

The Americanization of the British National Health Service:

Powell, Martin; Beland, Daniel; Waddan, Alex

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Abstract

There have been many different claims that the British National Health Service (NHS) is becoming ‘Americanized’. Focusing on the United Kingdom, this article critically analyses the ‘Americanization’ of the NHS in three main sections. First, we explore the basic meanings of the term. Second, we examine the development of the discourse about Americanization. Third, we focus on one of many possible meanings of Americanization, namely system change. Focusing on the most demanding dimension of Americanization, namely system change, we suggest that most changes have been ‘internal changes of levels’ (where there is a shift of levels in one or more dimensions but without changing the dominant form) or ‘internal system changes’ (where only one dimension changes its dominant form) rather than a ‘system change’ (from one ideal type to another).

Keywords: Americanization; British National Health Service; policy change; system change;

Introduction

Americanization has become one of the buzzwords in the public debate on the future of the welfare state (Starke et al 2008, p. 994). Similarly, much has been written since the Thatcher years (1979-1990) about the “Americanization” of the British (and since political devolution in 1999, the English) National Health Service (NHS). Although the term is used in many different ways, the overarching idea is that the NHS is moving towards a more market-oriented system, which British scholars tend to associate with the United States. This article critically analyses the “Americanization” of the NHS and is divided into three main sections. First, we explore the basic meanings of the term Americanization in the existing scholarship on the British/English NHS. Second, we examine the development of the discourse about Americanization in the literature about the NHS from 1979 to 2015. Third, we discuss existing typologies of health care systems in the advanced, industrial world that are linked with Hall’s (1993) work on policy change. Overall, this article has two main aims. First, it contributes to the literature by offering a critical perspective on an Americanization discourse that is typically grounded in a lack of direct engagement with the comparative and international literature on both health care systems and the nature and levels of policy change. Second, it offers one possible solution, based on the literature of health care typologies and

system change.

The Diverse Meanings of “Americanization”

The first use of the term we (or rather Google Scholar) can find is Kellor (1916) who stated that the word is rarely defined and there appears to be little consensus on its meaning. Over 100 years later, this view remains largely valid. For example, Kuo (1976) linked it with acculturation, while Muncie (2007, p. 186-7) make the connection to, and sometimes used it interchangeably with, globalization. On the other hand, Bell (1999) related it to post-industrial society and Zeitlin (2000) linked it with technology.

One of the earliest uses within health policy appears to be Mechanic (1995, see below). Since then, the term has been used in a number of studies in social policy (e.g. Alber, 2010; Dagurre, 2004; Daguerre & Taylor-Gooby, 2004; Deacon, 2000; Holmwood, 2000; Hulme, 2006; Walker, 1999) and in health policy (e.g. Davis, Lister, & Wrigley, 2015; Gabe, 1997; Glennerster & Lieberman, 2011; Light, 1997; Lister, 2008, 2013; Player & Leys 2011; Pollock, 2001, 2015). As in its wider usage, there is little consensus in these fields about what it is, with little in the way of definition or empirical evidence. Mechanic (1995, p. 52) and Alber (2010, p. 114) linked Americanization with growing similarities or convergence in policy. For Alber, Americanization meant that some of the peculiar features of the American welfare state are adopted or strengthened in other countries, so that they converged with the US system. Holmwood (2000) and Glennerster and Lieberman (2011) discussed two different issues related to convergence and regime change. As Holmwood (2000) pointed out, since it is a “Liberal welfare regime,” the Americanization of British social policy is precisely what is to be expected; put crudely, it is American, rather than Americanized. What remains unexplained is that there was a time when British social policy (such as the NHS) did not

seem to be American, leading Holmwood to ask why the UK had moved from one type of welfare regime to another.

Annesley (2003) and Alber (2010) discussed Europeanisation, while Holmwood (2000) pointed to the paradox of the process of the Americanization of British social policy and the Europeanization of Scottish social policy. For health care, Glennerster and Lieberman (2011, p. 8) found a “mixed picture of convergence and divergence” (cf. Waddan, 2011) but suggested “a converging future?” (p. 25). Starke, Obinger, and Castles (2008) have one of the few quantitative studies of Americanization in social policy. They examined the degree of convergence (Americanization) of some OECD welfare states since 1980 on the criteria of social expenditure, taxes and decommodification. They concluded that the evidence does not support an interpretation of recent social policy developments within the OECD as Americanization. Rather than following the neo-liberal path towards Americanization, countries in general appeared rather to have increased their distance from the US on a number of central dimensions.

Americanization since 1979

In their *longue durée* accounts, Marmor and Plowden (1991) and Glennerster and Lieberman (2011) claimed that the earlier West to East flow of policies in the nineteenth and early twentieth centuries was reversed after the Second World War. In this section, we look at the major claims that have been advanced about the Americanization of the NHS over the three governments since 1979.

Conservatives (1979-1997)

According to Lister (2008, p. 97), in 1988, a Royal College of Surgeons Working Paper recommended the establishment of US-style Regional Trauma Centres. However, Lister

argued that the choice of an American model of service was particularly inappropriate for trauma care since so much of the workload of US trauma centres consisted of people suffering from gunshot wounds and knife injuries, problems thankfully rare in Britain.

Most claims about Americanization in the Thatcher (1979-1990) and Major (1990-1997) eras were linked to the debate on NHS reform that produced the “Working for Patients” (WfP) (DH, 1989) White Paper. Robin Cook, then Labour Shadow Secretary for Health, insisted that the Government was promoting “market medicine as it is practised across the Atlantic” (quoted in Klein, 2013, p. 152). Timmins (2012, p. 15) noted that critics warned that the Conservative market-based changes marked “the end of the NHS as we know it” taking it down a road towards US-style privatized care. The basis of this argument was linked to the “purchaser/provider split” and the creation of the so-called “internal market” that was designed to foster competition between NHS providers. Prior to the release of WfP, there was a broad discussion about convergence and lessons for Britain (e.g. Havighurst, Helms, Bladen, & Pauly, 1988), particularly on the themes of managed competition and Health Maintenance Organisations (HMOs) (O’Neill, 2000). A number of commentators (e.g. Freeman, 1999; Marmor & Plowden, 1991; O’Neill, 2000; Rayner, 1988) pointed out that the debate drew heavily on the ideas of the American economist, Alain Enthoven (1985, p. 42), who suggested an “internal market” based on District Health Authorities. However, while Enthoven believed that this would offer “substantial improvements” over the present NHS structure, it would not promise the full benefits of the kind of competing HMO structure that was developing in the US. Enthoven (1985, p. 42) declared that, “when all of the alternatives have been considered, it becomes apparent that there is nothing like a competitive market to motivate quality and economy of service.”

As Rayner (1988) stressed, Enthoven personally favoured the model of the corporate HMO, but in the British context promoted “market socialism” of a more competitive

environment between health districts as a second-best alternative. Rayner went on to discuss “primary care HMOs” similar to the ones British health economist Alan Maynard had suggested. There were early indications that the government might support HMO development in primary care. Although the Department of Health and Social Security’s (DHSS) consultation document on the future of primary care (DHSS, 1986) commended the growth of HMOs, the resulting White Paper (DHSS, 1987) noted that the idea had received little support. However, in a further twist (discussed below) the broad idea was revived as General Practitioner Fund Holding (GPFH) in WfP (DH, 1989).

Butler (1986) discussed HMO management lessons and introducing the HMO to Britain. Willetts and Goldsmith (1988) praised the HMO model, but added that “it is not possible simply to adopt an American model” (in Lister, 2008). Moreover, Fairfield, Hunter, Mechanic, and Rosleff (1997) and O’Neill (2000) stated that the NHS already showed some of the important features of managed care, while Light (1997, p. 3000) noted that “the NHS can be regarded as one giant managed care system.”

Mechanic (1995, p. 54) concluded that “it is not too far-fetched to suggest that the Thatcher reforms were to some degree an Americanization of the NHS.” However, some of his other claims are unclear and others still are weak. For example, his claim that, “as in the United States, efforts are being made to promote improved lifestyles and public education and practice” (p. 57) is far from compelling since the 1990s were not the first time that such efforts had been made. As well, countries other than the US were also making similar efforts.

Light (1997) argued that Mechanic (1995) pointed out five ways in which the NHS was becoming Americanized (the role of markets and competition; the internal market is similar to public contracting in the US; the creation of trusts make hospitals similar to non-profits; the GPFH makes mini HMOs; and efforts to promote health) but eight ways in which the NHS remains substantially different from the US system, “leaving it unclear what one is

to conclude” (p. 333). He concluded that the NHS is not becoming very Americanized in the ways Mechanic highlighted, but rather in “darker ways”: using tax breaks to drive up expenditures on health care by providing discounts on health insurance at taxpayers’ expense; fostering two-tier access to vital services through public law; transferring public property to investors at favourable rates; using public money to pay for private services with generous built-in profits; and shrinking NHS services for persons with chronic problems (p. 333-4).

Fairfield, Hunter, Mechanic, and Rosleff (1997) stated that, despite the many differences in British and American health policies, there were growing similarities between the two. They argued that the development of total fundholding by general practitioners and multifunds in Britain mirrored the development of health maintenance organizations in the United States. O’Neill (2000, p. 73) wrote that the “new buzzword of ‘managed care’ is now a dominant feature of the American health care system”, and has been termed “the de facto national health policy of the United States.” HMOs were the most widespread embodiment of these new principles in action. At the same time, she argued that the elevation of the primary care “gatekeeping” role and a reduction in choice represented two of the ways in which the American system is moving closer to the British.

Labour (1997-2010)

The major debate in the 1997-2010 period involved Kaiser Permanente (e.g. Leys and Player, 2011, p. 56; Player, 2013, p. 39-40) as a model for NHS reform. Feachem, Sekhri, and White (2002) sought to compare the costs and performance of the NHS with those of an integrated system for the financing and delivery of health services (i.e. Kaiser Permanente) in California. They claimed that “in many ways Kaiser Permanente is like the NHS,” but that it is a more integrated system than the NHS, that “Kaiser achieved better performance at roughly the same cost as the NHS,” and that Kaiser’s use of acute hospital beds was

considerably lower than that of the NHS. Talbot-Smith, Gnani, Pollock, and Pereira Gray (2004) strongly criticized this article, noting that it attracted an unusual amount of attention and citations (with 82 rapid responses in the BMJ alone (see also, Himmelstein et al. 2002).

Similarly, Ham, York, Sutch, and Shaw (2003) compared the utilization of hospital beds in the NHS in England to Kaiser Permanente in California. They found bed day use in the NHS for the 11 leading causes to be 3.5 times that of Kaiser's standardized rate, which Kaiser achieved through a combination of low admission rates and relatively short stays. They claimed that the NHS can learn from Kaiser's integrated approach, the focus on chronic diseases and their effective management, the emphasis placed on self-care, the role of intermediate care, and the leadership provided by doctors in developing and supporting this model of care.

Ham (2005) noted that while the UK and the US were at opposite ends of the health financing spectrum, as an integrated financing and delivery system, Kaiser Permanente was in some ways more similar to the NHS than to other types of health care organizations in the US. According to Ham (2005), there was no single or simple reason for the differences in bed day use between Kaiser and the NHS. He concluded with the possibility that Kaiser's distinctly un-American approach may in the longer term have a bigger impact in countries like the UK whose values are more in keeping with this approach than in the rest of the US.

According to Ham (2006, 2010), the Feacham, Sekhri, and White (2002) paper stimulated a pilot program to adapt the experience of Kaiser in three areas of England (Birmingham and Solihull, Northumbria, and Torbay) in the NHS Kaiser Beacon sites, which produced "promising early reports." Moreover, partly as a response to Dixon's (2002, p. 142) commentary in the *British Medical Journal* that suggested that politicians "should encourage a few seasoned chief executives in the NHS with a good track record to go to study Kaiser, take time to learn the lessons, and genuinely follow the maxim 'what counts is what works,'"

the then NHS Modernisation Agency arranged visits to Kaiser. The Health Strategy Review Adair Turner undertook for the Prime Minister in 2001 examined the lessons the NHS might learn from integrated systems like Kaiser Permanente. Ham (2010) updated his earlier report (Ham, 2006), arguing that the Kaiser NHS Beacon sites had continued to make progress in improving services to the populations they served, with examples of innovation in all sites and increasing evidence of improvements for patients.

Ham (2007) also focused on the Veteran's Health Association (VHA), arguing that evidence indicated that integrated delivery systems such as the VHA and Kaiser Permanente achieved good outcomes for people with chronic diseases. He discussed vertical integration organizations (where hospitals themselves are joined with medical groups) and virtual integration (where hospitals remain organizationally distinct and form long-term alliances with one or more multi-specialty medical groups). Examples of both approaches could be found in the US, with Kaiser Permanente in northern California taking the form of a vertically integrated organization, and Kaiser Permanente in Colorado being an example of a virtually integrated organization. He stated that Kaiser Permanente in Colorado achieved consistently high levels of performance among the Kaiser regions. While this might have suggested there were advantages in virtual integration, Ham argued that it was worth invoking the experience of another integrated delivery system, the VHA, whose performance had improved remarkably since 1995. One of the most important factors in its improved record was its conversion from a hospital-centred system to an organization where care is organized into regionally-based integrated service networks. The experience of the VHA suggested that vertical integration holds as much promise as virtual integration. Kaiser has no commissioning process because commissioning is internalized within an integrated system, perhaps suggesting that complex transactions such as health care tend to favour hierarchy rather than markets. Ham concluded that a fundamental feature of the integrated systems in

the US is that they achieve high levels of performance not through contracts and transactional reform, but by engaging clinicians (especially doctors) in the quest for improvement and by aligning the incentives facing the organization with those of the key front-line decision makers.

Oliver (2007) agreed that the VHA is the largest integrated health care system in the US. It was financed mostly from general tax revenue, offered a broad range of health care services to meet veterans' needs, and could be characterized loosely as a veteran specific national health service. He concluded that it is ironic that, through VHA, the US has implemented a model of integrated public sector health care that appeared on balance to work quite well. This raises questions about what is meant by Americanization. To the extent that there was any effort to emulate Kaiser and the VHA in the UK, it is important to point out that these programs are not typical of the US health care model. As Woolhandler and Himmelstein (2007) noted, the US health care system's dismal record arose from health policies that emphasize market incentives. However, the VHA, a network of hospitals and clinics owned and operated by government that was long derided as a US example of failed Soviet-style central planning, became "the major success story of recent US health policy." That said, the VHA has since become embroiled in controversy after it was revealed that VHA hospitals had been manipulating data (Shear & Weisman, 2014).

In another critique, Pollock (2001) argued that the Health and Social Care Bill of 2000 could move the UK towards a US-style health care system. The bill allowed Primary Care Trusts (PCT), as "NHS trading bodies," to generate non-NHS income through user charges by becoming care trusts and holding pooled budgets for health and social care. For the first time, an NHS body would be able to charge for personal care and hotel costs. This use of private finance in primary care premises witnessed the entry of commercial property developers and for-profit health care companies, paralleling developments in the NHS

hospital sector. She pointed to “the spectre of US-style HMOs to which the new structures of the NHS conformed.” Like HMOs, PCTs would increasingly operate in the market as trading bodies.

Lister (2008, p. 183-4) cited a 2006 article by Timmins in the *Financial Times* that “insurers invited into NHS economy” would likely include big US insurers such as UnitedHealth and Kaiser Permanente. Lister argued that, “at first sight the very notion was a sick and silly joke: putting these companies in charge of the NHS budget was like putting Dracula in charge of a blood bank.” However, commentators such as Ham (2005) observed that there are large differences between “insurers” and HMOs. Referring to the rankings produced by the Commonwealth Fund, Leys and Player (2011, p. 10) stated that embracing the idea of replacing one of the most cost-efficient and fairest health systems in the world (the British) with one modelled on the most expensive and unequal (the US) sets a new standard for ideologically-driven (and interest-driven) policy making.

Finally, Lister (2008, p. 238) pointed out that Hampshire PCT appointed Roger Hymas, a strategy advisor from US giant insurance company Humana, as its director of commissioning on a two-year secondment. He claimed that the regulator of Foundation Trusts, Monitor, was “largely privatised,” with two thirds of its £15.5 million first year budget spent on hiring private management consultants from the US and flying in “American whizz-kids” from McKinsey consulting, including Chelsea Clinton (daughter of former president, Bill Clinton). This theme of “over paid and over here” continued into the next period.

Conservative/ Liberal Democrat Coalition (2010-2015)

In the 2010-2015 period, Secretary of State Andrew Lansley’s White Paper, “Liberating the NHS” (DH, 2010), which formed the basis of the 2012 Health and Social Care Act (HSCA),

provided the main point of reference for Americanization. Leys and Player (2011, p. 143) stated that in the long run, the Lansley project would lead to something close to the US health system: a low quality basic health service increasingly based on the ability to pay. Leys and Player (2011, p. 145) cited Claire Gerada, president of Royal College of General Practitioners, that Lansley's Act would lead to the "end of the NHS" and would make England's health system look more and more like that in the US. Similarly, Davis, Lister, and Wrigley (2015, p. 149) argued that the HSCA moved the UK towards an NHS where care is still publicly funded but is increasingly outsourced to the private sector. The US system of Medicare ran along the same lines as those being forced on the NHS: publicly funded but privately delivered. Similarly, Davis, Lister, and Wrigley (2015, p. 152) argued that politicians dismissed comparisons with the US and reassured the British population that they were not going down the "American route" in terms of its health care system and that a significant percentage of US health care was publicly funded and privately delivered and, thus, formed a useful indication of how this market-based system worked.

Davis, Lister, and Wrigley (2015, p. 277) claimed that new structures such as multi-specialty community providers and primary and acute care systems are akin to the accountable care organizations modelled on Kaiser Permanente. They continued that some argue that their appearance could prepare the way for an insurance based system for the NHS and allow private multinationals to run the NHS as US-style HMOs and hospital chains. While the "Five Year Forward View" (NHS England, 2014) carefully skirted around any reference to competition or markets, it contained avenues that could lead to further privatization. Indeed, Rahman (2014) labelled it "a wish list for privatisers": 39 pages of sophisticated propaganda dressed up in bland language about "integration" that contained hand grenades for the NHS.

Americanization was regarded as integral to the “plot against the NHS” (Leys & Player, 2011, p. 2) with the “real” aim of replacing the NHS with a health care market on American lines, to be run by a variety of multinational health companies, private equity funds, and local businessmen. These large multinational corporations, including consultancy firms such as McKinsey and “private equity” capital firms were ‘the scavengers of capitalism” (Lister, 2013, p. 9-10). Player (2013, p. 55-6) pointed to the international “policy community,” including UnitedHealth, McKinsey, and Humana, that had links with UK health policy organizations. A number of commentators pointed to the “revolving door” between the NHS and the private sector, including American corporations (e.g. Davis et al., 2015; Leys & Player, 2011).

Pollock (2015) expressed an additional concern, focusing on the devolution of budgets to commissioning groups:

Health services in England were moving to a US model in which increasingly access will not be through automatic entitlement but through local eligibility criteria as commissioners decide what services will be funded by the NHS and what will be paid for... In this system patient choice does not mean patients having choice of providers, but rather providers being able to choose their patients and treatments on the basis of ability to pay.

In other words, GPs will seek to manage their budgets by avoiding commissioning expensive treatments for patients (although GPs always had the right to refuse to accept a patient or remove them from their list).

Davis, Lister, and Wrigley (2015, p. 278) returned to the “over paid and over here” personnel theme, pointing out that Simon Stevens, a senior executive at United Health, but also a former NHS manager, was appointed as CEO of NHS England and used the concept of

“integration” to dress up his US-inspired models of care. Finally, as a proof of Americanization, commentators pointed to Americans, such as Ken Anderson, appointed to high level position within the NHS (e.g. Davis & Tallis, 2013; Davis et al., 2015; Leys & Player, 2011).

Taylor (2013, p. 134-5) pointed out that the head of the Merseyside Trades Union Council (TUC) criticised the reconfiguration of vascular surgery as “an Americanization of our local health facilities.” However, he did not see why this centralisation is regarded as Americanization since, on the whole, America’s market-driven system tended to suffer from precisely the opposite problem of far too little centralisation and little integration between centres of excellence, local hospitals, and ambulance crews.

The various arguments cited here amount to a series of diverse claims over a long period since 1979. While there are few clear definitions, implicit criteria of Americanization appear to include staff increasing private provision; increasing private finance; an increasing use of US for-profit companies and multinational corporations; centralisation (e.g. regional trauma centres); institutional isomorphism (e.g. HMOs, Kaiser, VHA, Medicare); policy borrowing (e.g. HMO, Kaiser, VHA, Medicare); and reduced universalism/residualism, convergence, regime, or type change (see Table 1).

However, these accounts tend to “accentuate the negative” and omit possibly “good” aspects of Americanization. For example, one of the examples Ettelt, Mays, and Nolte (2012) give suggests that the ban on smoking in public places could be regarded as “Americanization.” Similarly, learning from the “safest hospital in the world” (Virginia Mason, Seattle) might be regarded as positive (NHS Improving Quality, 2015). Moreover, critics tended to use “thin end of the wedge” arguments, including McKee and Stuckler (2011) who point to residualisation where, for example, public hospitals in the US are “a service for the poor.” Finally, they also neglected contrary evidence where the NHS model

has been reinforced. For example, when elected in 1997, the Labour government quickly ended the tax break for retired people who bought their own private health insurance and then, through the 2000s, significantly increased public spending on the NHS. Since 2010 the increase in spending has stopped, but the HSCA did not contain any direct provisions to incentivise private health insurance.

In addition to being diverse, many of these claims of Americanization are overly vague, with insufficient clarity on criteria, variables, or degree and direction of policy change. As suggested above, the studies often do not provide a clear definition of the term. However, inductively there appear to be a range of implicit criteria or evidence (Table 1).

Table 1: Dimensions of Americanization in Health Care

Criteria	Studies	Examples of Evidence
Growing similarities/ Convergence	Mechanic (1995), Gabe (1997), Fairfield et al. (1997), O’Neill (2000), Pollock (2001), Lister (2008), Alber (2010), Rothgang et al (2010), Glennerster & Lieberman (2011), Waddan (2011)	<ul style="list-style-type: none"> • Mechanic (1995, p. 52) suggests “greater similarities” between the US and UK systems • Glennerster and Lieberman (2011) suggest “a converging future?”
Policy learning or borrowing: ideas	Enthoven (1985), Rayner (1988), Marmor & Plowden (1991), Freeman (1999), O’Neil (2000)	<ul style="list-style-type: none"> • “competitive market” (Enthoven, 1985) • Enthoven’s pro-market ideas represented “an instance of almost pure theory being transplanted across an ocean” (Marmor & Plowden, 1991, p. 812). • What was transferred was not an established institution or program but rather a general set of ideas (O’Neill, 2000, p. 67).
Policy learning or borrowing: institutions	Butler (1986), Fairfield et al. (1997), O’Neill (2000), Feachem et al. (2002), Ham (2006, 2007, 2010), Oliver (2007), Lister (2008), Annesley (2003), Leys & Player (2011), Player (2013), Davis et al. (2015)	<ul style="list-style-type: none"> • HMO (Butler, 1986) • GPFH mirroring HMOs (Fairfield et al. (1997). • HMOs as “managed care” (O’Neill, 2000) • Kaiser Permanente (Feachem et al., 2002; Ham 2006, 2010; Leys & Player 2011; Player, 2013)

		<ul style="list-style-type: none"> • VHA (Ham, 2007; Oliver, 2007) • Accountable Care Organisations (Davis et al., 2015) • “The process of Americanization is quite a straightforward case of policy transfer” (Annesley, 2003)
Borrowing: personnel	Lister (2008); Leys & Player (2011), Davis et al. (2015)	<ul style="list-style-type: none"> • Individuals and large multinational corporations including consultancy firms (e.g. Leys & Player, 2011)
System change	Holmwood (2000); Leys & Player (2011), Timmins (2012); Davis et al. (2015), Pollock (2015)	<ul style="list-style-type: none"> • Critics warned that the WFP changes were taking the NHS “down a road towards US-style privatised care” (in Timmins, 2012). • Embracing the idea of replacing one of the most cost-efficient and fairest health systems in the world (the British) with one modelled on the most expensive and unequal (the American) (Leys & Player (2011, 10). • Trend towards publicly funded and privately delivered care (Davis et al., 2015) • Health services in England are moving to a US model (Pollock, 2015)

Two specific points can be made about the dimensions in Table 1. First, convergence is a multifaceted concept with several types, such as *sigma*-convergence, *beta*-convergence, and *delta*-convergence (Starke et al, 2008; Rothgang et al 2010). Focusing on welfare state change, Starke et al (2008) explore Americanization as *delta*-convergence, or a trend towards a particular policy model or benchmark. However, as noted above, they find no evidence of a strong and uniform Americanization trend. Although they do not use the term ‘Americanization’, Rothgang et al (2010), focusing on health care, find that the three distinct funding models are quite persistent over time, which goes against the idea of *delta*-convergence, or convergence towards one single financing model.

Second, despite having been linked with regulated competition and ‘New Public Management’, a potential element in the policy borrowing category of Diagnostic Related Groups (DRGs) appears to be discussed with reference to global policy diffusion rather than Americanization per se. DRGs classify patients according to their case-mix and serve as a basis for hospital funding, management, planning, and utilization review. Schmid and Götze (2009) state that DRGs are now a global phenomenon, partly through the involvement of international organizations such as the World Health Organization and the European Union. They developed in the late 1960s at Yale University, and were implemented in the US Medicare programme in 1983. Geissler et al (2015) note that DRGs have been introduced worldwide, and especially in Europe, in a large number of countries with very different health care systems to become the principal means of hospital payment in most countries. However, if ‘Americanization’ is regarded as ‘made in the USA’ and exported to other health care systems, then DRGs seem to be the Americanization dog that did not bark.

More generally, at worst, some claims of “Americanization” can be seen as loose terms of abuse (i.e. everything American is bad). At one extreme, it is possible to argue that *any* small change towards the US results in the NHS being Americanized. While there have clearly been changes to the organization of the NHS with the creation of the internal market in 1990, followed by the introduction of competition from private providers for NHS work in the 2000s (Arora, Charlesworth, Kelly, & Stoye, 2013), it is evident that significant differences between the funding, delivery, and regulation of health care in England and the US remain. If the claims of Americanization with regard to the NHS are to provide grounds for a meaningful discussion of policy change, there needs to be an organizing framework for rigorous analysis. This can be based on any of the above dimensions (see e.g. Author Ref for the case of policy transfer). However, in the following section we focus on the most

demanding definition of system change and suggest that this framework can be based on the literature on health care system types.

Types of Health Care Systems

Many attempts have been made to develop classifications of health care systems (Freeman & Frisina, 2010; Rothgang et al, 2010). However, the modal or standard classification consists of three types: national health services, social insurance systems, and private insurance systems.

Freeman and Frisina (2010) pointed to three main weaknesses in the use of these classifications. First, there was “perennial misrepresentation” of the US as “private,” but it is not. Rather, it is the closest approximation to a category logically required by the classificatory scheme to which no other OECD country came close. This meant that if the US health care system did not exist we would have to invent it. Bohm, Schmid, Gotze, Landwehr, and Rothgang (2013) state that Private Healthcare Systems were characterized by the dominance of private market actors in the coordination of the health care system, funding from private sources such as insurance premiums or out-of-pocket payments, and services performed by for-profit providers. This health care system type was generally considered the most common system until the early 20th century. However, ever since Switzerland switched to the corporatist Social Health Insurance (SHI) in 1996, the private system only prevailed in one large OECD country: the US. Nevertheless, due to public programs such as Medicare and Medicaid, public sources already played a very important role in health care funding in the US, contributing around 46% to overall health funding. When tax exemptions, which effectively subsidize the employer provided insurance system, were taken into account, the private share drops below 50%. Moreover, the state had key regulatory competencies in public programs that cover around one-fourth of the population. Bohm, Schmid, Gotze,

Landwehr, and Rothgang (2013) continued that although the private nature of the US health care system still dominated, the recent Obama reforms tended to move toward more public funding and stronger state regulation.

The second weakness identified by Freeman and Frisina (2010) was that classifications tended to be binary: a case is deemed either to belong to a specified category or not. However, what is in principle a set of binary decisions (about finance, provision, and regulation) was regularly reduced to one fundamental decision as a result of the priority given to financing mechanisms, both in description and classification. The third, and linked, weakness was the relative paucity of attention given to the matter of regulation.

Freeman and Frisina (2010) further argued that some studies set out distinctions between different kinds of health systems to claim an increasing convergence between them. Some classifications assumed some sort of evolution toward greater state or public responsibility for health care in respect to each of the dimensions according to which countries were previously distinguished (financing, provision, and regulation). However, while there was much talk of “mixed forms” of financing, provision, and regulation, a “blurring” of regimes is not the same as convergence on a single model.

We draw on the recent analyses of Wendt, Rothgang, and colleagues (Bohm et al., 2013; Rothgang et al., 2010; Wendt, 2009, 2014) who develop a typology of health care systems based on three functional processes (financing, provision, and regulation) and three modes or domains of co-ordination (state, society, and market) resulting in 27 (3 x 3 x 3) different combinations.

Wendt (2014) performed cluster analyses for 2001 and 2007 to classify 32 OECD health care systems. He reported four clusters, with NHS systems, including the UK, in cluster 1. Although it was not possible to classify the US (or Korea, Norway, or Switzerland), the US and Switzerland shared high levels of low total health expenditure (THE), GPs' fee-

for-service payments, and doctors' free choice with cluster 4 countries. However, the share of public financing was even lower than in cluster 3, and private out-of-pocket payments (OOP) are much higher in Switzerland. Interestingly, the US and Switzerland shared a preference for in-patient care opposed to out-patient care, which is the case with Type 1 countries. Finally, he considered that countries such as Switzerland and the US, whose private health care market is of great importance, do not seem to have much in common and do not form their own private health insurance model.

Wendt (2014) found that the hypothesis that health care systems can still best be classified as NHS, social health insurance, or private health insurance has, to a certain extent, been confirmed. Between 2001 and 2007, the clusters and country groupings proved to be robust, but he found some evidence for the hypothesis of health care system change. However, institutions like health care systems changed slowly, like "elephants on the move" (Hinrichs 2001). Health care system change has been identified mainly in the areas of health care expenditure and access regulation. In contrast, patterns of public financing, private co-payments, health care provision, and doctors' remuneration have proven rather stable.

Wendt (2009) drew on Hall's (1993) concept of first, second, and third-order change, and suggested three forms of change: a "system change" (from one ideal type to another), an "internal system change" (where only one dimension changes its dominant form, e.g. the provision of health care shifts from public to private actors), and an "internal change of levels" (where there is a shift of levels in one or more dimensions but the dominant form remains unchanged). Similarly, Waddan (2011) drew on Moran's (2000) typology of health care regimes with the UK and US as "command and control" and "supply" health care states, respectively. Waddan pointed out that if either moved from one category to the other (i.e. that there really was Americanization or socialization) it would constitute a remarkable transformation.

A significant degree of variation exists within types (Bohm et al., 2013; Wendt 2014). For example, within the NHS family, hospital beds in public ownership exceed 90% in Scandinavia and the UK, but are around 66-75% of all beds in Spain and Portugal. Moreover, a closer look at financing reveals elements of SHI in some NHS types, where the financing share of contributions is between 1.2% (Portugal) and 28.3% (Iceland). Bohm et al. (2013) suggest that 27 “plausible health care types” can be reduced to five main categories: National Health Service (e.g. UK), National Health Insurance (NHI) (e.g. Canada), Social Health Insurance (e.g. Germany), Private Health System (only example is US), and Statist Social Health Insurance (e.g. France).

This suggests that a NHS type system (state financing, provision, and regulation) would have to show significant moves in all three dimensions before it transformed into a private system (private financing, provision, and regulation). For example, a significant move on service provision alone towards private rather than public providers would lead to an NHI type (state regulation and finance, but societal-actor provision). This is perhaps best represented by a system like the Canadian one, which is often described in the US as a single-payer system but differs from the traditional model of the UK’s NHS where secondary care providers have been in the public sector (e.g. Canadianization?).

It is difficult to detect Americanization in this very demanding sense of system change. Claims appear to be based on the implicit assumption that only two types are possible (a false binary). However, Americanization occurs only with significant “paradigmatic” change of an NHS type system moving from “public” to “private” in all three dimensions of provision, finance, and regulation (cf. Bohm et al., 2013, p. 262). Relatively small changes may lead to internal/within type changes, and even “system” changes may result in changes to types other than the private type. If the dimensions are largely independent, it is conceptually possible to move towards the US in one dimension but away from it in another.

Even if the direction of travel is clear, the slow change—“elephants on the move”—is likely to take many years to become a private system.

These problems highlight the importance of clarity when discussing the Americanization of the NHS. First, are commentators referring to the NHS moving towards the US model as it actually, and very messily, exists, or to an ideal type of a private health care system, one without a real world exemplar? When describing US health care arrangements, the economist Paul Krugman (2011) reflected, “American health care is remarkably diverse. In terms of how care is paid for and delivered, many of us effectively live in Canada, some live in Switzerland, some live in Britain, and some live in the unregulated market of conservative dreams.” Second, are the three dimensions (funding, provision, and regulation) to be treated equally, or is one to be prioritized? Third, are Americanization and convergence to be regarded as one or distinct phenomena? The former suggests a simple shift of the NHS towards the US model, the latter that both systems are moving (or in fact that all system types of moving toward each other).

Conclusion

We have seen that there have been many claims regarding the Americanization of British health care over a period of over 30 years. However, these relate to very different, and largely implicit, definitions of the term.

We have analysed these claims through the lens of the health care typologies literature. Drawing on this literature and on Hall’s (1993) work on levels of policy change, we claim that it is difficult to detect Americanization in the very demanding sense of a change of health care system type. A move from one polar type (NHS) to the private system of the US involves significant paradigmatic changes in all three dimensions of provision, finance, and regulation. Changes may be within type, and a system change on one dimension

may suggest, for example, more Canadianization than Americanization. In short, while it is difficult to come to any clear verdict on Americanization as the field appears to lack much consensus on definitions, types of change, criteria of change, or significance of change, there is little evidence that the term can be substantively applied according to any meaningful set of criteria.

Klein (1997, p. 1270-1) wrote that the experience of other countries serves to provide ammunition for domestic conflicts, with battles to impose a particular view of the world in a universe of multiple versions of the truth. He stated that the experience of the US is often invoked in political debate to elicit a knee-jerk repudiation of anything that looks remotely like a market, while conversely, in the US, the experience of Britain's NHS is invoked to provoke horror at the very idea of "socialized medicine" (c.f. Ehlke, 2011; Waddan, 2011). Changes have clearly been made to the NHS over the last three decades, particularly on the provider side with the private sector providers now to some extent competing with the traditional NHS providers. Furthermore there have been an array of organizational shifts at the top of the NHS with different bodies taking responsibility for auditing hospitals, directing commissioning and maintaining quality standards. While these changes are important, understanding them is not helped by trying to force a particular interpretation of simple binary change or change of health care system type on them. Concepts for studying healthcare systems have been poorly equipped to analyze healthcare system change. Much like welfare state typologies, earlier healthcare system typologies suggested what could be interpreted as 'frozen types'. This explains why a system change perspective is important (Rothgang et al, 2010; Wendt 2014). In the end, only rigorous comparative research informed by existing health care typologies and a clear understanding of what paradigmatic (or system) change entails is likely to provide more systematic evidence about the potential

Americanization of the NHS and, more importantly, the nature, scope, and overall meaning of the ongoing policy changes taking place within it.

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