

**Experiences with the UK National Health
Service Reforms:
A case of the infernal market?**

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ABSTRACT

The 1991 NHS Reforms introduced an internal market within the UK National Health Service. The move to this form of managed competition represented the greatest change to health services in the UK since the NHS was established, with the separation of the responsibilities for commissioning and providing health care. Under the internal market, purchasers (District Health Authorities and General Practitioner fundholders) are responsible for commissioning health care which best meets the needs of their resident populations. Commissioning occurs through contracts made with health care providers (NHS trusts), and providers are allowed to compete for these contracts. The performance of the internal market will be discussed in this paper in terms of four main criteria: quality, efficiency, choice, and equity. Special attention will be paid to key elements of the system, including General Practitioner fundholders, the contracting process, and the extent of competition between providers.

TABLE OF CONTENTS

1	Introduction	1
2	Managed Competition	2
3	The NHS Reforms and the Internal Market	5
4	Performance of the Internal Market	8
4.1	Quality	8
4.2	Efficiency	9
4.3	Choice and Responsiveness	11
4.4	Equity	12
5	Conclusions	14
	References	16

1 INTRODUCTION

Managed competition models of health systems are receiving significant attention from health professionals, academics, and policy makers alike. The notion of managed competition has underpinned major health care reforms in many countries in recent years, the most notable being the Netherlands, New Zealand, the United States, and the UK. Several states in Australia have also been experimenting with managed competition, with varying degrees of success. To some managed competition is the panacea for rising health care costs and lengthy waiting lists, to others it is an attempt to introduce a market based system where it has no place.

This paper assesses the performance of the National Health Service (NHS) internal market, which contains elements of managed competition, in its sixth year of operation. Section 2 outlines the key concepts which underpin managed competition and its use in health care. Section 3 describes the NHS internal market and how it operates, and section 4 examines what we have learnt about the performance of the internal market. Section 5 draws conclusions and assesses implications for the future.

2 MANAGED COMPETITION

At the most general level, health systems can be characterized by the nature of the finance and the provision of health care. That is, a distinction can be drawn between health systems depending on whether health care is financed privately (through private health insurance or out of pocket payments) or publicly (through taxation or social insurance), and whether health care is provided by private or public individuals and institutions.

This distinction can be thought of as a spectrum. One end of the spectrum describes a health system in which all health care is financed and provided privately, and the other end of the spectrum describes a health system in which all health care is financed and provided publicly. Most countries, including Australia, would appear in the middle of the spectrum with a mix of both public and private finance and organization. However, in studying models of health care systems it is often most fruitful to examine the most extreme points on the spectrum. The United States would lie closest to private end of the spectrum for developed countries. It has the highest level of private sector involvement in health care of any developed country in the world, with approximately 60 per cent of finance raised privately and health care delivery dominated by private providers. The United Kingdom, on the other hand, would lie closest to the public end of the spectrum for developed countries. Only 5 per cent of health care in the UK is financed privately, and the private provision of health care is extremely limited.

The US and the UK systems both have advantages and disadvantages. The de-centralized market system in the US may promote increased responsiveness to consumer demands amongst providers, with low waiting lists and only limited political intervention. However, the US has experienced high health care cost inflation and significant inequities in health care provision. The UK centralized and regulated system has historically performed better in containing costs, and has attempted to achieve explicit equity goals in the provision of health care. The centralized control of finance and capacity has however, led to waiting lists, weak incentives to be responsive to consumer demands, and prioritization by political groups, which might be expected to reduce

the efficiency of the system. Managed competition arose as an attempt to combine the desirable properties of equity, efficiency, and cost containment of these types of systems.

Many authors have suggested that the qualified and regulated use of market forces could achieve the best of both worlds: market driven efficiency with regulatory control of expenditure, and equity in access and financing. Managed competition models attempt to do this by separating the funding and provision elements of the health system, and by establishing clearer objectives in the system with appropriate incentive and sanction mechanisms. Society should determine the overall size of the health budget (through the political process), and health priorities for specific population groups. The health care market then determines how specific health needs are to be met.

Managed competition can be described by the roles of key “actors” within the health care system.

- Regulator Monitors and regulates the operation of the market, applies incentives and sanctions rules, and may act as an arbitrator (usually the role of the government).
- Funder Acts as a financier, collects taxes or fees and distributes them to purchasers (often also the role of the government).
- Purchasers/
Budget holders Act as agents for particular population groups by contracting for the provision of health care services to best meet the health needs of those groups.
- Providers Sell health care services to purchasers at an agreed price (and quality).
- Consumers Choose an appropriate purchaser and lobby for their health care needs if currently not being met to their satisfaction.

This approach to health system design has two main features. Firstly, consumers have a choice of regulated purchasing organizations which procure health care to meet consumers health needs. Secondly, the purchasers/budget holders, have a choice of provider organizations to procure such health care from. This has incentives for efficient behaviour through competition between providers in the supply of health care, and through competition for consumers between purchasers/budget holders which offer different “health plans” for different population groups. These two forms of competition relate to the two types of efficiency which economists typically distinguish between:

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- Technical efficiency Health care interventions should be provided at minimum resource use (least cost). Managed competition seeks to achieve this through competition between providers.
 - Allocative efficiency The mix of health care interventions should maximize the overall health benefits to the population as a whole. Managed competition seeks to achieve this through competition between purchasers for consumers.

3 THE NHS REFORMS AND THE INTERNAL MARKET

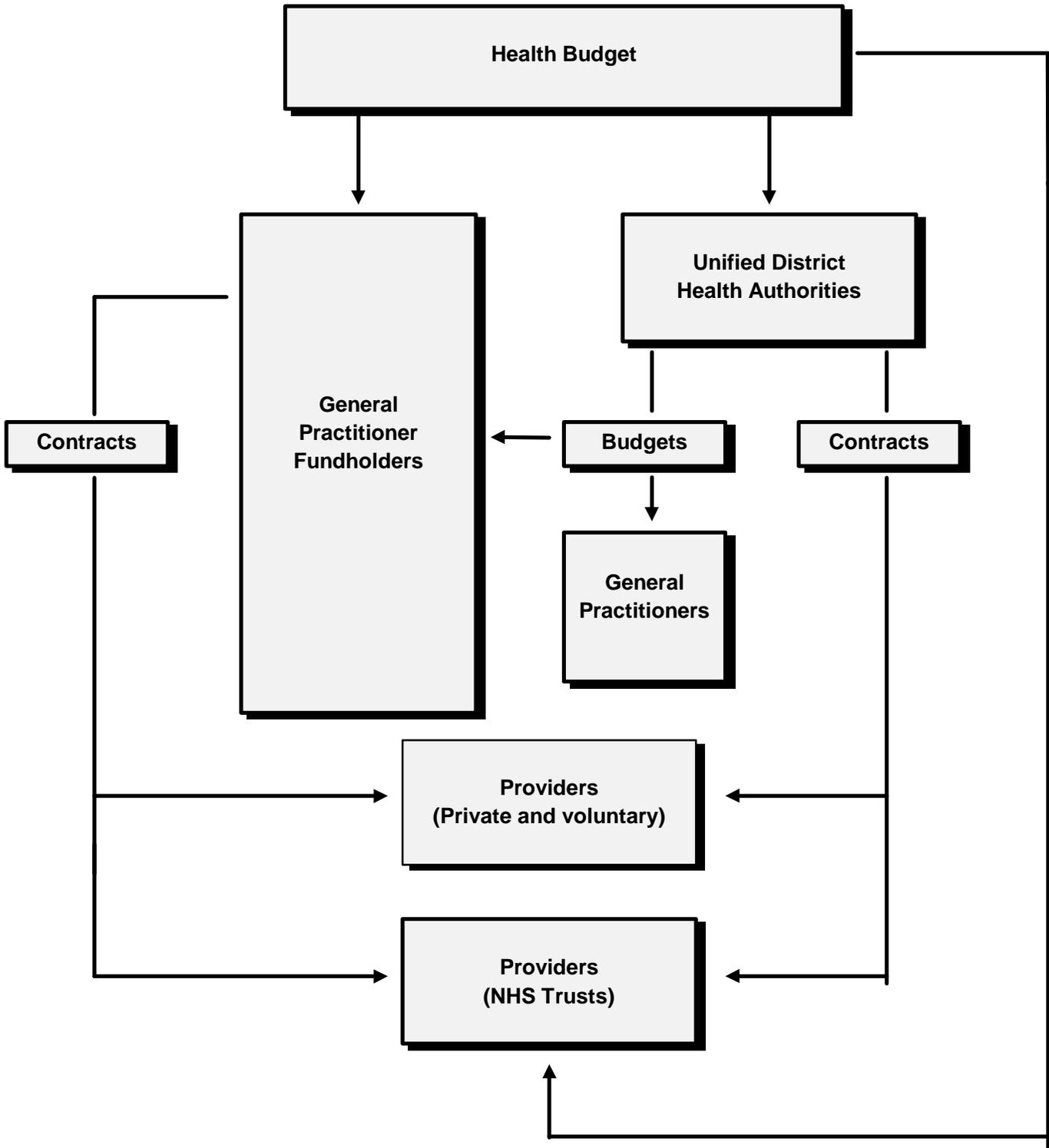
In 1989 the Conservative Government released two White Papers which outlined the most radical shake up of health services in the UK since the NHS was established (Department of Health, 1989a; Department of Health, 1989b). An internal market was introduced in April 1991, as part of what have become more commonly known as the NHS reforms.

The internal market was created through separation of the procurement and provision functions of the NHS, sometimes referred to as the purchaser-provider split. Under the internal market system purchasers (Unified District Health Authorities and General Practitioner fundholders) receive funds from the central funder (the Government) and undertake to commission health care for their respective populations from providers (NHS Trusts, private, and voluntary providers). Health care is purchased through the use of contracts placed by the purchaser with different providers. The structure of the internal market is shown in figure 1.

Unified purchasing authorities are emerging from the merger of District Health Authorities, which were broadly responsible for secondary and tertiary care under the original reforms, and Family Health Service Authorities which are responsible for GP services. Funding arrangements for District Health Authorities are based on a weighted capitation formula for hospital and community health services (Carr-Hill et al, 1994), and GP services look set to move towards weighted capitation based funding in the future.

GP fundholding consists of a budget allocated to each practice which is used for purchasing drugs, some elective inpatient and outpatient care, and some community health services. The range of health care services covered under fundholding budgets may increase in the future however, as total fundholding (under which GPs purchase all health care services for their patients) is currently being piloted at sites across the UK. Fundholders can retain surpluses to invest in their practices.

FIGURE 1 The NHS Internal Market



Providers receive income through contracts with Health Authorities and GP fundholders, and NHS Trusts also receive capital funds directly from the NHS Executive central body. Contract prices are set equal to cost, and providers are not allowed to cross subsidize service provision from other areas of their contracts (Mason and Morgan, 1995). NHS trusts are owned by the NHS but are self governing bodies, and are allowed to retain a percentage of any surpluses made.

Contracts between purchasers and providers usually take one of three forms. The simplest type of contract is the block contract, where the contract revenue is specified but the volume of activity a provider is to meet is not specified. Under this type of contract a provider typically must treat all cases presenting at the hospital for conditions specified under the contract. The block contract was widely used in the early years of the internal market when purchasers had little information and experience in forecasting demand, but it is still used in certain areas such as Accident and Emergency services where demand is unpredictable. Block contracts maximize the incentives for providers to control costs, as contract revenue is fixed whilst activity levels may vary (the provider bears the financial risk of expenditure exceeding revenue).

The second form of contract is the cost and volume contract, where both revenue and volume of activity are preset. These contracts are beginning to dominate the internal market, and each contract may cover a number of conditions. As contracting has developed so has the sophistication of contracts, with many cost and volume contracts now having clauses for treating extra patients (above the volume set by the contract) with reimbursement at marginal cost where there is “unplanned excess capacity”.

The third type of contract is the cost per case contract, where revenue is paid on the basis of individual cases treated. This form of contract is rare in the NHS, and is usually reserved for rare and very high cost conditions. Cost per case contracts place financial risk on the purchasers, and may only generate weak incentives for providers to control costs as all activity is reimbursed at cost.

4 PERFORMANCE OF THE INTERNAL MARKET

Le Grand (1994) has identified four major dimensions over which the performance of the NHS internal market can be assessed:

- Quality
- Efficiency
- Choice and Responsiveness
- Equity

4.1 Quality

Evidence relating to the impact of the NHS reforms on quality can be split between the effects on non-clinical (process) factors and clinical factors.

In general the reforms appear to have had only a limited impact on non-clinical factors. In a study of 2,400 elderly patients receiving inpatient care between 1990 and 1992 process factors such as waiting times, information provided prior to admission, and food and cleanliness were found to have deteriorated following the reforms, whilst communication by health service staff during an inpatient stay was found to have improved (Jones, Lester, and West, 1994). Conclusive evidence on whether GP fundholding has increased quality of care is not currently available (Dixon and Glennerster, 1995). However, fundholding has presented some encouraging results, with reports of better communications between hospital consultants and GPs, reduced waiting times for patients at fundholding practices, and improved access to services such as pathology and radiology. Fundholding practices have also reported improvements in services due to

investments in more practice staff made from reduced expenditure on drugs (Glennerster et al., 1994). These results should be interpreted with caution however as they relate to evidence from the first set of fundholding practices to be established. The first wave of fundholders are likely to have been the more dynamic practices in the NHS, and it has been suggested that these practices received greater shares of funds than non-fundholding practices.

Evidence on the impact of the reforms on clinical factors has been limited to anecdotal comments. Whilst the contracting process has raised awareness of costs and outcomes in health care, contracting in the NHS to date has been focused on activity measures rather than on the quality of care and health outcomes. This is a result of the lack of available information on the quality factors and outcomes associated with different interventions and types of care. There is some evidence that purchasers are beginning to address quality of care more directly through contract negotiations. For instance, in the care of patients with End Stage Renal Failure some purchasers are beginning to stipulate the types of dialysis machines to be used, water quality for dialysis, and erythropoietin targets in their contracts with renal units (Greenwood et al, 1992). Despite such developments outcome and cost-effective based purchasing in the NHS is still in its formative stages (Drummond, 1995). The challenge for the NHS is two-fold: firstly to move in the long term to outcome based decision making using the criteria of cost-effectiveness; and secondly, to develop meaningful process measures on which to base medium and short term contracts. It may be argued on this latter point that the UK still has some way to go in particular, as contracts are based on Finished Consultant Episodes which are cruder process measures than DRGs and other alternatives. In the longer term the development of outcomes based purchasing will depend upon the resolution of significant issues in the measurement of health itself, and on the availability of sound evaluative evidence for different forms of health care. To this end organizations such as the Cochrane Centres will play a vital role in informing health care decision making.

One element of the reforms directly aimed at improving clinical factors was the introduction of Medical Audit. This process has evolved to mean peer review of good practice within providers, largely through reference to case notes. Little evidence of the effectiveness of Medical Audit in improving quality in health care delivery is available as yet, and critics of the process have focused on the lack of attention paid to costs and health gain measurement in Medical Audit, and the lack of involvement of purchasers.

4.2 Efficiency

It is questionable whether genuine competition exists between providers in many areas of health care. Access issues tend to dominate purchasing strategies for many conditions and specialties, with purchasers and consumers preferring to commission health care from a local provider than from distant providers for many conditions and types of care. This raises the potential for local monopolies in certain areas of care, with weakened incentives for providers to minimize costs (technical efficiency). Where competition does occur it is likely to be in large urban centres where there are a number of local providers offering competing health care services, and on the fringes of District Health Authorities' boundaries.

Indeed many areas of the health sector in the UK are oligopolistic in nature (small numbers of large providers who have a degree of market power), due to the historically centralized nature of the NHS and the high capital costs of providing many forms of health care (Ferguson and Palmer, 1994). Such providers may tend to exhibit what is known as satisficing behaviour (achieving “acceptable” goals) rather than attempting to achieve efficient provision of health care (Cyert and March, 1963). Competition in such markets tends to be limited to amenity factors rather than price and quality (European airlines provide a good example of this type of market: competition tends to be via in-flight meals, flight attendant service, etc. rather than through prices), and has led to accusations of managed marketing rather than managed competition emerging in the NHS (Paton, 1995). Evidence from the United States has suggested that non-price competition in health care results in excess capacity, duplication of services, and increased costs of health care provision (Maynard, 1993).

Many providers in the UK also have significantly more information than purchasers, particularly on the costs and quality of care, giving them a stronger negotiating standpoint in contracting and enhancing their ability to wield market power. This has led to calls for openness in cost and price information in the NHS (Ferguson and Palmer, 1994), whilst other authors have suggested such information is not of vital importance and stress the role of negotiations in obtaining relevant price information (Dawson, 1994).

As the internal market matures in the UK there is a real possibility that local bilateral monopolies will emerge (Ferguson, 1996). This occurs when there is a single local provider, and a single local purchaser. This is emerging as Family Health Service Authorities merge with District Health Authorities to form large purchasing consortia, coupled with hospital mergers and the development of longer term contracting arrangements. Whilst larger purchasers have the potential to countervail the market power of local provider monopolies (Dawson, 1995), bilateral monopolies may be characterized by the provision of health care based on the relative power, and the negotiation skills, of the purchaser and provider rather than price and quality issues.

A major criticism of the internal market has been the costs of establishing and running the contracting process. The negotiation of contracts takes most of the financial year for both purchasers and providers. This involves significant costs to both parties, which economists term transaction costs. Such costs include the search costs of finding and collating information, and the costs of negotiating, monitoring, and enforcing contracts. Whilst evidence has suggested that the types of markets found under managed competition generally increase transaction costs (Rosen and McKee, 1995), the appropriate question to ask is whether the transaction costs of the contracting process outweigh any efficiency savings made. To date no research has been published to assess this trade-off, largely due to difficulties isolating any efficiency gains due to the internal market rather than due to other policy changes in the NHS. The presence of significant transaction costs has led to a need for medium and long term contracts between purchasers and providers. This may have potential advantages as long term agreements are necessary for effective investment in infrastructure, and longer term contracts may be more consistent with notions of continuity of care.

The introduction of the General Practitioner fundholding scheme was perhaps the most controversial element of the NHS reforms, not least in the eyes of GPs themselves. However, evidence suggests that the scheme has yielded some important benefits. Several studies have shown that fundholding reduces prescribing costs in, with stimulation of the use of generic prescribing (Dixon and Glennerster, 1995). Fundholding has also led to increased diversity in the range of services offered by practices, through the use of savings made from lower expenditure on drugs, but the efficiency implications (in terms of health outcomes) of the increase in the range of services provided are unclear (Dixon and Glennerster, 1995). Competition between NHS Trusts has also been stimulated by fundholding, as Trusts compete for business from different fundholding practices, but at present this represents only a limited amount of the total amount of health care delivered by NHS providers.

4.3 Choice and Responsiveness

Proponents of managed competition models suggest that consumer choice will be enhanced as providers become increasingly responsive to purchasers demands through the operation of sanctions on contracts, and that the health system will be more responsive to consumers themselves as budgets are devolved to GPs and hence closer to patients.

However, it appears that consumers in general remain largely uninvolved in health care decision making despite the reforms and attempts at raising the awareness of patient rights through the Patients Charter in the UK. Evidence suggests that the reforms have had little impact in patient involvement in the choice of consultant and hospital for referral, and that only fundholding GPs have had increased choices available to them in referring patients (Mahon, Wilkin, and Whitehouse, 1994). A major reason for the lack of consumer involvement in health care decision making is the lack of information an individual has about the choice of available interventions and their likely impact on the individuals well being. This suggests the NHS still has a long way to go to reach a point where individuals genuinely participate in making informed choices about their health care. However, there is also a question about whether some individuals will actually want to be involved in some choices regarding their health care, even given good information and real choices between providers. Different individuals may want different levels of involvement in health care choices, especially when decisions are emotive and the consequences for the individual of the decision are potentially serious.

Another concern is to what extent consumers have good information on which to base their choice of GP, and how easy is it to actually change GP. Anecdotal evidence suggests that individuals probably will not be very well informed about relative merits of one GP or one practice versus another. Individuals are more likely to base their decisions on which GP to see on word of mouth and on the proximity of the practice, rather than on available evidence of the quality of GP services (Newman, 1995). In the past it has also been rather difficult to change GP in the UK and it is unclear whether individuals are aware of recent changes in the NHS which make changing GPs easier.

The NHS internal market does not offer consumers the choice between large purchasers instead, health care is purchased for consumers by the District Health Authority which covers the geographical area they live in. Of course, in theory, a dissatisfied consumer can move to change District and hence purchaser, but it appears to be implausible to suggest that an individual would move home solely on the basis of dissatisfaction with their District Health Authority. Hence the NHS internal market does not conform to the “full” managed competition model, and this weakens both the incentives for Districts to act in their patients’ best interests, and the incentives for purchasers to act in an allocatively efficient manner. Instead the system relies on the more traditional NHS values of Districts acting altruistically and being accountable to the communities they serve.

Incentives for GP fundholders to act in the best interests of their populations appear to be stronger however, particularly as individuals have the opportunity to represent themselves directly through GP consultations, and have the choice of which practice to attend. Moreover, the GP fundholding scheme is set for expansion in the UK (NHS Executive, 1994) with a move towards total fundholding practices. Total fundholders will purchase all health care for their patients, including maternity, accident and emergency, and medical and psychiatric inpatient services, with the scheme currently being piloted across the country in several practices. This proposal also has its problems, as large numbers of total fundholding practices negotiating contracts will incur significant administrative costs for the NHS, and only some GPs will have (or may not want to develop) the appropriate skills to manage a budget. The response to this may well be the development of total fundholding purchasing consortia, with individuals having the choice of which consortium to use for purchasing their health care. Another perceived advantage of the move towards total fundholding is that this will place the emphasis firmly on primary care in the NHS (Ham, 1996a).

4.4 Equity

In the earliest years of the reforms fundholding was criticised for creating a “two tier system”, where patients at fundholding practices received hospital care more quickly than those at non-fundholding practices. Whilst sound evaluative evidence has not been published to confirm or refute this allegation, anecdotal evidence does suggest that there was significant potential for non-fundholding patients to wait longer for hospital care. The fundholding scheme has increasingly been embraced by the GP community, with over 40 per cent of the population now registered at fundholding practices (Ham and Shapiro, 1995). This figure continues rise, with the anticipation that most practices will be fundholders in the near future. As a result, the problem of a two tier system will fall away in some areas as patients will be left with a choice of only fundholding practices, and will be free to choose whichever practice they feel will best meet their health care needs. However, this choice must be seen in light of previous comments on the availability of information to consumers in the decision of which practice to attend, or which GP to see. Furthermore, it is unlikely that all GPs will become fundholders, especially in the case of single GP practices. Single GP practices tend to be more common in inner city areas, particularly in London, leaving the possibility that a two tier system may exist for many years in some areas of the UK.

Some real concerns do remain about the fundholding system. GPs now have the incentive to cream-skim if fundholding budgets are not fully adjusted for risk, that is they may not accept potentially high cost patients on to their practice lists as this may reduce surpluses (Glennister et al, 1992). They also have the incentive to under refer and under treat patients. The incentive to cream-skim may have been reduced by the use of a £5,000 ceiling on the expenditure a GP fundholder can incur in the treatment of an individual, with the excess being paid for by the District Health Authority. The use of such a ceiling has the disadvantage of reducing the GPs incentive to be efficient.

Perhaps graver concerns about equity arise with purchaser behaviour. Whilst District Health Authorities receive funds on a weighted capitation basis with the explicit equity goal of equal inputs for equal health care needs, Districts appear to have little concern for equity issues in their decision making (Whitehead, 1994). Moreover, the move towards care in the community (and away from long term institutional care) in the UK has raised serious equity issues around the incidence of health care costs on the elderly.

5 CONCLUSIONS

Under the NHS internal market there has been (at least) the perception of a shift in the emphasis of decision making towards the provision of health care which is based on the health care needs of populations and the cost-effectiveness of alternative interventions. This has led to an increasing awareness amongst health service decision makers of costs and outcomes (Mechanic, 1995). Purchasers appear to be gradually becoming more adept at assessing the health care needs of their residents and more adept at commissioning health care which is both evidence based and cost-effective. In turn providers have made significant efforts to demonstrate that care provided is needed or demanded by the community and that health care is being provided at least cost. However, it is unclear whether these advances are a result of the process of change rather than the result of specific health system reforms themselves (the Hawthorne effect). Indeed many major advances appear to have been made by District Health Authorities who are not subject to “the discipline of the market” as they do not have to compete for consumers. This leaves the question of whether the most beneficial elements of the new NHS could not have been achieved through other means than the wholesale restructuring of the health service. Could District Health Authorities have been encouraged to provide care based on health needs and cost-effectiveness criteria by the implementation of less draconian management measures?

The move towards cost-effective purchasing has also highlighted the value of information within the NHS. At present there is a clear need for the development of outcome measures across the whole spectrum of health and social care if we are to truly embrace the notions of evidence based medicine and the direction of health care resources to those who will most benefit from them. Such developments may take many years. In the meantime there is even greater need to assess the availability and quality of information on resources and activity. Much of this information resides with providers, and openness and sharing of this information with purchasers will be vital to long term health care planning in the UK. Of equal importance is the need for the NHS to recognize, as a whole, the importance of investment in effective information technology systems which are vital if efficiency gains are to be made from a managed competition framework.

Without timely and good quality information potential efficiency gains from the NHS reforms may be lost as decisions are poorly informed and their impact poorly monitored.

Perhaps the most important observation about the NHS reforms is not that they have either been a success or a failure, but that there is only very limited evidence on the performance of the internal market. There are only a handful of sound evaluations of different aspects of the internal market and of the new system as a whole. This means we are not in a position to be able to draw any firm conclusions on the success or failure of the NHS internal market, an observation which has also been made by academics in the UK (Ferguson, 1996; Le Grand, 1994). Evidence quoted in the press, academic journals, and by politicians alike has all too often been anecdotal in nature and hence potentially misleading. The reasons for the lack of evaluation include the complexity of the NHS and the services it provides and, more importantly, the political imperative which drove the reforms through the health service at such speed. The internal market was never piloted, nor was there the time (or the political will) to put in place an evaluation framework before the internal market was created. For other countries this means that lessons to be learnt from the UK experience with managed competition tend to be somewhat unclear. One lesson is evident, however, that health systems reforms should be trialed and evaluated in the same way as many new health care interventions are evaluated. There is a clear need for evidence based policy, as well as evidence based medicine. In order to achieve this it is also apparent that policy makers, health professionals, and academics should attempt to dampen the political imperatives which drive the hasty introduction of wholesale health care reforms.

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