

This paper analyses the growth of regulation in the National Health Service (NHS) between 1985 and 2004. It argues that the development of the NHS over this period conforms to the pattern, asserted more generally in existing scholarship, of a rise of the regulatory state in Western European countries. One conventional explanation for the pattern of development—the increasing importance placed on establishing credible policy commitments—is shown to be compatible with observed patterns of development in the NHS. This is labelled the 'regulatory state hypothesis'. Building on the earlier work of Rudolf Klein, which argued that the organisation of the NHS was underpinned by an implicit concordat between politicians and the medical profession, it is argued here that regulatory state type institutions both potentially undermine this concordat, but that careful attention to the legal and administrative framework for regulation can, to some extent at least, reconcile the need for credible commitment to the concordat and the demand for greater governmental regulation of both cost and quality of health services. Adapting an analytical framework developed by Brian Levy and Pablo Spiller, this paper argues that regulatory reforms in the NHS are unlikely to achieve their publicly pronounced objectives if the legal and administrative framework for regulation does not demonstrate credible commitment to the implicit concordat. This is labelled the 'regulatory commitment hypothesis'. In order to assess the plausibility of this hypothesis, two episodes of regulatory reform are examined which, on the basis of the modified Levy and Spiller framework, can be said to engender different degrees of commitment. These episodes are: (1) the Limited List of NHS Drugs; (2) The National Institute for Clinical Excellence. Evidence from these two case studies suggests outcomes consistent with the expectations of regulatory commitment hypothesis.