The State, the Market and Social Services

Julian Le Grand

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Biographical Note

Professor Julian Le Grand is Richard Titmuss Professor of Social Policy at the London School of Economics, having previously held academic posts at universities in the UK, USA and Australia. He is the author of twelve books and over ninety articles in academic journals, in the fields of welfare reform and health policy. He has served as non-executive director of two health authorities and is currently a Commissioner on the Commission for Health Improvement. He has advised the World Health Organisation, the European Commission, Downing Street and Whitehall on welfare reform, social exclusion and health policy.

From Pawn to Queen:
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In most countries, the state has historically played a major role in both the finance and the delivery of social services such as education and health care. Often this role has taken the form of a state bureaucracy of some kind actually providing the service, while simultaneously using state revenues to subsidise it such that it is free (or offered at highly subsidised prices) at the point of use. Thus in many countries governments - central, state or local - run schools and colleges, usually providing school education free and college education either free or at a fee well

below cost. Governments of countries with national health systems own and operate the principal medical facilities, and supply the health care offered by those facilities free or with low co-payments. Many governments also both finance and provide other social services, such as long-term care for elderly people, care for those with a physical or mental disability, and public housing for the less well off.

During the 1980s and '90s, social services of these kinds saw something of a revolution. In several countries where a combination of state provision and state finance had been the norm, the state, while retaining control of finance, began to pull back from provision. Instead of providing the service through monolithic state bureaucracies, provision became competitive with independent providers competing for custom in market or

'quasi'-market settings. These reforms were always controversial and in some countries there have been attempts to reverse them - although often more at the level of rhetoric than in reality. Together with colleagues, I have discussed the overall merits or otherwise of these changes extensively elsewhere[1] and I do not wish to go over old ground here. However there are two central issues concerning them that I would like to address in this lecture. They concern the assumptions that policy-makers make in devising policy structures - especially those concerned with markets or 'quasi'-markets in social services - concerning *human motivation* and *individual agency*. I shall look at each in turn, discussing some global shifts in policy-makers' beliefs concerning them and the implications of those shifts for the use of markets or 'quasi'- markets in social service delivery. I then examine some of the evidence concerning the use of,

particularly, 'quasi'-markets in the delivery of health care and explore the implications of that for the belief shifts discussed in the earlier section. Since I refer frequently to the 'quasi'-market introduced by the then Conservative Government for the British National Health Service in 1991, an appendix provides some details of its workings and also of the Labour Government's subsequent modifications to it.

Motivation and Policy

Views about the mainsprings of human motivation divide the great political philosophies of our time. They go some way towards explaining why those philosophies end in different places so far as their recommendations for social and economic policy are concerned. Divergences in beliefs about motivation are not the only factor in explaining policy differences, of course; differences in values or in the ends to be

achieved are also important. Social democrats, for instance, are likely to give a greater weight to promoting social justice, and therefore to egalitarian policies, than neo-liberals, while the latter will prefer to emphasise policies that further individual liberty. However, even when the end to be achieved is the same, different beliefs about motivation will lead to different views on the desirability of alternative forms of economic and social organisation for achieving it.

So, for instance, it is likely that most philosophical belief systems would agree that other things being equal, improving the level of people's welfare on average is a desirable end. However, the view as to the best way to get there will depend in large part on beliefs about motivation. On the Right, neo-liberals believe that all human beings are fundamentally self-interested. Inevitably,

therefore, given this belief, they endorse the competitive market as the principal means for organising economic and social production; for, as we know from the works of Adam Smith, the market is the method by which self-interest can be harnessed to serve the common good. Economic agents operating in a competitive market will find it in their own self-interest to provide goods and services of high quality and at low prices; for, if they do not, they will lose business and therefore income and ultimately their livelihood. As Smith put it in the well-known passage from *The Wealth of Nations*:

> *'It is not from the benevolence of the butcher, the brewer or the baker that we expect our dinner but their regard to their own interest. We address ourselves not to their humanity but to their self-love, and never talk to them of our own necessities but of their advantages'.*

Later he goes on:

> *'He, generally, indeed, neither intends to*

promote the public interest, nor knows how much he is promoting it….he intends only his own gain, and he is in this…led by an invisible hand to promote an end which was not part of his intention. Nor is it always the worse for society that it was no part of it. By pursuing his own interest he frequently promotes that of society more effectively than when he really intends to promote it'.[2]

Not only does their belief about the fundamental self-centredness of human nature leads neo-liberals to endorse the competitive market, it fuels a parallel distrust of collective institutions, including those of government. For, if the pursuit of self-interest promotes the common good in a market context, it is highly destructive in a collective one. In an environment where production is organised collectively, selfish individuals will try to 'free-ride' on the activities of others. That is, they will sit back and wait until others do all the hard work of production and only then come forward to consume its fruits. If everyone

behaves this way - and, by assumption, everyone will, because they are all equally self-interested - then nothing will be produced; or, at best, things will only be produced that can be of direct benefit to the producer him/herself.

Many of those on the Left, from socialists to social democrats, have a greater faith in human public-spiritedness. They would argue that individuals have a greater capacity than is acknowledged by neo-liberals of acting in ways that further others' interests as well as, or indeed even instead of, their own. Hence collective - or more generally non-market - institutions can work. Indeed, in certain circumstances, they may work more effectively than market ones. Thus Richard Titmuss, in his celebrated study of blood donation, *The Gift Relationship,* argued that:

'The private market...narrows the choices for all men - whatever freedom it may bestow, for a time, on some men to live as they like. It is the responsibility of the state, acting sometimes through the processes we call 'social policy', to reduce or eliminate or control the forces of market coercions which place men in situations in which they have less freedom or little freedom to make moral choices, and to behave altruistically if they so will'.

Emphasising the role of motivation, he went on:

'If it is accepted that man has a sociological and biological need to help then to deny him opportunities to express this need is to deny him the freedom to enter into gift relationships'.[3]

Titmuss's mention of 'social policy' is significant since it is in the realm of social policy that we can see most clearly the impact of assumptions concerning motivations on the development of policy. To this I shall turn in due course.

I now want to discuss the other area of

concern for this lecture: that of individuals' capacity for autonomous action or agency.

Agency and Policy

It is not only with respect to beliefs about motivation that the great philosophies differ. There is also a divide concerning beliefs about agency: that is, about human beings' capacity for autonomous action. On much of the old left it was generally believed that individuals are largely or wholly the product of their environment; indeed even the individual as a concept is a social construct. Hence individual behaviour is best understood by focusing on the constraints under which individuals operate and, in consequence, policy should focus on these. So the poor, for instance, are viewed as victims of the system, at the mercy of structural forces over which they have no control.

That the Left tended to regard individuals as inactive victims is a point well made by Alan Deacon and Kirk Mann, who go on to point out its relevance to academic debates concerning social policy.

> *'It is important to stress that the question of agency was not merely neglected in academic studies of social policy, but was consciously dismissed. For much of the post-war period it was not considered to be a proper subject for concern and enquiry'.*[4]

An attitude whose predominance they ascribe to, again, Richard Titmuss. Reacting in part to the judgmental individualism that characterised much 19th century policy towards the poor, Titmuss and his followers did not believe that the autonomous behaviour of individuals was relevant to social policy. As Deacon and Mann put it:

> *'Above all [Titmuss] was resolutely opposed to anything that might appear to reopen the debate about personal responsibility for social pathology.*

Arguments about problem families or cycles of deprivation were an irrelevance or worse. Anyone who either could not or would not understand that was simply beyond the pale'. [5]

In contrast, social policy analysts further to the Right, such as Frank Field, Lawrence Mead and Charles Murray view individuals not as victims of unavoidable circumstance but as autonomous beings who do have a measure of control over, and responsibility for, their own lives. Such thinkers strongly reject the determinism of the Left. Thus Deacon and Mann quote Mead castigating what he terms 'sociologism' which 'construes the personality as essentially passive', and where

'The poor are seen as inert, not active. They are spoken of in the passive voice. They are people who are *or* have been *disadvantaged in multiple ways. They do not* do *things but rather have things* done *to them. They are the objects, not the subjects of action. They are not to blame for conditions such as dropping out of school, AIDS, or drug addiction but rather*

'at risk' for them. They 'experience' behaviours such as crime or illegitimacy rather than commit them'.[6]

This belief in the autonomy of the individual appears to be both empirical - individuals, even poor ones, in reality *do* have choices - and normative - individuals *should* have choices and should be held responsible for the choices they make. So policy-makers should not treat the people their policies are trying to help as passive, partly because that would be empirically incorrect (welfare recipients are not passive, but active agents who respond to incentive structures) and may lead to the policies concerned having perverse consequences (as with Charles Murray's contention in *Losing Ground* that the welfare state, through its failure to pay attention to incentives, has actually made the plight of the poor worse[7]), and also because it is the morally incorrect thing to do.

Markets in Social Services

What has all this to do with markets in social services? Simply this: that the introduction of market or 'quasi'-market mechanisms into the delivery of social services reflected a dramatic shift in policy-makers' perceptions about both motivation and agency.

First, the shift in perceptions concerning motivation. Elsewhere, I have argued that the welfare state that the British built following World War II (one on which many countries modelled their own welfare state) was constructed on two key assumptions[8]. The first was that the individuals who worked within the welfare state - those involved in the delivery of its services including civil servants, professionals, public sector managers - were motivated, not by self-interest or self-concern, but by a public-spirited interest in the welfare of the people they were supposed to be

helping. Thus doctors were assumed to have as the welfare of their patients as their principal concern; teachers, the welfare of their pupils; social workers, their clients; public housing managers, the tenants of the housing estates they managed. Civil servants were supposed to be exactly what their name implies: servants of the civil society, concerned with the promotion of the public good over any interests that they themselves might have.

The second assumption concerned the people for whom these services were to be provided. These were supposed to be essentially passive: accepting whatever service that was offered without protest, their only reaction being a respectful humility coupled with gratitude for the privilege for being cared for. Thus National Health Service patients were supposed to live up to their appellation and be

patient: to put up with long waits for service, to have no choice of provider, to deal with patronising doctors when they finally saw one, and to be offered horrible food amid a depressing environment if they had the misfortune to be admitted to hospital. Neither children nor their parents had much choice over where to go to school; they also had very little say over what went on when they got there. Tenants of public housing had little control over their dwellings or its environment: even the front doors had to be a painted a uniform colour.

With the advent of Mrs Thatcher's Conservative Government in 1979, as with much else in Britain, there was a significant change in attitude. This Government viewed the public sector in general, and public sector professionals in particular, with great suspicion. It considered professionals and

other workers in the public sector to be much more in the business of pursuing their own interests than pursuing the public interest. Moreover, because of the state monopoly in provision of social services, they were able to exploit their monopoly position; for if users were dissatisfied with the service they received they had nowhere else to go. Hence they could be treated as passive recipients with relative immunity. This situation, in the view of the new Government, was fundamentally undesirable: the consumer should be king.

So there were two changes in belief here. One was essentially empirical: a change in belief about the way the world worked - in particular about what actually motivated individuals, especially those who worked within the public sector. The other involved more a shift in values: users of services ought

not to be treated as passive, but should have the lead role in determining the quantity and quality of the services they received.

These changes had a direct consequence for the Government's view about the way in which social services ought to be delivered. For, if it is believed that workers are primarily self-interested and that consumers ought to be king, then there is only one appropriate mechanism of service delivery: the market. For, as the earlier quotes from Adam Smith made clear, the market is the way in which the pursuit of self-interest by providers can be corralled to serve the interests of consumers. So the Thatcher Government's instinct was to try to deal with what it perceived to be the major problems in the welfare state by injecting market mechanisms in one form or another.

Although that Government flirted briefly with the alternative of full privatisation of social services, it rapidly realised that there were both political and economic reasons why that would not be possible in the British context. These included the adverse consequences for equity of full private markets: no British government could allow the distribution of health care or other social services to be left to be determined by the distribution of income. But the Government also became aware of economists' arguments concerning market failure in these areas, especially those that derived from poor information on the part of users and the opportunities that this gave self-interested providers to exploit their knowledge monopoly.

Hence the chosen mechanism was the 'quasi'-market. In such a market the state retains control of financing the service. This divorces

the distribution of the service from the distribution of income and thus contributes to a more equitable distribution of the former. However, instead of also providing the service concerned, the state allows provision to be undertaken by independent providers competing with one another for custom. The state gives potential users a voucher to purchase the service concerned or, to overcome the problem of poor information, it appoints and funds an informed purchasing agent of some kind to purchase the service on behalf of the user.

Although they all had this basic structure, the 'quasi'-markets actually put in place by the Government took slightly different forms in different sectors. So the National Health Service had two kinds of state-funded purchasers: health authorities, who purchased on behalf of districts, and General Practitioner

fundholders or primary care practitioners who purchased secondary care on behalf of the patients on their lists. Providers were semi-independent, non-profit units who provided hospital and other services[9]. In education, what was effectively a voucher scheme was set up. Parents were given free choice of school; schools were given budgetary independence, and encouraged to compete for pupils through a funding formula that was based on the number of pupils they managed to attract. In social care, social workers were appointed as 'case-managers' and given a budget to purchase care on behalf of their clients from private, non-profit or public providers. In housing, public housing tenants were given the option of changing their land-lord to a nonprofit housing association; they and private tenants were also eligible for a means-tested benefit to pay their rent - again effectively a voucher.

I have ascribed these changes to Britain's Mrs Thatcher. She and her Government were indeed active agents in the process, but the shifts in attitude they represented were part of a much wider, more global movement. Fuelled by a disenchantment with large state bureaucracies and with their perceived inefficiency and unresponsiveness, and increasingly influenced by the public choice school of economists and political scientists, many countries have been experimenting with market or 'quasi'-market mechanisms for delivering social services. Sweden introduced a 'quasi'-market in health care in the Stockholm region; and the Netherlands planned (although in the end did not implement) a competitive scheme for public health insurers. Belgium has had a 'quasi'-market in education for many years. Cleveland and Milwaukee and the state of Florida in the United States have introduced

fully fledged voucher schemes in education. Many states in the US are introducing so-called 'charter' schools - independent schools that receive a 'charter' from a state agency and, like the British system, are funded on a per-pupil basis and so have to compete for pupils for economic survival.

But perhaps the country that took the ideas furthest was New Zealand. Health services were split into purchaser and provider in a similar fashion to the British and competition between providers encouraged. Operating responsibility for schools was transferred from the Department of Education to each school's board of trustees, and full parental choice of schools was introduced, setting up a 'quasi'-market for the state system.

So the shifts in governmental beliefs and attitudes that I have been describing are not

peculiar to Britain, but are, I think, world-wide. Moreover, despite changes of government, they endure. If I may return to the British case for a moment, the Labour Government of Tony Blair that replaced the Conservative administration in 1997 has espoused many of the same values as its predecessor, especially with respect to the importance of having a responsive system for users, and, with one partial exception, has done little to reverse the 'quasi'-market changes that the Conservatives introduced. The exception concerns the National Health Service, where the 'quasi'-market has been allegedly abolished. However, in fact, key elements of the market remain, including the purchaser-provider split, the possibility that purchasers can shift their purchasing between competing providers, and secondary care purchasing being undertaken by primary care organisations[10].

So we have seen something of a global shift in policy-makers' beliefs and values. This has moved towards two positions: first, that those who deliver social services are more self-interested than public spirited, and second, that users of services ought to be treated as kings. Both of these judgements lead in turn to a third view: that the appropriate way to deliver social services is via market or 'quasi'-market-type mechanisms. But were these shifts soundly based? Have the 'quasi'-market experiments succeeded in meeting the aims of their supporters? To this I now turn.

'Quasi'-markets: did they work?

Many of the 'quasi'-markets mentioned above have been subject to some kind of evaluation and I cannot hope to review all the relevant literature here. Inevitably therefore I will be selective and - equally inevitably - I will select the evidence that supports the points I would

like to make. In this section that evidence is probably best provided by some of the evidence concerning the operation of the 'quasi'-market in the British National Health Service.

The first point to make about the evidence concerning the working of the National Health Service 'quasi'-market is that there is not very much of it and what there is, with one or two exceptions, is not very helpful. This is for two reasons. First, the Conservative Government set its face against sponsoring its own evaluative studies, suspecting (with some justification) that those who called for experimentation and evaluation when the internal market was proposed intended to brake and perhaps even to derail the reforms. Moreover, there were few independent foundations or research institutions with resources big enough to undertake the kind of large-scale evaluation that a macro-reform of

this kind needed. Second, the process of undertaking evaluation of whole system changes of this kind was fraught with methodological difficulties: confounding factors, time lags, measurement problems and so on.

However, a systematic review of such evidence as there was came to a striking conclusion: that the 'quasi'-market had had relatively little impact[11]. There was a small improvement in overall efficiency, at least when activity rates were compared with resource inputs. There were some prescribing savings mostly attributable to General Practitioner fundholders. There was no increase in the choices open to patients, but some improvement in the information they were given. There were some, largely unmeasurable, changes in culture - improved cost-awareness, and a shift of emphasis and

power towards primary care - but of measurable change, other than that mentioned above, very little.

So what went wrong? The review put forward two possible explanations. The first concerned the incentives in the market and the relationship of those incentives to the constraints the principal actors faced. The incentives were in most cases fairly weak. For instance, providers could not retain and invest their surpluses, so they had little positive incentive to generate a surplus. Nor was there much by the way of negative incentives: providers that found themselves in deficit did not face much penalty but, more often than not were simply bailed out by the government. The constraints on the other hand were very strong. Central government kept a tight hold of the reins through its budgetary mechanisms, through direct instructions and through controlling providers' pricing and

investment decisions. In these circumstances it is perhaps not very surprising that there was not much change attributable to the workings of the 'quasi'-market.

But the review also put forward another possible explanation for the lack of impact. This concerned the principal motivations of the actors concerned. As we have seen, for markets to work effectively, individuals need to be primarily motivated by the furtherance of their own interests, narrowly defined. They should seize all profit-generating opportunities regardless of the impact on the service provided or the people using that service; they should act ruthlessly to cut down competitors (actual or potential); and they should only co-operate when it is in their direct self-interest to do so.

However, in practice, those working in the National Health Service, whether doctors, nurses, managers or ancillary staff, often did not see themselves in this light. Rather they felt that they were engaged in the provision of a public service, with provider relationships (both with each other and with their patients) based on more on considerations of mutual trust than on adversarial competition. So, even if proper market incentives had been available, they might not have responded appropriately; for instance, hospital doctors might have preferred to carry on treating patients even if a consequence was that their hospital trust moved into financial deficit.

Conclusion

So where does this review of the evidence concerning the National Health Service internal market leave the 'quasi'-market idea? More generally, where does it leave the shift in

policy-makers' perceptions concerning motivation and agency to which the earlier part of this lecture drew attention? Clearly this shift and this particular 'quasi'-market policy development to which it led has not resulted in the major changes that were expected. However, I do not think this completely discredits the ideas concerned. It is important to remember the systems that the 'quasi'-markets were replacing were far from perfect as well. The search is for the least-worst system for delivering social services. My own feeling is that the potential for 'quasi'-markets in social services to be that least-worst system - to perform better than other systems - is still there. But the right incentive structure would have to be found. The current Labour Government has introduced changes in the internal market (see Appendix) that do change the incentive structure in certain respects: encouraging more co-operative behaviour

while preserving the right of purchasers to switch providers as a last resort. Whether this will turn out to be a more effective motivational structure, only time will tell.

APPENDIX: 'Quasi'-Markets in the British National Health Service

The 1991 reforms instigated by the Conservative Government of Mrs Thatcher introduced a 'quasi'-market in secondary health services. There, in contrast to the old single bureaucracy system, the purchasers were separated from the providers of health services. As under the old system, the purchasers were funded by the government from general taxation; but the providers became 'quasi'-independent entities, managing their own budgets and financing those budgets from contracts with purchasers. There was therefore the potential for competition between providers, with hospitals and other secondary care suppliers competing with one another for contracts.

There were two kinds of purchaser. One was a district-based Health Authority, allocated a budget to purchase secondary care based on the size and characteristics of the district's population. The other was the General Practitioner fund-holder: a primary practice with a patient list over a certain size that was given a budget from which to purchase a more limited range of secondary treatments on behalf of their patients (usually elective

surgery). General Practitioners could volunteer to become fundholders; those that did so received a budget based on their past referral activity for the treatment concerned. So, for instance, if the fundholder was to purchase elective surgery, the budget was determined by the estimated cost of all the elective referrals made by the practice in the year before it started fundholding. The budget was deducted from the budget received by the Health Authority in which the fundholder was situated. The treatments concerned comprised about 30% of total referrals to secondary care.

As the scheme evolved different levels of fundholding were permitted. At one end, small practices were allowed to purchase only community services; at the other extreme, some experimental 'total purchasing' pilots were introduced where a practice - or, more commonly, groups of practices - were allowed to purchase all forms of secondary care, including accident and emergency treatment. Fundholders (but not health authorities) were allowed to keep any surplus they made on their budget provided that it was spent on services or facilities of benefit to patients.

On the provider side, hospitals and the providers of other services became independent 'trusts', though still nominally within the National Health Service. These

providers contracted with health authorities and General Practitioner fundholders to provide services and had certain freedoms of action concerning pay, skill-mix and service delivery. However, they had to conform to central guidelines concerning pricing and investment; and they could not retain any surpluses they might generate.

In 1997 the newly elected Labour Government introduced a further set of changes in England. The purchaser/provider split remains, but with an emphasis on co-operative relationships, not competitive ones. However, as a last resort, purchasers can switch their purchasing away from their current providers.

Purchasers are becoming Primary Care Groups (PCGs) or, increasingly Primary Care Trusts (PCTs), led by General Practitioners. All General Practitioners are required to join PCG/Ts. PCG/Ts vary in the size of the population they serve from around 30,000 to 250,000. They can retain surpluses from their budgets, surpluses that can be spent on services or facilities of benefit to patients. Provider trusts remain; however they now can retain surpluses.

PCGs/Ts and providers are supposed to engage in planning and other forms of co-operative behaviour.

Fundholders have been absorbed into PCG/Ts. Health authorities have lost their purchasing role, except for certain highly specialised services, but have become the instrument for PCG/T accountability. A performance 'framework', with performance indicators emphasising effectiveness and outcomes, is being put in place by the central government. Two national regulatory bodies have been set up: one - National Institute for Clinical Effectiveness or NICE - to set standards; the other - Council for Health Improvement or CHI - to enforce them.

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[1] See, for instance, Le Grand and Bartlett (1993), Bartlett *et al* (1994), Glennerster *et al* (1994), Glennerster and Le Grand (1995), Bartlett, Roberts and Le Grand (1998), Le Grand, Mays and Mulligan (1998).

[2] Smith (1776), Book 1, Ch.II, Book IV

[3] Titmuss (1971/1997) pp.310-311.

[4] Deacon and Mann (1999) p. 417.

[5] *Ibid*, p. 418.

[6] Mead (1992) pp.129-30.

[7] Murray (1984)

[8] Le Grand (1987)

[9] More details can be found in the Appendix.

[10] See Appendix.

[11] Le Grand, Mays and Mulligan (1998).

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