses. (3) Fundholders will be absorbed into PCGs. Health authorities will lose their purchasing role, except for certain highly specialized services, but will become the instrument for PCG accountability. A new performance "framework," with new performance indicators emphasizing effectiveness and outcomes, will be put in place by the central government. There will be two new national bodies: National Institute for Clinical Effectiveness (NICE), to set standards; and Council for Health Improvement (CHIMP), to enforce them.

The first striking point about these proposals is that, despite rhetoric to the contrary, key elements of the internal market are retained. The purchaser/provider split remains. The new GP-led commissioning organizations will hold budgets and in consequence will look remarkably like TPPs—institutions that some regard as the ultimate extension of fundholding. Trusts and PCGs are both to be allowed to retain their surpluses. And purchasers will be able to switch to other providers if they are dissatisfied with their existing ones: So competition—or at least contestability (the potential *in extremis* for competition)—will remain.

All of this seems consistent with the lessons to be learned from the internal market experience. As noted, the purchaser/provider split was generally thought to be one of the more successful elements. The evidence on the experience of different purchasing models showed that GPs with budgets tended to be the most effective purchasers. We noted the importance of retention of surpluses for purchasers and trusts. And it would be impossible to retain the purchaser/provider split without some possibility of competition.

But questions remain: What incentives are there for GPs to take

part, and what sanctions will PCG leaders have over "free-riding" colleagues? The experience of TPPs suggests that the smaller groups did better, largely because they had less need to invest in interpractice organizational development.[26] Another concern relates to the size of the PCGs. The bigger the commissioning authority, in a politically sensitive, highly managed system, the greater the danger that that authority's purchasing constitutes too large a portion of local trusts' income, thereby restricting the authority's ability to shift business elsewhere. This problem was particularly acute for the old health authorities, which often found their attempts to alter their pattern of purchasing stymied by the threat (either genuine or synthetic) of collapse because of the trusts' loss of business.

Perhaps the area of greatest worry is the role of the central government. The performance management framework in the Labour White Paper is centralist in tone with a large number of performance indicators (thirty-seven are now proposed) and with the introduction of institutions (NICE and CHIMP) designed to monitor performance and, if necessary, to intervene. Care will have to be taken that the government does not make the mistakes of its predecessor in paying lip service to the ideal of decentralization while at the same time trying to retain a strong grip from the center.[27]

Concluding Comments

In one view, the British quasi-market in health care neither succeeded nor failed, simply because it was never tried. The central government constrained the principal actors in the quasi-market—health authorities and trusts—from responding to market signals, while providing them with few true market incentives. It was not a quasi-market but simply a representation of one. In the battle between market competition and central control, control won.

Moreover, perhaps the quasi-market never could have been tried. As we have seen, markets require freedom of action; but it may be that health is too sensitive an issue in Britain for central government ever to let the relevant agents have enough freedom. Klein notes Aneurin Bevan's remark on founding the NHS that if a bedpan fell off a hospital bed, the sound would now resound throughout the Palace of Westminster.[28] Since then, however, both Parliament and Whitehall have been deafened by the sound of falling bedpans. In consequence, their priority has been always to keep the noise down—and that they can only do (they believe) by keeping tight central control. Real decentralization of resource allocation in health care, especially of the kind required by market mechanisms, is simply not possible in the British political system. According to this view, the quasi-market was doomed even before it started.

THE NHS IS NOW IN THE NEW WORLD of the Labour reforms. Important elements of the quasi-market remain: the purchaser/provider split and GP-led purchasing and commissioning. Moreover, as we have seen, these were arguably the most successful elements of the market. However, as Klein has pointed out, central control also remains and indeed has been strengthened in key ways.[29] Only time will tell whether Labour's new version of the market will dominate the continuing need for the central government to retain control. If the story told here is correct, however, a shrewd gambler would not bet on the market to win.

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NOTES

1. A. Enthoven, *Reflections on the Management of the NHS* (London: Nuffield Provincial Hospitals Trust, 1985); and J. Le Grand and W. Bartlett, eds., *Quasi-Markets and Social Policy* (London: Macmillan, 1993).
2. R. Klein, "Why Britain Is Reorganizing Its National Health Service—Yet Again," *Health Affairs* (July/August 1998): 111–125.
3. The treatments in question were about 30 percent of total referrals to secondary care. As the scheme evolved, different levels of fundholding were permitted. At one end, small practices were allowed to purchase only community services; at the other extreme, some experimental "total purchasing pilots" (TPPs) were introduced where a practice (or, more commonly, groups of practices) were allowed to purchase all forms of secondary care, including accident and emergency treatment.
4. So, for instance, if the fundholder were to purchase elective surgery, the budget was determined by the estimated cost of all of the elective referrals made by the practice in the year before it started fundholding. This gave practices an incentive to increase their referrals in that year, an incentive to which they responded; see B. Croxson, C. Propper, and A. Perkins, "Do Doctors Respond to Financial Incentives? UK Family Doctors and the GP Fundholder Scheme" (Unpublished paper, University of Bristol, 1998).
5. Much of this section is based on material in J. Le Grand, N. Mays, and J. Mulligan, eds., *Learning from the NHS Internal Market* (London: King's Fund, 1998). I am grateful to my King's Fund colleagues and to the Department of Health for allowing me to use the material here; however, the views expressed are entirely my own.
6. J. Mulligan, "Health Authority Purchasing," in *Learning from the NHS Internal Market*, chap. 3, 24.
7. H. Glennerster, M. Matsaganis, and P. Owens, *Implementing Fundholding: Wild Card or Winning Hand?* (Buckingham: Open University Press, 1994); and N. Goodwin, "General Practice Fundholding," in *Learning from the NHS Internal Market*, chap. 4, 62–64.
8. C. Harris and G. Scrivener, "Fundholders' Prescribing Costs: The First Five Years," *British Medical Journal* 313 (1996): 1531–1534; and Goodwin, "General Practice Fundholding," 45–48 and 53–54.
9. B. Dowling, "Effect of Fundholding on Waiting Times: Database Study," *British*

Medical Journal 315 (1998): 290–292.
10. Management Costs (King's Fund press briefing, 1997).
11. U.K. Department of Health, *Statistical Bulletin 1996/19* (London: Department of Health, 1996). The numbers are controversial since they were affected by a reclassification of staff from other pay scales, such as senior nurses involved in management tasks. Also, the increases began before the implementation of the internal market, and some of them could be attributed to the demands placed on managers as a result of other changes in the NHS, such as new requirements for improved corporate governance, complaints procedures, and so on.
12. R. Scheffler, "Adverse Selection: The Achilles Heel of the NHS Reforms," *Lancet i* (1989): 950–952.
13. M. Fotaki, "The Impact of Market-Oriented Reforms on Patient Choice and Information: A Case Study of Outer London and Stockholm," *Social Science and Medicine* (forthcoming).
14. J. Le Grand, N. Mays, and J. Dixon, "The Reforms: Success, Failure, or Neither?" in *Learning from the NHS Internal Market*, chap. 8, 127–128.
15. Goodwin, "General Practice Fundholding," 48–50.
16. Klein, "Why Britain Is Reorganizing Its National Health Service," 115.
17. N. Mays and J. Dixon, *Purchaser Plurality in U.K. Health Care: Is a Consensus Emerging and Is It the Right One?* (London: King's Fund, 1996); and J. Smith et al., *Mapping Approaches to Commissioning: Extending the Mosaic* (Birmingham: Health Services Management Centre, University of Birmingham, 1997).
18. See Le Grand and Bartlett, *Quasi-Markets and Social Policy*, chap. 2.
19. David Hume drew attention to the maxim that in designing constitutions, "every man ought to be supposed a knave and to have no other end, in all his actions, than private interest." He did not necessarily subscribe to this view, asking why "a maxim should be true in politics that is false in fact." D. Hume, "On the Independency of Parliament," in *Essays, Moral, Political and Literary*, vol. 1, ed. T. Green and T. Gross (London: Longmans, 1875), 117–118.
20. J. Le Grand, "Knights, Knaves, or Pawns? Human Behaviour and Social Policy," *Journal of Social Policy* 26, no. 2 (1997): 149–169.
21. R. Flynn, G. Williams, and S. Pickard, *Markets and Networks: Contracting in Community Health Services* (Buckingham: Open University Press, 1996).
22. P. Spurgeon et al., "The Experience of Contracting in Health Care," in *Contracting for Health: Quasi-Markets and the National Health Service*, ed. R. Flynn and G. Williams (Oxford: Oxford University Press, 1997), 135–152.
23. U.K. Audit Commission, *What the Doctor Ordered: A Study of GP Fundholding in England and Wales* (London: Her Majesty's Stationery Office, 1996); and C. Ennew, T. Feighan, and D. Whynes, "Entrepreneurial Activity in the Public Sector: Evidence from U.K. Primary Care," in *Choice and Public Policy*, ed. P. Taylor-Goodby (Houndmills: Macmillan, 1998), chap. 3, 42–61.
24. K. Arrow, "Uncertainty and the Economics of Medical Care," *American Economic Review* 53 (1963): 941–973.
25. Department of Health, *The New NHS—Modern, Dependable* (London: HMSO, 1997).
26. N. Mays et al., "What Were the Achievements of Total Purchasing Pilots in Their First Year and How Can They Be Explained?" Total Purchasing National Evaluation Team Working Paper (London: King's Fund, 1998).
27. At a recent meeting of trust and health authority chief executives, members complained that under the new government they were subject to command-and-control performance management that curtailed their initiative and overloaded them with guidance (*Health Service Journal*, October 1998, 14–15).
28. Klein, "Why Britain Is Reorganizing Its National Health Service," 117.
29. Ibid., 122.