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a national health service, by comparison

Richard Freeman
University of Edinburgh

Abstract

The NHS has always been compared to other things, to other organisations and systems both at home and abroad. This paper explores those comparisons, beginning with the origins of national public health care in Lloyd George's study of German social insurance, and ending with Gordon Brown's claims for the NHS as 'the best insurance policy in the world'. It considers the comparisons and contrasts made for and with the NHS at the time of its foundation and the comparison of state and market around 1990, before reviewing the contemporary function of comparison as form and basis of health governance. The paper presents three related patterns of thought: one prompted by encounter with the other, one sustained by metaphor and one developed in more formal, analytic comparison. It concludes by discussing why comparison itself is such a dangerous and contested thing.

Keywords: National Health Service; health policy; comparison; metaphor; learning; governance

The question I start off with is: what are we and what are we today? (Michel Foucault)¹

Foucault's question explains his interest in 'the genealogy of problems'. His point, famously, as he puts it elsewhere, was 'not that everything is bad, but that everything is dangerous', and that dealing with (and thinking about) what is dangerous gives us something to do.² Now, that might be the occasion for a synoptic essay on health, if not the whole of human history. All I am concerned

¹ In Lotringer 1996, p 411, cit Nóvoa and Yariv-Mashal 2003, p 430.

² Foucault 1984, p 343, cit Bernstein 1992, p 157.

with here, however, is a particular aspect of a way of thinking in and about the NHS.

I'm interested in the part comparison plays in the 'genealogy of problems' which have formed and defined the NHS. A hundred years ago, in August 1908, Lloyd George, then Chancellor of the Exchequer, went to Germany, where he met officials responsible for the operation and administration of Bismarck's social insurance programmes. Much taken with what he saw and heard, he returned to England to commit the government to the compulsory, contributory health insurance scheme for which it legislated in 1911. A hundred years later, more or less, in September 2007, Gordon Brown, now Prime Minister, described the National Health Service as 'the best insurance policy in the world'.³ At each end of the hundred-year span of public health care in Britain, that is to say, as well as periodically in between, its architects and administrators have drawn comparisons with their counterparts in other countries. Those comparisons have by turns informed and inspired, provoked and pressured those who make them and have them made for them.

Comparing countries is continuous with comparing forms of organisation, as debates about planning and professionalism, the state and the market demonstrate. In turn, comparing organisations – and individuals - by various means of performance assessment has become a principal mechanism of health governance. Now, comparisons are everywhere. There is little thinking in or about the NHS without them.

Comparison and policy

Of course, to the extent that there is little thinking of any kind without them, comparisons appear trivial. We know what something is at least in part by knowing what it is not. We know who we are by comparing ourselves to others, and noting the characterisations they make of us. That suggests comparison is ordinary and often mundane, but not, in fact, trivial. Even more fundamentally, comparison underpins our systems and structures of thought; it is embedded in our language. The concepts we use derive their power and specificity – their very meaning – from their patterns of similarity with others: in this way, our thought is metaphorical.⁴ More explicit comparisons, meanwhile, entail categories: to posit and explore a likeness between things supposes that they are comparable, that they are members of some set of things which have like qualities. By the same token, they entail contrasts, the noting of difference and the drawing of divisions and distinctions. And these are deeply significant, even dangerous things, as I shall try to show.

³ <http://www.labour.org.uk/conference/brown_speech>, accessed 1 June 2008. For discussion, see below.

⁴ Lakoff and Johnson 2003.

But I want to begin by noting the academic use of cross-national comparison by economists, sociologists and political scientists in trying to understand the NHS. This has its own history, its sources in Titmuss's elaboration of different models of welfare state and Anderson's more empirical specification of kinds of health system.⁵ Throughout, the function and purpose of comparison has been essentially twofold: to evaluate (that is, to work out what kinds of health care organisation, system or policy seem most effective in meeting specified criteria) and to explain (that is, to work out why different health systems, as well as the social, economic and political systems in which they are embedded, seem to work in the way they do). On both counts, comparison is associated with claims for learning: both evaluation and explanation, developed in this way, seem to carry important lessons for policy makers. In this standard version, comparison appears to belong properly to the academy, while the comparisons drawn by politicians and policy makers are regularly dismissed as 'policy warfare'.⁶ It is consistently said that the cross-national comparisons which recur in health policy debate are inappropriate, unjustified or invalid. But we should recognise that they are made, nevertheless.

What comparativists have missed is that comparison is a condition of policy making, not an abstract, analytic process by which it might be informed and understood (whether well or badly). In a foundational paper published half a century ago, Charles Lindblom drew attention to what he called 'successive limited comparison' as the normal condition or process of policy making.⁷ In contrast to the ideal assumption of a 'rational-comprehensive method', policy makers engage in successive comparison of a contingent and restricted range of alternatives, unguided by formal theory. The purpose and outcome of such comparison is discovered ad hoc, as those comparisons are made, debated and agreed or discarded.

What, then, do we mean by comparison? Can we define it in such a way as to make sense of both academic and policy making standards and practices? James Sully defined comparison as 'that act of the mind by which it concentrates attention on two mental contents in such a way as to ascertain their relation of similarity or dissimilarity. By a mental content is meant either a presentation or a representation'.⁸ His definition has several important implications. First, he emphasises that comparison is volitional process, in which the mind actively relates and makes sense of (at least) two objects. Second, Sully argues that our assessments of similarity and difference are informed by what we take to be normal or usual degrees of each: 'In truth, the problem of ascertaining a bare resemblance or difference continually tends to become a question of estimating its degree in relation to some customary standard'.⁹ For what is customary is

⁵ Titmuss 1974; Anderson 1963; Freeman and Marmor 2003, Marmor, Freeman and Okma 2005.

⁶ Marmor and Plowden 1991.

⁷ Lindblom 1959.

⁸ Sully 1885, p 490.

⁹ Sully 1885, p 511.

collectively determined: to this extent at least, cognition-by-comparison is a social process. As Mary Douglas has it so simply, 'similarity is an institution'.¹⁰ Third, note Sully's ancillary definition of 'a mental content' as 'either a presentation or a representation'.¹¹ Comparison takes place not between things themselves, but between impressions and appreciations of them, mediated by the way they are presented to us.

Comparison, then, is an active process, socially shaped and informed, which constructs relationships of similarity and difference between things, or more precisely representations of things. It is more active than assimilative; it is more than interpretation, and might be better described as translation. For it takes place somewhere between two objects, themselves less than fully defined. It is an unstable, mediating process, in which objects become defined in relation to each other, in that process of being compared. In this sense, comparison is generative rather than reflective, a mode of production as much as of regulation.

So what comparisons do policy makers make, both explicitly and implicitly, and what should we make of them? This paper explores the comparisons which appear to have defined the NHS. The three central parts of the paper highlight three forms of thinking 'by comparison': through encounters with others, through metaphor and by the construction of formal categories. The schema is historical, as befits this journal, but that is not to claim that these three thought styles succeed each other. Rather, they are closely impacted one upon the other; they entail each other. All three depend, in turn, on the dangerous business of resemblance, which is treated in a concluding section. It goes without saying that the paper is risky and experimental, as comparisons are.

the NHS and its others

Britain and Germany

Lloyd George arrived in Germany on 6 August, 1908, in the company of Harold Spender, a journalist, and the parliamentarian Charles Henry and his wife. Henry paid for the trip, which was part holiday (a 'motor tour'), part covert diplomatic exercise and part study visit. The diplomacy concerned the intensifying naval competition between Britain and Germany, which the Chancellor had taken upon himself to try to moderate. But he was also concerned with unemployment at home, and how its effects might be alleviated. He went to Berlin on the 21st August, where he met Bethman-Hollweg, then Minister of the Interior and later himself German Chancellor. He looked around the Imperial Insurance Office and went to Hamburg on the 23rd, returning to England on the 26th.

¹⁰ Douglas 1986, Freeman and Frisina, forthcoming.

¹¹ Sully 1885, p 490.

What he discovered was that the invalidity and old age pensions schemes he was interested in were not only more extensive and effective than he had first understood, but also that they were predicated on a complementary sickness insurance scheme. Taking their cue from him, a delegation of trade union leaders followed Lloyd George to Germany a few months later, in November. Further studies of social insurance in Belgium and Austria were produced by the end of the year, by civil servants who themselves made visits to respective countries.

By April 1909, in delivering his budget speech, the Chancellor felt able to commit in principle to a system of compulsory, contributory national insurance, shifting policy away from earlier proposals for a more limited, tax-funded scheme.¹² The period which followed was one of learning from German administrative detail, and included sending his adviser Braithwaite back to Berlin for more information at the end of December 1910. Leaving the German capital, Braithwaite enjoyed a run through the Brenner to brief the Chancellor a couple of days later on the pier in Nice.¹³

When it was presented to Parliament on 4 May, 1911, the National Insurance Bill was supported by a general explanatory memorandum, a detailed comparison of German arrangements with the proposed British scheme,¹⁴ and a further collection of accounts by German workers, employers and administrative authorities testifying to the merits of social insurance. In his speech to the Commons, Lloyd George referred nine times to German precedent, as both positive and negative example as well as to claim superiority for he what he set out. In turn, the British debate was followed closely by the German authorities. The Ministry of the Interior evaluated the British scheme from an official German point of view, and briefed the Kaiser accordingly.

Policy-makers' attitudes to Germany over the period, as Hennock describes them, were characterised by 'revulsion, imitation and rivalry'.¹⁵ For Lloyd George, Germany was a source of ideas but also ambition, which he realised in doing things more cheaply. Braithwaite, 'Lloyd George's ambulance driver',¹⁶ had been horrified by the bureaucracy of the German scheme and was determined to do things differently. Though Britain, following Germany, developed a health insurance scheme, the structures of contributions and benefits (uniform in Britain, in Germany proportionate to salary), though 'outwardly so similar in kind', were 'inwardly completely different'.¹⁷

¹² Hennock 1987.

¹³ Braithwaite 1957, pp 82ff.

¹⁴ For detailed discussion of that comparison, following all its manipulations and ramifications, see Hennock 1987, chapter 12.

¹⁵ Hennock 1987, p 176.

¹⁶ Braithwaite 1957.

¹⁷ Hennock 1987, p 200.

By the early 1900s, Germany had become Britain's most significant other, a model and rival in Europe, if not the world. Germany was interesting to policy makers and reformers because its industrial development was that most closely comparable to Britain's (Hennock 1987, p 32). Its systems of technical education and town planning in particular were recognised as standard-setting (or what we might now term benchmarks). But to the extent that Germany was seen to be increasingly strong and increasingly successful, that very comparability was a source of uncertainty. This was a period of international exhibitions and congresses, of what Sutcliffe described as 'creative internationalism' (Hennock 1987, p 29), but also of incipient crisis in international relations. Policy makers seemed to be negotiating a complicated love-hate relationship with some 'other who is also the same'.¹⁸

Warfare and welfare

The NHS was conceived within the framework of a 'welfare state'. The significance of this idea lay in its being counterposed to that of the 'warfare state', though it also betrayed (even reprised) an ambivalent relationship with Germany. In his seminal use of it in 1941, Archbishop William Temple meant to contrast the welfare state with Germany's warfare state, though it also held then unnoticed connotations of the German *Wohlfahrtsstaat* (welfare state), the origins of which lie at least as far as back as state theorist Gottlob von Justi's *Staatswirtschaft* (1759)¹⁹ and had been current among social reformers since Bismarck.

The National Health Service was a nationalisation of health services, like those of rail, coal and gas which took place at almost exactly the same time, in 1948. Health care was, by implication, a public good, part of the national infrastructure and better run by government than by private enterprise. Though sorely challenged in the 1990s, assumptions about health care have held firmer and for longer than they have in respect of the utilities. Bevan's NHS – still Bevan's, as Labour health ministers still acknowledge at party conferences – has retained something of the aura which has protected Reith's BBC.

At the same time, of course, it was and is very unlike other welfare services. Public health had always been local government business, as education and housing were, and as social work would be. Bevan's trick in negotiating with local government, hospital, medical and other interests was to propose a combination of nationalisation and regionalisation,²⁰ keeping health away from local authorities. Its effective local units were Hospital Management Committees, which were controlled by doctors. Paradoxically, the hierarchical subordination of health care to central government was, most notably for the professions, a way of avoiding government, a way in which health care would remain an arena of

¹⁸ The phrase is de Beauvoir's, from *The Second Sex*, which she uses in explaining phenomenologically the way men value other men more than women: Heinämaa 2003, p 126.

¹⁹ Kruse, Porta and Saraceno 1997,

²⁰ Webster 2002.

'private government'.²¹ Health care took place somewhere apart from government, in a world of its own, even as it was nationalised.

Government, medicine and health

There followed a period in which the health service, in this world of its own, seems to have been much less concerned with comparison or with the world outside. This period, which, perhaps not coincidentally, appears in retrospect as the 'golden age' of the NHS, was one of relative certainty about what it was and what it was for. Its politics concerned the relationship between government and medicine, between professional and administrative authority. Administrative logic - or what then counted for administrative logic - achieved its fullest expression in the reorganisation of 1974.

In the background, there was continued wondering about what it meant or should mean to be a National Health Service rather than a National Sicknes Service, and what the relationships between individual and public health and health and health care should be. In practice, however, these shored up rather than threatened the assumptions underpinning the NHS. Revisiting the distinction between health service and local government responsibilities for health resulted only in it being resolved in favour of the NHS, for example,²² while debates about 'prevention' seemed to be a way of managing the boundaries between the health service and its environment.²³

Meanwhile, the NHS had made the mutual dependence of profession and state obvious. Before then, and even in some ways since, it had been obscured by a tradition of Anglo-Saxon thought which assumes that professions and states can and should be independent of each other. A very different continental tradition would more readily see the professions as part of the state (and, by the same token, the civil service as a profession). The deal struck in 1946 was that the government had the money and the doctors had the medicine. This made for what Rudolf Klein so memorably characterised as the 'politics of the double bed'.²⁴ That's the analyst's metaphor, not the actors', and what it means depends on what you think goes on in double beds. I infer 'not much, really' (though perhaps I'm just a bit tired) and I pursue the metaphor only because it seems to capture some of the existential tensions of the NHS even in its most established form. Klein seems to give a sense of lives lived in parallel, partners needing each other but otherwise demanding very little, the pleasures of 'propinquity'²⁵ and routine occasionally disturbed only to return again to normal.

²¹ Klein 1989, p 32.

²² DHSS 1988, Allsop and Freeman 1993.

²³ Freeman 1992, 1995.

²⁴ Klein 1990.

²⁵ Klein 1990, p 702.

Things are always difficult when one partner starts getting at the other's habits. Part of the original deal, gladly overlooked in the first flush of things in 1946, was the consultants' right to use a small proportion of NHS beds to treat private patients. Barbara Castle's attempt to abolish so called 'pay beds' made for protracted, bitter arguments in the 1970s. A decade and a half later, however, the ideological poles of state and market, public and private appeared to be reversed.

market and state, metaphor and reality

Alain Enthoven was a 'whizz kid' ('the whizziest', in fact, as Time magazine claimed when it put him on its cover in June, 1963).²⁶ He had joined Robert McNamara's Department of Defense in 1961, where he was part of the team which developed PPBS (the Planning-Programming-Budgeting System), which was a method by which different defense programmes could be compared with each other and evaluated in terms of cost and effectiveness.²⁷ As the Vietnam conflict escalated, the method met with increasing opposition from military leaders and defence contractors (who saw their professional autonomy and market freedoms constrained), as well as anti-war protesters, who denounced it as unethical. Enthoven's own memoir acknowledges its lack of success.²⁸ He left the Department first for private industry and then for Stanford University, where he became Professor of Management and Health Care Economics in 1973.

Enthoven submitted a proposal for regulated competition in health care to the Carter administration in 1977, developing the idea further in numerous publications through the 1980s and 1990s.²⁹ He was part of the Jackson Hole group, which emerged as the major provider of consultancy and advice to the Clintons' Presidential Health Care Task Force.³⁰ He spent a year in London, meanwhile, in 1984-1985, when he was Rock Carling Fellow at the Nuffield Trust, producing papers which, though read by senior civil servants at the DHSS, initially found little resonance there.³¹

²⁶ <<http://www.time.com/time/magazine/article/0,9171,874947,00.html>>, accessed 1 June 2008.

²⁷ This was part of an approach or set of instruments which Alice Rivlin, head of the Congressional Budget Office in the late 60s, called 'tools for systematic thinking'. CBA (another military invention), network analysis, social indicators and social reporting and zero based budgeting all date from the sixties or earlier and have their roots in the US. McNamara was Secretary of Defense during the Vietnam war, had formerly been CEO of Ford and later moved onto the World Bank.

²⁸ Enthoven and Smith 1971.

²⁹ Enthoven 1978, 1986, 1988, 1991, 1993.

³⁰ Ellwood, Enthoven and Etheredge 1992.

³¹ My account of Alain Enthoven and managed competition owes much to Howard Waitzkin: see, for example, Waitzkin (1994).

Yet when, by 1988, successive Thatcher administrations had driven the NHS into a crisis of underfunding and underprovision, it was Enthoven's ideas which were called up by the Ministerial Review which led to the *Working for Patients* white paper of 1990. Kenneth Clarke, who became Secretary of State midway through the Review in July 1988, though initially mistrustful, later acknowledged that Enthoven provided 'the germ of the idea'.³² 'The idea' was based on the assumption that health care was like other goods which can be bought and sold in markets, according to standard principles of economic competition. Acknowledging particular problems in the supply of and demand for health care, that competition needs to be regulated in some way, or 'managed'.

The *Working for Patients* proposals brought much protest, not least from doctors. Thatcher moved Clarke to Education and brought William Waldegrave to Richmond House, essentially to calm things down. Talk of markets and competition declined, replaced by that of commissioning and contracting. In retrospect, Waldegrave thought, 'we had got into a muddle between what was metaphor and what was reality'.³³

Waldegrave's observation is revealing. For what is a metaphor, and why had this one caused such a muddle? A metaphor is a kind of comparison, but one which works in a very powerful way. Etymologically, derived from from the Greek, it means a 'carrying across' (the same process of derivation, from the Latin, gives us 'translation'). But this translation changes the terms of what is translated, such that the objects of comparison begin to colour each other, can only be understood in reciprocal terms. As Mary Hesse explains, 'The metaphor works by transferring the associated ideas and implications of the secondary to the primary system. These select, emphasise, or suppress features of the primary; new slants on the primary are illuminated; the primary is "seen through" the frame of the secondary... the two systems are seen as more like each other; they seem to interact and adapt to one another, even to the point of invalidating their original literal descriptions if these are understood in the new, post-metaphoric sense'.³⁴ And this is what makes for the 'muddle'. For the issue was (and remains) less whether or not the production and distribution of health care functions like a market, but that those should have become the terms of the debate. It became necessary to describe (and defend) the NHS in terms – like production and distribution – consistent with those used to advocate its radical reform. So what was the NHS now?³⁵

The muddle was the greater because the metaphor was deemed illegitimate. For it was the market – though it had rarely been thought of as such – which the NHS

³² Ham 2000, p 7. Clarke first thought of Enthoven as 'a right wing sort of eccentric who I don't agree with': Ham 2000, p7. The effective extent of his influence has been questioned: see, for example, Martin Gorsky in this issue of SHM.

³³ Ham 2000, p 30.

³⁴ Hesse 1964, p 252.

³⁵ For discussion of the origins and implications of the market metaphor, as well as of other metaphorical frames for thinking about the NHS, see Elkind 1998.

had been set up to replace. And now what was at issue was an 'internal market', an internalisation of the other: the NHS was set to nurture processes which at the same time it sought to deny. The operation and functioning of market processes, furthermore, was predicated on a managerial capacity only recently introduced into health care in Britain.³⁶ And that had been the work of another outsider, Roy Griffiths, another invader from the other world of the firm.

Enthoven's ideas were of uncertain heritage, alien and unformed, notoriously untested. But they were also American ideas. For some time now, of course, America had taken Germany's place in an awkward relationship (however 'special') of competition and collaboration with the UK. In the same way, the NHS had long been studied by US scholars, being read both positively (as a model of equity) and negatively (as 'socialized medicine', more or less the same thing), according to the cycles of America's own health policy agenda.³⁷ On both sides of the Atlantic, metaphorical or comparative thinking – at least in public debate - appears limited by taboo, or what Deborah Stone has described as 'the assumption of the contaminated source'.³⁸ This, too, accounts for some of the fury of the response to Feachem's comparison of the NHS with California's Kaiser Permanente, a health maintenance organisation (Feachem, Sekhri and White 2002).³⁹

comparison: the new health governance

Comparison – of state with market, of public sector organisations with private sector ones – was part of the logic by which management was introduced into the NHS. In turn, it became one of its principal tools. Over the course of 1990s and into the next century, instruments of performance assessment were developed which compared organisations and individuals against notional best practice and each other. The drafting of hospital league tables followed that of school league tables, hospital Trusts were given 'star ratings' (replaced in 2006 by 'annual health checks'), different areas of delivery were matched to 'service frameworks', a Quality and Outcomes Framework was incorporated into the GP contract from 2004; surgical mortality rates are now (May 2008) to be published in England as they already are in Scotland. NHS provider organisations are now intent upon 'world class commissioning'. A series of new bodies (NICE, the Healthcare Commission and now an Institute for Innovation and Improvement), have been tasked with the management of comparison.

This 'conduct of conduct' by comparison in increasingly routinised forms has taken place in not only in intranational, but also international domains. It has become an aspect not only of NHS governance, but also of an emergent global

³⁶ National Health Service Management Inquiry 1983.

³⁷ Klein 1991.

³⁸ Stone 1981, p 281.

³⁹ For more purposeful reflection, see Ham (2005).

health governance. It was the OECD which set the terms of international debate in health policy (efficiency and cost containment) as well as providing its essential currency.⁴⁰ Its *Measuring Health Care* appeared in 1985, and the statistical database *OECD Health Data* from 1993. The health project's early emphasis on finance and productivity now includes measures of quality. For all its problems, OECD statistical data has become ubiquitous in health policy making, providing points of orientation even for self-descriptions of national systems.

WHO had experimented with targets in its *Health for All* programme launched in 1977, but made explicit, evaluative comparison of national performance in health policy with the rankings presented in 2000's *World Health Report*. The Report was met with substantial complaint as to its technical and methodological adequacy,⁴¹ and in particular as to the way it used composite indicators to measure performance.⁴² More radical criticism was made of its purpose⁴³ and implications.⁴⁴ Nevertheless, the Report and the reaction to it has made for more sophisticated discussion of methodological issues of cross-national comparison than had existed before.⁴⁵

The performativity of comparison

International debates about health care turn on and in turn produce a sense of the equivalence of health systems.⁴⁶ The attention to performance is itself performative: to compare is to designate respective entities as comparable, and so subject to evaluation and judgement. The comparisons implicit and explicit in international journals and reports and which feature increasingly in national debates serve to institutionalise the commensurability of health systems; put another way, the concepts, indicators and data they depend on serve to resolve the incommensurability which makes systems difficult to govern. How does this work?

WHO and other performance assessment exercises take an instrument developed to measure industrial performance and apply it to health care, presuming the two to be comparable and in fact making them so. It deploys composite indicators, categorisations which create new conceptual phenomena, and which are expressed in an abstract terminology which must be retranslated

⁴⁰ Klein 1991.

⁴¹ Almeida et al 2001.

⁴² Hurst and Jee-Hughes 2000, pp 15-16.

⁴³ Williams 2001.

⁴⁴ Navarro 2000, 2001.

⁴⁵ Richardson et al 2003. WHO's reflections on its benchmarking exercise, including responses to various criticisms of it are presented in WHO 2001. It sought to improve data collection through its World Health Survey, while efforts at connecting (translating) its analysis to policy making were grouped under a new Enhancing Health Systems Performance Initiative. For more detailed and wide-ranging discussion, see Murray and Evans 2003.

⁴⁶ Claudio Radaelli, similarly, remarks on 'the OMC fascination that makes different things look similar': Radaelli 2003, p 32.

in order to make local sense.⁴⁷ Benchmarking is a form of comparison which takes two (and usually many more) health services and makes them look more like each other and less like either or any of them was before.

This is because every new case added to a category changes the way we think about both case and category, which is what is described in the sociology of scientific knowledge as the problem of 'meaning finitism': 'The essential point is that our classifications are always underdetermined by the promptings of experience or by previous acts of classification. Each new application of a term is sociologically problematic... every act of classification has the form of a judgment, every act changes the basis for the next act, every act is defeasible and revisable, and every act involves reference, not just to the 'meaning' of the term applied, but also to the 'meaning' of all the other terms currently accepted for use in the context'.⁴⁸ As Garfinkel has it, each application of a term is made for "another first time."⁴⁹

This makes the process of classification and comparison somehow fragile and uncertain. That is to say that every comparison is a translation, an iteration between complex data and the conceptual vocabulary available to represent it, between empirical detail and the abstract and generic terms which best seem to fit. It is a way of associating the datum with the theoretical construct, and both together with other similar associations. The process changes both the way the datum is understood and the classificatory scheme which is the resource for that understanding. Such changes are most evident in changes of nomenclature, and in the frequent addition and subtraction of categories or classes. They are, moreover, collective processes, socially validated by researchers, policy makers and practitioners working in contexts which, whether by competition or collaboration (or both) they define for each other. 'Science and common-sense inquiry alike do not discover the ways in which events are grouped in the world; they invent ways of grouping'.⁵⁰ To take up the terms of the previous section, they work metaphorically.

The best insurance policy in the world

In January 2000, UK Prime Minister Tony Blair pledged to raise UK health spending, then taken to be just less than seven per cent of GDP, to the European average (eight per cent).⁵¹ The announcement was seemingly unplanned, made in a television interview as the government was under pressure from opposition

⁴⁷ In this way, health policy makers are following a practice already set in medicine by the international classification of diseases. The ICD, similarly, 'makes a certain set of discoveries, which validate its own framework, much more likely than an alternative set outside of the framework' (Bowker and Star 1999, p 82).

⁴⁸ Barnes, Bloor and Henry 1996, p ix.

⁴⁹ Barnes, Bloor and Henry 1996, p 56.

⁵⁰ Bruner, Goodnow and Austin 1956, cit Abercrombie 1989, p 113.

⁵¹ Ferriman 2000.

politicians and medical professional leaders over NHS capacity. Asked where the money would come from, Blair discounted the prospect of higher taxation.

Blair's announcement has been described as the most important single policy statement to be made about the NHS since Margaret Thatcher's announcement in 1988 of the review which led to the *Working for Patients* white paper and the 'internal market' reforms of 1991.⁵² It was followed by much discussion about what it really meant: in particular, the government's figure of eight per cent of GDP for average health spending in the EU was contested, while a debate opened up about the possible sources of the promised extra investment.⁵³

Two months later, in March, then Chancellor of the Exchequer Gordon Brown committed substantially increased (five per cent in real terms) funding to the NHS. The following year, in March 2001, he commissioned a review of the likely continuing resource needs of the NHS over the next twenty years. In his final report submitted in April 2002, review chair Derek Wanless set out scenarios⁵⁴ by which the NHS might 'catch up' and 'keep up' both with 'other major countries' and, by extension, with best practice (mentioned in a covering letter to the Chancellor which accompanied the report). These were predicated on a key recommendation that the principal means of financing the NHS (by general taxation) should remain the same. This had been justified, in turn, by an interim report issued the previous November,⁵⁵ which 'concluded that the current method by which health care is financed through general taxation is both a fair and efficient one, with no evidence that any alternative financing method to the UK's would deliver a given level of health care at a lower cost to the economy'.⁵⁶

Wanless's terms of reference had been specific about public funding.⁵⁷ His interim report had distinguished two sources of such funding for health care: general taxation and social insurance.⁵⁸ Placing the NHS clearly in the former category, his report argued strongly in favour of maintaining the existing system of funding by general taxation, noting the risks of social insurance systems' concentrating their revenue base on employment.⁵⁹ In reaching this position, the review team had selected as benchmark comparators both European (France, Germany, the Netherlands, Sweden) and Commonwealth (Australia, Canada,

⁵² Towse and Sussex 2000.

⁵³ Towse and Sussex 2000, Appleby and Boyle 2000.

⁵⁴ Wanless 2002, box 5.1, p 78.

⁵⁵ Wanless 2001.

⁵⁶ Wanless 2002, para 1.18, cf paras 6.59-6.67.

⁵⁷ The review was asked to identify 'the key factors which will determine the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay' (Wanless 2002, box 1.1, p2).

⁵⁸ Wanless 2002, annex C, para 18.

⁵⁹ Wanless 2002, annex C, paras 19 and 20.

New Zealand) countries, considering health outcomes as well as service inputs of financial, human and other technological resources.⁶⁰

Just before Wanless's final report was published, the Chancellor made a key speech which prefigured its conclusions and sought to shape the way it would be received and understood. Following much of the argument of Wanless's interim statement, Brown reviewed alternative funding options for the NHS, including user charges, private insurance, social insurance and general taxation, concluding that the NHS as currently funded (by general taxation) could be 'the best insurance policy in the world'. This is an extraordinary phrase, its intended effect derived from the paradox it represents.⁶¹ Think of the heuristic moves it entails.

First, Blair's response to pressure is isomorphic: one way of dealing with uncertainty is to do what others do, to seek safety in numbers.⁶² His implicit assumption is that Britain is like other European countries (by the same token, there is no suggestion that health spending in the UK should match that of the US or Australia or Taiwan). Second, and more subtly, what is being said is that respective countries are comparable, and that cross-national comparison is a relevant and productive way of knowing and thinking about health care in the UK. Blair's comparison is performative: in the terms of this paper, what is being enacted is the idea that comparison is both possible and appropriate. It is in this context that Wanless's review was undertaken. Wanless establishes not only that Britain is like other countries, but also that its health system is more specifically comparable with theirs in respect of goals, inputs and outcomes.⁶³ His report provides Brown with a set of ideal types of health care funding, a vocabulary of categories.

Brown in turn reproduces and then transforms these, conflating them into what becomes a superordinate category of 'insurance'. Moving to a higher level of

⁶⁰ As well as consulting widely within the UK, the team visited Australia, Canada and the US before presenting its interim findings, and then France, Germany and Sweden (as well as holding discussions with representatives of the Netherlands) before making its final report. It also commissioned case studies of eight countries' health care systems (which included New Zealand and Denmark as well as the other European countries mentioned).

⁶¹ It is also clearly intended to be the signal phrase of the speech as a whole: it is first used as the Chancellor begins to discuss health financing by general taxation, contrasting it with private insurance. It occurs again in a long sentence which ends the speech's penultimate paragraph: '... reformed and renewed, [the NHS] can be the most efficient and equitable guarantee of health care for millions, provide the better choices and service they need and become, for the British people, the best insurance policy in the world: the best for each of us and the best for all of us.' It then comprises its closing words. This is also a line Brown has returned to several times: in delivering his budget in April 2002, in speaking to the British Council in July 2004 and to union leaders at the TUC conference in September 2006 as well as in his first speech to the Labour conference as Prime Minister (above).

⁶² DiMaggio and Powell 1983.

⁶³ In 1992, OECD had noted a basic similarity across countries in the goals or objectives of health policy, including adequate coverage, equity in access supported by income protection, freedom of choice for consumers and autonomy for providers: OECD 1992.

abstraction, Brown establishes a commonality between all health systems in Europe based principally on the collective management of risk. But there is a further move still, a fourth. Brown's ambition is to devise the 'best' insurance policy: where Blair identifies a behavioural norm (average health spending), Brown indicates a normative standard, 'the best'.⁶⁴ His comparison is not only associative but evaluative; more precisely, it associates in order to evaluate. It is a benchmarking statement.

a National Health Service, by comparison

I want to reflect on three aspects of these comparisons in and of the NHS. The first is to take up the idea first mooted at the beginning of the paper and echoed along the way, which is why comparison appears dangerous. It seems to follow from that that it is important, and worth further consideration. So my second reflection is on what it might mean to study comparison more intensively and extensively than I have been able to here. And the third is to reflect on the kinds of comparison I have identified, to go back to Foucault, and to wonder about the historical emergence of comparison he describes.

Comparison and risk

In context, Hennock's 'revulsion, imitation and rivalry' are intuitively compelling. They seem, moreover, to have been sustained over time: they characterise responses to rankings and arguments about organisation just as much ministerial encounters abroad. They surely denote something more than simple 'learning' by comparison. They are kinds of learning, but the comparisons they entail appear more subtle, complex, tentative and dangerous than that. Why dangerous?

Comparison is difficult just as learning is difficult. It is concerned, ultimately, with an original, fundamental and primal distinction between self and other. Remember that we come to know and understand ourselves by developing our understanding of others' understandings of us. Interpreting and negotiating those understandings is difficult, subtle and complex, and a source - because it has to do with who we are - of anxiety. In Freudian psychology, and in a body of thought most closely associated with Melanie Klein, what is called 'splitting' is a critical stage of development, and overcoming it an important psychological task. For the small child, the other - the parent - is only ever entirely good or entirely bad; developing a less polarised, more nuanced understanding of the nature of difference is critical to psychic well-being. Where that development is somehow impaired, where differences (and understanding of them) between self and other remain insecure, splitting continues to serve as a defence mechanism. If boundaries are not clear, proximity and intimacy seem to risk fusion with the

⁶⁴ In passing, note that he also extends the scope of comparison, from Europe to 'the world'.

other, and loss of self. To preserve a sense of self, the other must be decried. But where there is no clear separation from an other which is now deemed bad, the self begins to seem bad, too. This problem is solved by again reversing the poles of emotional logic, reconstructing both self and other as good. Individual identity is persistently subject to these unstable oscillations.

We worry about the NHS, not least because we think it is of existential significance. For most of us, it is the guarantor of health care, and for many of us it provides other kinds of security such as income and employment, whether directly or indirectly. We compare our hospital and our health service with others, perhaps in part to find ways of improving them but just as much to make sense of them, to find ways of understanding and thinking about them. But this work of comparing call these things into question, reveals our securities as relative insecurities. In this way, comparison is a development mechanism bound by a defence mechanism. Doing it appropriately and effectively entails deeply significant emotional as well as intellectual work.

Learning, too – and here learning and comparison become virtually indistinguishable - is a kind of risk-taking. As Bateson observed, it is inevitably bound up with anxiety.⁶⁵ It implies leaving behind what we do in order to do something else, or to do it differently. To learn is somehow to overcome who we are: it implies relinquishing, momentarily, who we are in order to find ourselves anew. In this context, the new governance arrangements give order to comparison. They internalise and institutionalise it, developing what we might call a 'contained comparison', disciplined rather than undisciplined. They seek an improbable systematisation of metaphorical thinking, the taming of learning.

Comparison as an object of study

So what should we, the academy, do with comparison? Where does this leave comparative health policy, comparative politics and public policy, comparative history? My argument here suggests that comparativists have both overestimated and underestimated comparison. They have overestimated the prospect of policy makers and practitioners learning from comparative research – or, perhaps better, they have failed to theorise fully what tends to be characterised as the resistance or stickiness of institutions. At the same time, they have underestimated or failed to appreciate the comparisons that policy makers and practitioners themselves make. And it is these which drive – literally 'make up' – health policy and practice.

Comparison tends to have been favoured more by political scientists and policy researchers, commentators and analysts than by historians. Yet, as I have tried to show here, comparing is a process that unfolds in and over time. Comparisons have a history, which means not that we need comparative history but that we need a history of comparisons.

⁶⁵ Bateson 1973.

We need this, I think, because in order to understand the development of things like hospitals and health services, we need to know what policy makers know, what made it possible to think, to imagine, to plan certain kinds of things and not others. And by the same token, we will come to understand the epistemology of contemporary policy making by relating it to others both previous and proximate – that is, by comparison.

I have used the idea of comparison here both specifically and generically, describing the new health governance as predicated on comparison but referring to other ways of thinking - exploratory and metaphorical – as comparative, too.⁶⁶ The typology (itself a provisional act of comparison) was developed through historical questioning but makes no claim that different ways of 'doing comparison' are historically ordered. Each of them remains in play at each point in time, and their reciprocal relations – the way one seems to entail the other – warrants further investigation. The thinking behind 'world class commissioning' would not have seemed so strange to William Braithwaite.

Comparison and resemblance

This might be because similarity is prior to difference. As Andrew Cooper explains, drawing on Bateson and Wittgenstein, 'For there to be "difference between", there must be a relation other than difference, which is similarity'.⁶⁷ The work of comparison is to create those relationships of difference out of similarity.

After that passage from Borges,⁶⁸ and after Velázquez and *Las Meninas*,⁶⁹ Foucault turns, in *The Order of Things*, to the matter of resemblance. Up to the end of the sixteenth century, he explains, Western thought was constituted through the production and explication of resemblance, through describing the ways in which one thing was echoed, mirrored, reflected and repeated in another. In an array of 'similitudes', or ways of constructing resemblance, four were key: simple 'convenience' (meaning here, as in its Latin root, adjacency or juxtaposition); emulation, or resemblance without the requirement of physical proximity; analogy, or resemblance between relationships rather than between things, and sympathy. 'Sympathy plays through the depths of the universe in a free state. It can traverse the vastest spaces in an instant... it can be brought into being by a simple contact'. What is more, it 'excites the things of the world to

⁶⁶ Compare Miller 2006.

⁶⁷ Cooper 2000, p 92.

⁶⁸ Foucault quotes Borges, himself quoting (or claiming to) a 'certain Chinese encyclopaedia' which notes that 'animals are divided into: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) *et cetera*, (m) having just broken the water pitcher, (n) that from a long way off look like flies': Foucault 1970, preface, p xv.

⁶⁹ The discussion of *Las Meninas* is concerned with the representation of representation.

movement and can draw even the most distant of them together. It is a principle of mobility'. And further: 'Sympathy is an instance of the *Same* so strong and so insistent that it will not rest content to be merely one of the forms of likeness; it has the dangerous power of *assimilating*, of rendering things identical to one another, of mingling them, of causing their individuality to disappear – and thus of rendering them foreign to what they were before'.⁷⁰

Foucault turns then, as does the world he describes, to representation, language, classification and exchange, to a system of thought predicated on comparison. Comparison amounts to the testing or proving of resemblance, through measurement, definition and the production and precision of categories. 'The activity of the mind... no longer consist[s] in *drawing things together*, in setting out on a quest for everything that might reveal some sort of kinship, attraction, or secretly shared nature within them, but, on the contrary, in discriminating'.⁷¹

I want to question only the order or succession of his order of things. Whatever sympathy is, it seems to be just as characteristic of globalised, homogenised contemporary governance as comparison does. Comparison does not replace resemblance but is predicated on it, follows it, pursues it: 'At the border of knowledge, similitude is that barely sketched form, that rudimentary relation which knowledge must overlay to its full extent, but which continues, indefinitely, to reside below knowledge in the manner of a mute and ineffaceable necessity'.⁷²

What, then, is in the name? What do we mean when we speak of the National Health Service? Back to Velázquez, Philip IV and *Las Meninas*: 'It is in vain that we say what we see; what we see never resides in what we say. And it is in vain that we attempt to show, by the use of images, metaphors or similes' – or comparisons – 'what we are saying... the proper name, in this particular context, is merely an artifice: it gives us a finger to point with, in other words, to pass surreptitiously from the space where one speaks to the space where one looks; in other words, to fold one over the other as though they were equivalents'.⁷³

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⁷⁰ Foucault 1970, pp 23-24.

⁷¹ Foucault 1970, p 55, italics in original.

⁷² Foucault 1970, p 68.

⁷³ Foucault 1970, p9.

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