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**The Internal Market:**

**An Acceptable Means to a Desirable End**

by

A. J. Culyer

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### Abstract

This Discussion Paper argues that the government has been right both in its rejection of market solutions to health insurance and in its injection of competition into provider markets. The particular advantages of the latter are that the collective expression of demand is maintained, with impetus being given to the better identification of health care needs and the most effective ways of meeting them. The ill effects of provider competition in the United States are outlined and reasons for not expecting them to be replicated in Britain explained. Emphasis is laid on the powerful moral case for efficiency in the provision of health care, and clear definitions of this much-abused term are offered. The reforms of the White Paper are likely to strengthen the hands of ministers in securing a larger share of the public expenditure cake for health care. The changes pose no threat to the traditional pursuit of equity in the NHS and are appropriate means of attaining what Professor Culyer calls "communism in health" (to each according to her need; from each according to financial ability). Difficulties are anticipated both from the speed of implementation and, in particular, from the fragmentation of the demand side between health authorities, general practitioners, and local authorities. The need for further change and rationalisation is anticipated here.

## The Internal Market: An Acceptable Means to a Desirable End

A. J. Culyer

### 1. Only the End can Justify the Means

Let us assume, without too much discussion (even though it is plainly contentious), that the objective of health services is to promote health and to do so, moreover, in such a fashion as to maximise the impact on the nation's health of whatever resources are made available to that end, while satisfying various equity constraints to do with geographical availability and individual terms of access. If you accept that premise as a properly moral point of departure, then a number of major implications flow from it:

- (1) the health service should be as efficient as it can be made
- (2) we need better information on health needs and health outcomes than we currently have
- (3) competition among financing (viz. insurance) agencies is inconsistent with these aims
- (4) provider competition may be the most effective means of attaining the efficiency objective
- (5) provider competition need pose no threat to the traditional equity objectives of the NHS.

The rest of the paper seeks to explain these inferences. It is worth emphasising at the outset, however, that the fundamental touchstone relates to the meeting of the health needs of individuals: the patient (actual or potential) comes first. It is in terms of this end that means such as provider competition are to be evaluated. It is in this sense that means are to be justified (or not, as the case may be) by the ends. Indeed, it is hard to see what, other than ends, could ever possibly justify any means. This is not, of course, to say that any means can be justified by reference to an end. It is all too easy to imagine some means so awful that no end could possibly justify them. It is also easy to imagine some ends that are themselves so awful that we would immediately reject all means of attaining them. But if we agree on a morally acceptable end (or ends), then the question becomes one of selecting the most appropriate means of achieving it (or them). In this sense, it is only the end(s) that can justify the means - if anything can. I hope, therefore, that we can for present purposes accept the ends I have postulated (and, at least for the time being, bear with their ill-definition) and discuss provider competition in internal - or even wider - markets in terms of its appropriateness as a means.

### 2. The Morality of Efficiency

Efficiency has three meanings, which cumulatively embrace those that go before:

- a. Not using more resources than are necessary to achieve an end

This is sometimes referred to as efficacy or effectiveness. It enjoins us not to squander resources. Given an objective, such as returning the patient to normal functioning as speedily as possible, one should therefore seek those combinations of diagnostic procedures, medicines, surgical procedures, inpatient and outpatient care, health service and social service and family caring, and the patient's own time, that are most effective. To use more of any of these resources than is necessary is wasteful and inconsistent with the objective of maximising the impact of resources on health in the community. For, if more than is necessary is used, the excess could have been used at no cost to the patients in question in order to further the health of some other patients. Thus, overall community health is lower than it need be. Overall community SMRs may also be higher than they need be.

While this definition seems fine to me - so far as it goes - it does not really go terribly far. There is usually more than one combination of resources represented in more than one method of case management that satisfies the definition. There are substitutions between drugs, between medicine and surgery, between institutional and community care, and so on, which can be made. This gives rise to the great variety of practice that can be observed within health districts, between them, and across national boundaries. Although some of these variations may represent inefficiency, many of them may be equally efficient in the sense of effective. We therefore need a tighter definition.

The second meaning of efficiency meets this requirement.

- b. Not incurring a higher cost than is necessary to achieve an end

This is usually termed cost-effectiveness. It requires the selection from among the effective modes of case-management of that which is judged to be least costly. To incur a higher cost than is necessary is again wasteful and inconsistent with the objective of maximising the impact of resources on health in the community. If a higher cost than is necessary is incurred, the excess could have been used at no cost to the patients in question in order to further the health of some other patients. Thus, overall community health is lower than it need be.

The trouble with this definition is that, although it affords a clear criterion for evaluating the efficiency of whatever it is that one is doing so that, for a given expected outcome and other patient-oriented attributes of the procedure, the cost is minimised, it does not tell us whether the procedure is actually worth what it costs and, in particular, whether there are not other programmes of care whose health payoffs may be higher at the margin (given the resources currently committed to them) than those of the programme whose cost-effectiveness has just been considered.

It is worth noting that the notion of "cost" that I am employing is no simple financial concept, and that it is the economist's standard notion. If benefit is to be seen in terms of health outcomes obtained (or expected), then cost is the benefit

(similarly defined) that could have been obtained had the resources in question been applied in the most beneficial alternative way. In transactions in a well-functioning market, prices tend to signal the value of these lost benefits by virtue of the fact that competition for resources requires those who demand them to outbid other demanders, so the price reveals the alternative value in use. But without a market - for example, within a hospital - direct judgments have to be made about such opportunity costs, which should again, if they are to be consistent with the objective, be couched in terms of benefit to the patient.

Although the concept of cost may therefore be quite consistent with my point of departure, the second meaning of efficiency is still deficient. We need a still tighter definition. The third meaning of efficiency meets this requirement.

c. Not incurring a higher cost than is necessary to achieve an end plus attaining an appropriate rate of throughput or output

This meaning requires not only cost-effectiveness but also an appropriate workload, which may be higher, lower, or the same as the current rate. The judgment that needs to be made here is usually a marginal one: is the gain to be had in the form, say, of added community health from a cost-effective programme worth the additional cost or, in the case of a possibly reduced scale of activity, is the value placed upon the lost health smaller, larger, or the same as the costs thereby saved? The general idea

here is that a fully efficient health care system will have sufficient resources devoted to it such that, at the margin, the gain in health is judged to be of equal value to the additional costs incurred, and that the resources within the health care system are so distributed that their payoff per additional pound of cost is equalised across all programmes of care.<sup>1</sup>

The morality of this definition of efficiency is again clear: if the condition is not met, then either resources used elsewhere would be better employed in health care or resources used in health care would be better employed elsewhere. The "elsewhere" may, of course, be in programmes that affect health but that are not themselves health services.

Health needs and health outcomes

The NHS, like all health care systems, has been handicapped in its pursuit of both efficiency and equity by a desperate shortage of information about needs and outcomes. On the efficiency side, it is only recently that it has become possible to make approximate assessments of the health payoffs from alternative packages of care. The main reason for this has been the absence of quantitative measures of even an approximate type that would enable more subtle comparisons than can be made by means of relative mortality or survival rates. In the UK, one such new instrument that has proved useful in such fields as the care of the elderly and clinical practice is the Quality Adjusted Life Year (or QALY). The QALY has the great merit of highlighting the value content inherent in any outcome measure. While it is pretty obvious that there are important value

questions embodied in the notions of both benefit and cost discussed earlier, it is less obvious precisely what the crucial judgments are that need to be made and who should be making them. The QALY sets this agenda out very clearly. It also indicates that there are quite substantial variations in the average costs per QALY across programmes. Although these are not the marginal costs one would ideally prefer, data of the sort indicated in Table 1 suggest pretty strongly that current resource allocations are not making their maximal impact and they also suggest the general directions in which it may be sensible to try to redistribute resources.

Developments of this kind can also afford ministers an enhanced bargaining power with the Treasury in the PES round, as evidence for the expected payoff of judiciously targeted additional public expenditure. They also offer - at least in my judgment - the most satisfactory means of reaching a view on that very vexed question as to whether the NHS is underfunded.

A need for health care exists when a patient has the capacity to benefit from the consumption of health services<sup>2</sup>. If the care is not effective, it cannot be said to be needed. If the technology that would improve someone's health for the better does not currently exist, current services cannot be said to be needed (though it may well be that research is needed). In deciding what needs shall be met, however, it is essential to be able to form a judgment about the likely size of the benefit (in terms, say, of enhanced health). So, if needs are to be fairly met (for example, equal treatment for equal need) it becomes

Table 1: 'League Table' of Costs and QALYs for Selected Health Care Interventions (1983/4 prices)

Intervention	Present Value of Extra Cost per QALY Gained (£)
GP advice to stop smoking	170
Pacemaker implantation for heart block	700
Hip replacement	750
CABG for severe angina LMD	1040
GP control of total serum cholesterol	1700
CABG for severe angina with 2VD	2280
Kidney transplantation (cadaver)	3000
Breast cancer screening	3500
Heart transplantation	5000
CABG for mild angina 2VD	12600
Hospital haemodialysis	14000

Notes: CABG - coronary artery bypass graft  
 LMD - left main disease  
 2VD - two vessel disease

Adapted from: Williams, A.H., 'Economics of Coronary Artery Bypass Grafting', BMJ, 291, 1985, 326-9.

important to be able to prioritise need. It is also worth noting that the important thing about capacity to benefit is that it must be seen in terms of changes in health status. An absolutely or relatively high mortality or morbidity rate does not in itself indicate a high need: that depends on whether there is a capacity for the rate to be reduced sufficiently by the application of the relevant resources for it to command a priority relative to other needs. Moreover, it is the contribution of health care to the potential health improvement that is important. Many conditions are, for example, self-limiting, so one is concerned with the faster recovery that health care enables rather than the probability of recovery itself. In other cases one may not actually expect a payoff in

terms of better health than before, but rather in terms of better health than would otherwise have been the case - amelioration rather than cure, reduction rather than elimination of disability, slowing rather than stopping deteriorations.

There may also be a "big tradeoff" (to use Arthur Okun's phrase<sup>3</sup>) between efficiency and equity. For example, in remote areas where the population is thinly distributed, the cost per unit of effectiveness may be relatively high, implying that on efficiency grounds alone community health could be increased by redistributing resources away from such localities towards those where population density is greater and cost per case lower. This is, however, likely to offend against any equity principle that requires approximately equal geographical accessibility. If such is the case, it is natural to allocate general resources (say, in the form of regional or district budgets) on a capitation basis, with the pursuit of efficiency in the meeting of local needs being conducted within the constraints that the equity rule imposes, and accepting that the ultimate cost of equity may be higher overall mortality and morbidity than it actually lay within our power to attain.<sup>4</sup>

Time and space prohibit my indulging in the details of health and needs measurement - fascinating though such an indulgence would be. Moreover, I am well aware that "health" is not the only product of health services. I do not wish it to be thought that I think that the NHS should neglect important dimensions of performance like the supply of "reassurance", or comfort, courtesy and respect for individual dignity, or the

hotel dimensions of institutional care whose neglect the NHS has frequently been taken to task for in the past. If I have focussed on health status in all this talk about efficiency, equity and need, it is because this is the prime business of the NHS (I make no apology for asserting that) and because it is only relatively recently that it has become possible to assess effectiveness - and cost-effectiveness - in such a fashion that decision-makers like doctors and purchasing authorities are going to be able to use these ideas and real evidence to evaluate their practice and to frame the terms of contracts. It can scarcely be doubted that the reforms of Working for Patients also lend a renewed urgency to the further development of operationally and managerially sensible measures of need and outcome. Fortunately, there is now lots on which people can build.

#### 4. The NHS as a Demand-side Organisation

The traditional arguments for why health care is "different" from other goods and services are almost exclusively demand-side arguments<sup>4</sup> which argue in particular for a low or zero user-price, for low-cost subsidised insurance and for preserving so far as possible the integrity of the "agency" role of the physician - in particular for helping the doctor, whether in general or hospital practice, to form professional judgments about a patient's needs and how best they might be met out of available resources, without being contaminated by other professional (provider) interests (especially those that determine the doctor's pay).<sup>5</sup>

In my view these arguments amount to a pretty unassailable case for a health service having the following characteristics:

- (1) The insurance function is monopolised by the state rather than by competitive private insurers, thus avoiding premium-loading through failure to secure scale economies on the finance side, the possibility of monopoly premium-setting, extensive billing and fraud-checking administrative and legal costs, adverse selection through community premium-setting, inequity through experience premium-setting, a host of "gaps" in coverage arising from employment status and inability to pay, and publicly unaccountable methods of controlling the excess demands that all insurance systems throw up (such as indemnity limits, co-insurance, and privately determined quantity limits on the supply side).<sup>6</sup>
- (2) Access to care should be determined by need rather than (for example) insurance status, income, social or ethnic group, or any other nonhealth related factor.
- (3) The bargaining and regulatory power of the state should be used to countervail the monopoly professional and supplier organisations and to enforce standards of safety and quality determined in publicly accountable procedures.
- (4) Professionals should be rewarded adequately but primarily by salary and capitation rather than by fee for service.

It is striking that, while these desiderata all require the partial rejection of free market solutions, they do so for demand-side reasons and for the most part involve a heavy rejection of market-determined resource allocations only on the demand side. The relevance of the collective expression of demand lies in its ability to specify and regulate need. It is appropriate therefore that health authorities, for example, should specify a demand for the care of their client populations. But none of these traditional arguments for health care being "different" requires the public ownership of the means of production (viz. doctors' practices or institutional care providers). Not least among the benefits of Working for Patients is the clear distinction between purchaser and provider that it has introduced into public discussion. I contend that all of the major ideological strengths of the NHS relate to characteristics of demand. The job of the supply side is simply (!) to be cost-effective at meeting whatever demands are placed upon it by the demand side. Its ownership and structure ought to be whatever pattern of ownership and structural features prove as a practical matter to be cost-effective and responsive in the way just described. Nothing less than this, but also nothing more. What matters is what works. What matters is what means are best suited to the ends determined by the collective demanders. The supply side is not judged by ideological but by practical criteria. Whether directly managed units, or trusts, or private organisations (for-profit or non-profit) best satisfy the requirements of NHS demanders is something to be determined by experience and judgment. It is not an a priori matter. The NHS is essentially a demand-side organisation - or so it should be. Muddling supply-side features inside the public NHS not only begs

the question as to the most effective means of delivering what is needed, it also exposes it to the serious hazard of domination by supplier interests that are independent of, and may be inconsistent with, the true objectives of the patient-oriented demand side.

#### 5. Provider Competition

If competition between providers of finance has scarcely any redeeming features, the same cannot be said for competition between providers of care. The particular attraction of competition on the health care provider side is that it provides the very systematic<sup>7</sup> incentives for efficiency and innovation that are so conspicuously lacking in the NHS and dispenses with the need for the periodic sledgehammer strategy of financial squeeze (which has penalised the efficient and the inefficient rather indiscriminately).

There are two forms of competition that can be exploited, though Working for Patients emphasises only the first of these:

(1) competition within a market

and

(2) competition for a market.

The first of these is competition between existing or incumbent providers (public or private, trusts, or DMUs) for various contracts offered by purchasing authorities, fund-holding GPs, other GPs, local authorities, private demanders, and

overseas demanders (increasingly one may expect from the rest of the European Community). The second is competition between incumbents and potential new entrants to the market for the right to provide service. It is a competition for franchises and, in the economics literature, it goes under the generic term of "contestability".<sup>8</sup>

I want to fasten on to three aspects of provider competition as worthy of particular attention: the rather poor performance of competition in the USA; the problems arising from possible monopoly behaviour by providers and the attendant need (though this is not unequivocal) for some form of price, quantity and quality regulation; and the problems that may arise from having multiple demanders under the arrangements in Working for Patients. Let me address each of these briefly.

The US experience. Competition between providers in the USA has led, not to greater efficiency and lower costs, but to the duplication of services, excess capacity, higher costs (and hospital cost inflation persistently above general inflation) and (though the evidence is somewhat ambiguous here) inferior clinical outcomes. It is crucially important to understand that these adverse results are less due to provider competition per se than to the particular market environment in which US providers operate. One factor is that comprehensive insurance (despite the fact that 50 million US citizens have either no private or public cover, or extremely inadequate cover) reduces the incentive for demanders, whether patients or physicians, to select providers on the basis of quality balanced by cost, and generates pressures on providers to compete on a non-price basis. This is only

partially constrained by the consequential upward pressure on premiums, because premiums are not prices of using the service. Premiums enfranchise people to use a range of services at a user-price less than their cost. Hence premiums serve to reduce demand as they increase only through the effect they have on residual disposable income, rather than the direct disincentive that a rising user-price would have. Premiums are anyway subject to tax-relief and are normally part paid by employers. Moreover, rising costs arising from one's own use of service are borne by all policyholders. In the NHS, by contrast, purchasers are effectively expenditure capped and are to make contracts in the interests of entire resident populations or an entire GP's list. Demand, in general, is expressed in a collective fashion which sets the availability of resources into which the individual demand decisions of (mostly) doctors has to fit (and which is to be planned in conjunction with such expected individual demands).

Moreover, in the USA, the retrospective cost-based reimbursement system has enabled most providers to bill the insurer for whatever costs are implied by the services it has been decided (eg. by physicians and hospitals) to provide, usually on a fee for service and per diem basis. Third party reimbursement plus retrospective compensation at a rate determined by providers has confronted demanders with an effectively open-ended budget constraint which has been widely held responsible for the substantial hospital cost inflation experienced over many years in the USA (and to the visitor is most apparent in the spectacular atriums and lavish parklands that greet one on entering hospitals). This cannot happen under

the prospective budgeting arrangements in Working for Patients.<sup>9</sup>

Monopoly. Monopoly arises when there is a single provider or a small group of colluding providers. It affords them greater discretion over price, quality and output than they have under competition, and is generally associated with higher prices, lower output or throughput, and higher unit costs. The latter is particularly to be expected in non-profit organisations in which "profit" is taken in the form of a higher rate of use of some inputs than is necessary (especially highly skilled human ones and the technical equipment that every able technician can never get enough of). This enhances the job-satisfaction of the providers themselves and can easily be passed off to the innocent public as better quality. (The question is altogether begged, of course, as to whether the extra costs incurred actually benefit patients and, even if they do, as to whether the benefit is large enough to justify the expense).

The policy response to these problems can be of two kinds. The first seeks to suppress the operation of the market via centrally determined price schedules (based on DRGs for example) and myriad other controls. The second seeks to encourage the effective operation of the market via information dissemination (eg. about historic cost patterns locally and elsewhere, DRGs, performance indicators of various kinds, and prices struck elsewhere in the system between purchasers and providers) and by exposing incumbents (especially monopoly incumbents) to the threat of entry of new providers by making markets more contestable. I lean strongly towards the second of these two responses, partly on grounds that any suppression of the working

of the market tends to destroy beneficial as well as adverse effects (this is very evident in the case of centrally determined price schedules), partly on the ground that such regulation is costly and may also come, through customary political processes, to be dominated by provider interests, and partly on the ground that a strategy aimed at making the market operate more effectively is more likely to deliver cost-effective contracts, especially if there were a greater emphasis on contestability, which can be a complete answer to a monopoly problem posed by one or a few collusive incumbents.

However, there can be no denying that contestability, selective contracting, openness in costing and prices, can all impose an awkward dilemma for politicians, who may not be able to escape a residual responsibility for poor performers (in a world in which poor performance becomes increasingly easy to identify) and who may, in particular, come under intense political pressure to prevent some incumbents from going out of business - even though they offer services that no one wants and which purchasers have been able to purchase satisfactorily elsewhere with no net loss either of employment or of service for client populations.

Multiple demanders. Under the new arrangements, a collective demand is not expressed solely (as would in my judgment have proved preferable) by a single purchasing agency acting for its population catchment area, purchasing from a wide variety of potential providers (including voluntary agencies and local authority social services) and able to exert considerable

monopsony power<sup>10</sup> to hold down prices for maximum throughput of contracted caseloads with contracted arrangements for quality assurance, and the ability to stipulate the providers to whom GPs would normally be able to refer. What we have instead is the clear possibility of different local judgments of need being reached by health authorities, FPCs and local authorities, which may be difficult to reconcile and impossible, even if agreed, to enforce. With competition between GPs, moreover, (particularly non-fundholding GPs) there is the danger that they will be under greater pressure than hitherto to refer to non-contracted providers offering relatively attractive packages of services but whose cost consequences the health authority has little power to control. It is not possible to assess the likely practical significance of this at the present time but there is clearly the possibility that some of the adverse features of competition in the USA may arise in Britain since the demand decision and the bearing of the financial consequences are effectively separated.

The ability of health authorities to make appropriate deals with FPCs, fundholders, other GPs, and local authorities remains to be tested. It is an area of considerable uncertainty at present. As the number of fundholders increases, the problem in one sense will become less because the demand and its financial consequences will become increasingly localised on the same decision-making unit. However, by the same token, the bargaining power of health authorities will also fall as this process takes place and their recurrent funding becomes increasingly topsliced. As the principal agencies responsible for assessing a district's needs and determining the most cost-effective means of meeting them, health authorities may find themselves increasingly unable

to implement the strategies that would seem most appropriate. These problems will be the more pressing in a world in which local authorities feel their budgets to be under great pressure and might decide to allocate resources to non-health priority areas.

## 6. Equity

Provider competition poses in itself no particular impediment to the attainment of whatever equity objectives are set. Indeed, if its effect is to increase cost-effectiveness and better matches of case-mix, workload and quality to population needs, equity is likely to be enhanced. The revision of RAWP is not an inherent part of the competition strategy but budget allocations within regions can clearly depart from a strict capitation basis if regional needs assessments suggest this would be more equitable. Regional initiatives in clarifying and implementing appropriate local notions of equity will, of course, be need- rather than supply-based. If district funding is needs-based, decisions at that level about the place of treatment of patients will need to weigh the advantages of treatment close to patients' homes against the possibly lower unit costs and/or higher quality and/or shorter waiting times that may be available elsewhere. This partly involves equity issues, but it also involves judgments of effectiveness and efficiency in matters like the integration of community, GP and institutionally based services that are entirely appropriately made at local levels within the general equity constraints set by central government and region.

It will be important for purchasers to bear equity issues in mind when formulating and placing contracts. For example, the notion of "equal treatment for equal need" has implications for hospitals' admissions policies that will need to be made explicit - and to be monitored.

The development of much better information about community health care needs and the most cost-effective means of meeting them is one of the most promising parts of Working for Patients and will eventually enable much more explicit judgments to be made at all levels about both equity and efficiency. It can also be expected that, within regions and districts, not all will reach the same view of equity, how best to implement strategies designed to improve it, and the way in which tradeoffs between it and efficiency should be made when the two conflict. Perhaps this is as it should be for, if the notions of effectiveness and efficiency are reasonably clear - at least in principle - the same cannot be said for equity, for which many criteria vie for supremacy<sup>11</sup>. It may therefore be neither surprising nor undesirable if different criteria and different judgments in their application emerge in different places.

## 7. Conclusions

The strategy of Working for Patients seems to me to be one that can be welcomed by all who care about the NHS. It does not prejudice the equity objectives of the NHS and it offers considerable scope for enhancing its efficiency. This is highly acceptable morally because inefficiency implies that some

patients necessarily go without the care that a more efficient system would, with the same resource base, have provided. It also promises to be a more responsive service: more responsive, that is, both to the collective expression of need by authorities and to the individual preferences of patients. The NHS is, however, already relatively cost-effective in general - so far as one can tell from various international comparisons<sup>12</sup>. So whether the new strategy will generate sufficient cost-savings and sufficiently substantial resource reallocation between patient groups according to the best evidence of effectiveness, so as markedly to improve the impact of NHS resources on the nation's health, remains to be seen. However, at the very least it will, over time, make more clear what has previously been extremely opaque: the link (at the margin) between resources and outcome. I believe that this will help ministers in their battle for resources for the NHS in the PES round.

Any major change of the sort we are experiencing brings, of course, major uncertainty and major worry. I have alluded to my worries about the fragmented demand side. The pace is also frenetic. Indeed, the biggest threat to the strategy's success is probably that insufficient time will have been allowed to ensure that the early stages operate smoothly and without delays being imposed on patients and their doctors in the prompt matching of need and care.

Although I was once (in 1987/88) an advocate of regional experiment, I recognise now that such experiments could all too easily have served, as ministers have claimed, to postpone or

sabotage any real change. But even were that not so, such major experiments are quite extraordinarily difficult to evaluate independently of the vast array of incidental pressures and changes that inevitable accompany them. It is also always necessary to compromise in the design of any experiment based only on part of a system but intended to model the working of the whole (for example, by omitting regional interactions). So we are in for an all-or-none experiment and I am not much impressed by the (extraordinarily late in the day!) awakening of awareness in the Royal Colleges and the Upper House that a more limited experiment might (at one time) have been a sensible way of proceeding. It may not have told us much. It might have been used for destructive purposes. In any case it is now too late.

But the all-or-none game implies that we (and I think here especially of the research community) will have to monitor what goes on extremely carefully, and the government should be prepared to invest substantially in such monitoring of the system's behaviour. Policy makers at every level must be adaptable so as to close off avenues that are destructive of the ends of the strategy and to open up new avenues that might help. I expect that there will be a lot of "cleaning up" to be done, particularly on the demand side.

Provider competition is going to be, however, a reasonably assured success. The adverse effects of competition as seen in the USA are unlikely to emerge in the UK - the reason for doubt on this score lying in the possible behaviour of the GP sector. The strategy is has much to commend it in principle and, even if it is less than perfectly consistent on the demand side, we

shall have time enough to monitor progress and make the required changes.

A final area of uncertainty not discussed hitherto lies with the behaviour of politicians. The combination of better evidence of effectiveness in meeting need and of better quality (or of their absence) and the ruthless judgment of markets on poor performers is going to make politicians accountable in all sorts of ways that the opacity of the present system protects them from. If they prove chicken, their ability to compromise the good that the internal market can generate is, of course, limitless. So too is the power of politicians having an outdated and unwarranted commitment to supply-side socialism (though not the other kind). But if you really believe, as I do, in "communism in health" (to each according to her need and from each financially according to her ability) then the prospect of a tax-financed NHS in which demand is collectively expressed and providers are constrained by market forces to meet the needs thus specified, and the funding is at worst proportional to ability to pay, is a prospect that all should be able to welcome.

### Notes

1. This view is extensively developed in my Need and the National Health Service, London, Martin Robertson, 1976.
2. See my Need ..., op. cit., A.J. Culyer, R.J. Lavers and A. Williams, "Social indicators: health", Social Trends, 2, 1971, 31-42, and my "The normative economics of health care finance and provision", Oxford Review of Economic Policy, 5, 1, 1989, 34-58.
3. See A.M. Okun, Equity and Efficiency: the Big Tradeoff, Washington DC, Brookings Institution, 1975. Also, my "Inequality of health services is, in general, desirable" in D. Green (ed.) Acceptable Inequalities, London, Institute of Economic Affairs, 1988, 31-47; and "Commodities, characteristics of commodities, utilities and the quality of life" in S. Baldwin, C. Godfrey and C. Propper (eds.) The Quality of Life: Perspectives and Policies, London, Routledge, 1989, 9-27.
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10. Monopsony is the converse of monopoly: it is a buyer's rather than a seller's domination of the market. Although difficult to quantify, the monopsony power of the NHS must have been a major factor in containing health care expenditures in the UK through aggressive price and wage/salary strategies.
11. See, for example, G. Mooney, Economics, Medicine and Health Care, Brighton, Wheatsheaf, 1986, ch. 8.
12. See my "Cost-containment in Europe", Health Care Financing Review, Annual Suppl. 1989, 21-32.

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