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Purchasing in Markets and Networks: The Relationship Between General Practitioners and National Health Service Trusts

by

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A THESIS SUBMITTED FOR THE DEGREE OF
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Abstract

This thesis examines the role of General Practitioners (GPs) as purchasers within the National Health Service (NHS).

The GP purchasing role is considered in the light of two market policy objectives which are explored within the broader context of the nature of the purchaser-provider relationship in terms of both its content and process. The two policy objectives, outlined in the Government's White Paper "Working for Patients" (Department of Health 1989), are that GPs would stimulate: (1) improved efficiencies in secondary care services; and (2) a transfer of resources from secondary to primary care.

The study adopts a qualitative approach, gaining insight into purchasing relationships by way of interviews and non-participant observation, and by interpreting the data both inductively and deductively. Economic and social theories, in particular transactions cost theory and network theory, are used as a framework for the fieldwork and to inform the analysis and discussion.

This thesis argues that GPs have fulfilled the two original market policy objectives of stimulating secondary care efficiencies and resource transfer from secondary to primary care. The means by which they have achieved this, however, is not via neoclassical contracts negotiated in a competitive market context, as market proponents envisaged, but through economically efficient, relational contracts within ideologically/culturally and socially embedded networks, for which the market policy has been a catalyst. These networks have developed at an inter-GP practice and at a purchaser provider level, and are characterised by knowledge creation, innovation, learning, service (re)design, partnering and the pursuit of economic and social goals, in particular the enhancement of professional autonomy.

The study affirms the need for a socio-economic perspective in organisational studies, and suggests directions for theory development and future research which can follow from this study and which will further understanding and analysis of network relations and of the NHS context in particular.

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Acknowledgements

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Introduction

In 1990, Great Britain's National Health Service (NHS) was the subject of fundamental market reform. The creation of a market for health services, as articulated in the white paper "Working for Patients" (Department of Health 1989), represented one of the most important developments in social policy in recent years (Wistow and Hardy 1996) and served as one of the most fundamental changes ever to the 'business' of general practice (Bevan and Marinker 1989; NHS Management Executive 1992; Duggan 1995).

Two central objectives of the reform were to improve the efficiency of secondary health care services (ie, improved efficiency of resource utilisation), and to encourage the transfer of resources from secondary care into primary care. These objectives were to be achieved through competitive pressures brought to bear by the discretionary purchasing activities of health service purchasers who were expected to seek out providers offering the cheapest services.

Two types of purchasing agent were created to enact this purchasing role: large district purchasers and small general practice purchasers. General Practitioner (GP) purchasing, the focus of this study, was exercised, in the first instance, through a voluntary budget-holding scheme (GP fundholding) (Department of Health 1989). Practices who entered the scheme received budgetary control over staff costs, prescribing costs and certain secondary care services. They were then expected to engage in annual contracts with secondary care providers and to "negotiate the best deals they can" (Department of Health 1989:51) for their patients.

In 1994, the GP purchasing role was augmented in two ways (NHS Executive 1994): (1) the GP fundholding scheme was extended in order to embrace smaller practices and to offer fundholding schemes which differed in terms of the scope of their budgetary control (community/primary care fundholding and total fundholding); and (2) non-

fundholders were embraced in the purchasing process by being given a role in contributing to Health Authority (HA) (or in Scotland, Health Board (HB)) commissioning[1].

The creation of this NHS market, and in particular the purchasing role, not only presented health service practitioners with a weighty and ongoing agenda for change, but posed interesting macro and micro level challenges to the discipline of health services research (Ham 1994a; Ham and Maynard 1994; Coulter 1995; Laing et al. 1996) and also to other disciplines such as social policy (Le Grand and Bartlett 1993; Bartlett et al. 1994), economics (Donaldson 1993; Propper 1993; Matsaganis and Glennerster 1994; Maynard 1996), management (strategy and marketing) (Ferlie 1992; Prowle 1992; Freemantle, Watt, and Mason 1993; Ashburner, Ferlie, and FitzGerald 1996; Laing and Cotton 1996) and accounting and finance (Ellwood 1995, 1996; Lapsley, Llewellyn, and Grant 1997). At a macro level, debates ensued concerning issues such as the structure of the market (Bartlett 1991; Ham and Maynard 1994; Hunter 1995), the extent to which purchasers would have sufficient degrees of power to negotiate with providers (Le Grand and Bartlett 1993; Ham 1994a; Ham and Maynard 1994), the availability of purchasing information (Propper 1993; Deakin and Walsh 1996) and the transactions costs of a market-based contracting system (Ham 1994b; Deakin and Walsh 1996). At a micro level, issues included the ethics of the fundholding scheme (Glennerster et al. 1994), whether GPs had appropriate purchasing skills (Bowie and Harris 1994; May and Robinson 1995), and whether patients of fundholders would be given preferential treatment (Bartlett et al. 1994; Glennerster et al. 1994).

Attempts to research, evaluate and reflect on these issues have needed, however, to contend with several difficulties. The government, for example, was opposed to conducting any formal evaluations of fundholding (Robinson 1994). Simultaneous policy changes (Le Grand 1994) and ongoing injections of resources into the NHS (Petchey 1993) then made it impossible to isolate market factors from other influences.

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[1] Commissioning and purchasing are terms which have differing definitions and are explained in Chapter 2 (sec 2.6).

Nevertheless, despite these problems, a body of evidence began to grow. The evidence as it relates to GP purchasing suggested, however, that GPs had not changed their referral patterns and were not concerned with stimulating hospital efficiencies but had managed to initiate some transfers of resource from secondary to primary care and were active in improving service quality. Furthermore, GPs were proving to be non-price sensitive, reluctant to exercise buyer power and to switch provider, and were actively loyal to traditional, usually local, providers with whom they collaborated.

Whilst the research evidence revealed consistent findings, it also raised a number of questions about the underlying rationale for GP purchasing behaviour and the nature of their purchasing role. It was not clear, for example, whether GPs were disinterested in improving hospital efficiency or whether they might be creating pressures for efficiencies through some means other than formal contracting. It was also unclear how GPs were improving service quality and the nature of their relationship with their providers, the rationale for provider loyalty and their opposition to switching were only partially understood.

In response to these questions and the original policy objectives, this research aimed *to explore the role GPs are performing as purchasers and to identify which of the purchasing-/market-related issues are of particular concern to them.* More specifically, it sought to consider whether GPs are seeking to stimulate efficiency in secondary care, to find out whether GPs are seeking to initiate the transfer of resources from secondary to primary care and to understand the relationship between GPs (as purchasers) and hospital Trusts (as providers).

The pursuit of this research aim using a qualitative methodology, enables this thesis to make a number of empirical, methodological and theoretical contributions. Personal, local and NHS system-level socio-economic goals which motivate GPs are identified which contribute to previous explanations of purchasing behaviour. Insights gained through non-participant observation go on to show the ways in which pursuit of these goals has an effect upon efficiency and quality improvements as well as resource transfer. Exploration of the purchasing relationship in terms of content and process further identifies important collaborative processes and network properties which

contribute to innovation, learning and knowledge creation within purchasing relationships and thus allows a more informed evaluation of the purchasing function.

This study also makes a contribution to organisation theory by integrating economic and social theory in order to understand GP purchasing relationships. In so doing, it identifies network characteristics which encourage collaboration and which render networks an efficient form of organisation, and identifies certain limitations in the use of transactions cost theory, suggesting ways in which the theory needs to be further developed.

Other contributions concern the methodology and directions for future research. The thesis demonstrates the importance of observation techniques in the study of individual/organisational interaction and dynamic processes, and suggests two perspectives which could be developed directly from this study and adopted in future studies of general practice organisation and GP networks.

This thesis begins by explaining the historical and theoretical development of the NHS market and the purchasing models which were adopted, and emphasises the ways in which the role of the GP as an agent for change has become a central tenet of health service policy (Chapter 1). Key issues arising from market implementation and its social context are then discussed: firstly as they are dealt with in the NHS context (Chapter 2) and secondly as they can be understood from the perspective of particular social and economic theories (Chapter 3). Attention then turns to consider the empirical evidence concerning GP purchasing and fundholding and the research questions which arise from reviewing the evidence (Chapter 4).

Following these background and theoretical discussions, consideration is then given to the qualitative methodology employed in this research (Chapter 5). The interview, observation and analysis processes which were adopted are explained and attention is given to the limitations of the research before progressing to discuss the study's findings. The findings are presented as they relate to three relationship dimensions: the GPs' views of their purchasing role (Chapter 6); the interaction between GPs and their providers (Chapter 7); and the relationship between GP practices (Chapter 8).

These discussions identify motives behind purchasing behaviour and characterise the content of, and processes within, inter-organisational purchasing relationships.

Key findings are then reintegrated with the economic and social theory introduced earlier (Chapter 9). These discussions identify important theoretical issues which arise from the study and suggest ways in which the theory can be developed. The study is then drawn to its conclusion by way of a summary of the findings as they relate to the research aim and to the research gaps identified earlier (Chapter 10). The concluding discussion is integrated with a presentation of the study's contribution in terms of policy, managerial, methodological and theoretical implications, after which the thesis closes with suggestions for future research directions.

Chapter 1

The Case for Market Reform - Policy & Economics

Introduction

In 1989 the government published *"Working for Patients"* (Department of Health 1989b), the policy which brought the NHS market into being and heralded the most radical reform to have been brought to bear upon the NHS in its entire history. The market was introduced in response to growing financial pressures on public spending. In order to stem the flow of funds into the NHS, a split was created between purchasing and providing functions. Purchasing became the responsibility of district health authorities/health boards and the newly created budget holding General Practitioners. These purchasing agents were to be the engine to drive the reforms. They were expected to stimulate competition between providers thus creating efficiencies, driving down costs and improving quality. They were also expected to stimulate a more efficient allocation of resources between primary and secondary care.

This introductory chapter explains the ***theory*** behind the market and in particular behind the purchasing models adopted, whilst emphasising the underlying importance of improving NHS efficiency. It does so by presenting an ***historical*** perspective on the reforms which traces the formulation of the market notion and the origins and development of the purchasing models. The chapter places particular attention on the contribution of a non-government think tank, the Office of Health Economics, to the market ideas; a contribution not generally recognised in reviews of the reforms. Within this context, the chapter also discusses the central role of the ***GP as a purchaser*** in the market place and as an agent for change.

1.1 The Climate for Market Reform

The 1990s have been a time of radical change within the NHS during which a health care market was established and subsequently dismantled. The market was created in order to stimulate improved efficiencies in the allocation and utilisation of resources (Spurgeon 1993). The underlying philosophy represented a belief by the Conservative government that the NHS contained pockets of inefficiency and needed to be subjected to economic incentives and competitive forces in order to make efficiency gains and contain the level of public spending on health services (Spurgeon 1993; Maynard 1994).

1.1.1 The Resource 'Problem'

Since the creation of the service in 1948, demands for increased public funding have grown, contrary to the expectations of the service's founder, Aneurin Bevan. Bevan had believed that there was a fixed pool of ill health which would disappear if treatment was provided and that the cost of the NHS would thus reduce after initial backlogs of ill health had been eliminated (Teeling Smith 1984a; Vaizey 1984). On the contrary, however, demands for health services have increased. The UK has been faced with a growing elderly population, consumers have become increasingly educated about their rights to health care, and the costs of medical technology continue to increase (Teeling Smith 1984a; Enthoven 1985).

Two arguments have emerged in response to this increased demand and the Government's desire to contain costs. The first is that the NHS is under-resourced and cannot cope with demand without continued investment. The second is that it is inefficient in the way in which resources are allocated and utilised. Such claims were made as early as 1956 when, for example, the Guillebaud Committee (commissioned by Sir Winston Churchill) reported that the NHS was under-resourced because its founders had failed to take proper account of the impact on costs of demographic change and inflation (Klein 1989). However, there was little strategic response to the committee's observations. Instead, the government at the time placed its emphasis upon "keeping the machinery running, on care and maintenance rather than innovation and change" (Klein 1989: 44).

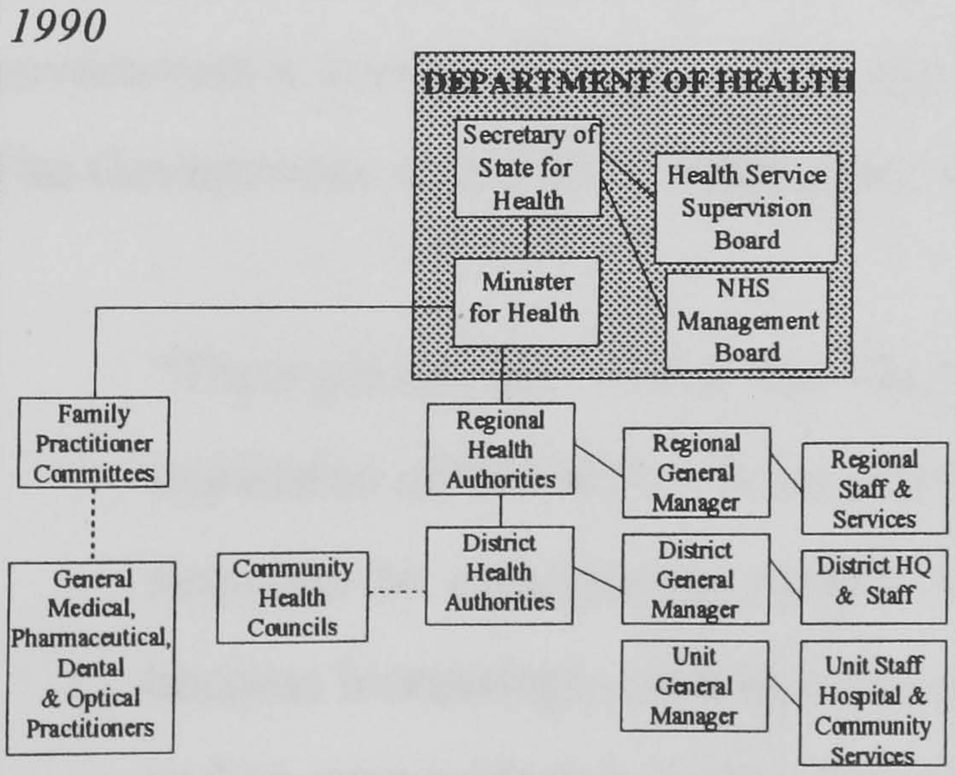
Despite a subsequent period of rapid growth in public expenditure during the 1960s and early 1970s, debates about allocative efficiency and resource utilisation increased. The period became marked by an "emphasis on efficiency and rationality in the use of resources... the development of an ideology of efficiency and the idea that policy should be directed towards squeezing the greatest possible output of health care ... out of an inevitably limited input of resources." (Klein 1989:64). The then health minister Enoch Powell (within the Macmillan government) also acknowledged that the NHS' capital stock had become run down due to a lack of modernisation since the war and there was no mechanism by which strategic priorities could be identified and

implemented. Enoch Powell's reflections and his proposed solution marked the beginning of administrative/structural reforms which in turn were the prelude to the managerial reforms of the 1980s (Klein 1989).

1.1.2 Administrative Reform

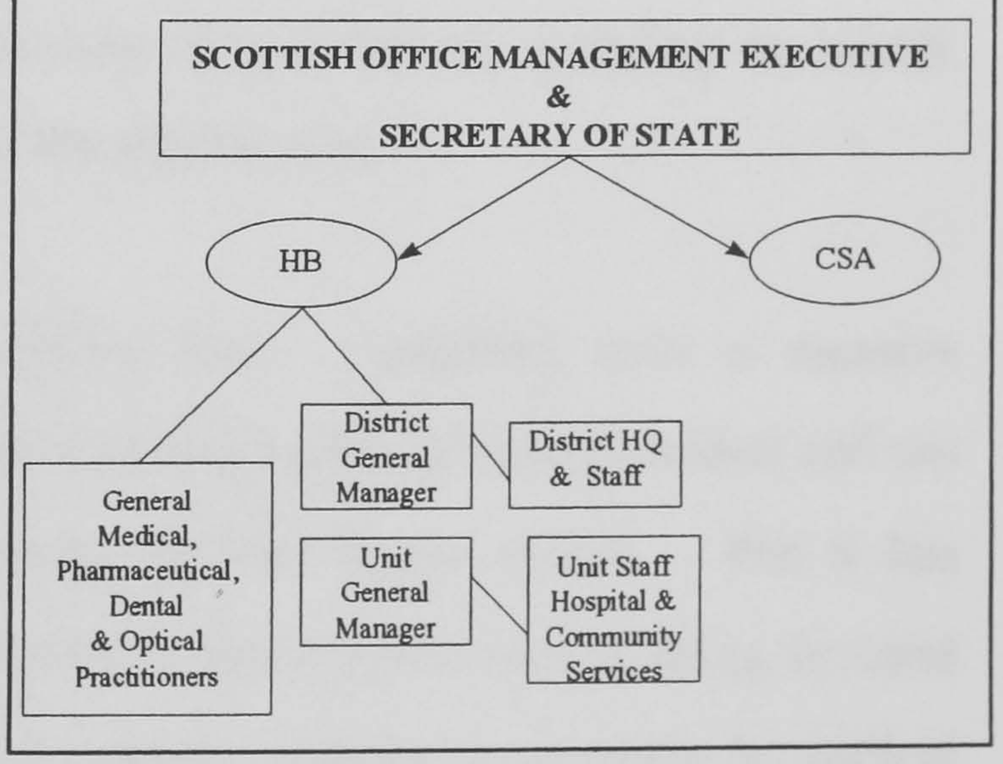
In 1974, an administrative arrangement was put in place whereby in England there were 14 Regional Health Authorities (RHAs) who were responsible for planning, finance and buildings. Below the RHA were smaller Area Health Authorities (AHAs). A separate agency, the Family Practitioner Committee (FPC) was set up to manage the 4 branches of primary care: general practice, dentistry, pharmacy and optometry. The arrangements in Scotland were slightly different. The regional functions (eg building division, ambulance and blood transfusion services) were performed by the Common Services Agency (CSA), District Health Authorities (DHAs) were known as Health Boards (HBs) and there was no separate FPC. Responsibility for primary care was contained within the HB remit. A new formula for allocating funding was then developed in 1976 and funding targets were set based on demographic data. This structure was altered in 1982 under the Thatcher government. AHAs were abolished and 190 DHAs were set up under the existing RHAs. A review system was also implemented and authority was delegated from the AHA level to individual hospital managers. In other words, a degree of decentralisation was introduced in order to enable the 1974 structure to function more effectively (see figures 1.1 and 1.2).

Figure 1.1: NHS Structure in England 1974/82-1990



Source: Harrison, Hunter, and Pollitt 1990

Figure 1.2: NHS Structure in Scotland 1974-1990



1.1.3 Managerial Reform

Subsequent changes during the remainder of the 1980s were, however, markedly different. Whilst earlier reforms had addressed administrative systems, a change of ethos in favour of general management occurred in 1984 (Pettigrew, Ferlie, and McKee 1994) such that by the end of 1985, general managers began to appear in the hospitals, challenging former management systems controlled by health professionals. This policy change was not only to affect structural change "but more ambitiously it was to change roles, 'ways of doing things', create a new cadre of 'leaders' who could energise decision making and even produce 'a new culture'." (ibid. pp31-32). At the same time, a Government level Supervisory Board and Management Board (known as the National Health Service Management Executive (NHSME)) was installed to enhance the co-ordination and central leadership of the NHS. Between 1985 and 1989, the use of performance indicators and management budgets for clinicians were implemented, and the management mode moved from (clinical) consensus management to (managerial) hierarchical control.

Despite the administrative reforms of the 1970s and the managerial reforms of the 1980s, demands for increased NHS resources continued. By the mid 1980s, it was clear that the NHS was still proving to be 'excessively' resource intensive.

1.2 Health Care Reform - The Politicians' Economic Dilemma

The creation of a market for health care was a direct and explicit response to the government's continued need to limit the amount of government spending on health. The Government stated in its white paper for the market that:

> "Throughout the 1980s the Government has ... presided over a massive expansion of the NHS. It has ensured that the quality of care provided and the response to emergencies remain among the best in the world. But it has become increasingly clear that more needs to be done because of rising demand and an ever-widening range of treatments made possible by advances in medical technology. It has also increasingly been recognised that simply injecting more

and more money is not, by itself, the answer." (Department of Health 1989b:2 para. 1.4)

Although the reforms stemmed from an NHS review instigated in 1987 by the then Prime Minister Mrs Thatcher, this chapter discusses two initiatives to examine NHS structures which occurred in parallel and which formed the basis of *"Working for Patients"*. One initiative was co-ordinated by the Office of Health Economics (OHE)[1]. who established a 'think tank' to begin developing ideas about NHS reforms. Around the same time, Professor Alain Enthoven an American sociologist[2], was invited by Gordon McLachlan, Secretary of the Nuffield Provincial Hospitals Trust, to review the management and organisation of the NHS.

1.2.1 The OHE 'Think Tank'

Prior to Mrs Thatcher's review, the OHE had recognised the need for NHS reform and so brought together representatives from the pharmaceutical industry, the Kings Fund[3], the Department of Social Security and a number of Universities, to discuss the economic problems facing the NHS and to consider possible solutions. Two particular meetings served as the forum for developing the market ideas. At the first meeting in 1984, the group took its direction and focus from Lord Vaizey (the Principal of St. Catherine's Foundation) who had said,

"...it is not too soon to be looking at how Britain's National Health Service should be developed to cater for the situation which can be expected in the 1990s ... An NHS conceived to deal with the medical and social problems which existed in the 1930s and the 1940s cannot be expected to cater for the problems of the 1990s." (quoted in (Teeling Smith 1984a:3)).

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[1] An autonomous organisation set up in 1962.

[2] Enthoven is professor of public and private management at the Graduate School of Business, Stanford University.

[3] The King's Fund is an independent charity which undertakes health policy research and analysis and which promotes good practice in health and social care. It is based in, and focuses its work on, London.

The group, chaired by George Teeling Smith (Director of the OHE), identified seven crucial problems with the 1946 NHS Act (see Box 1.1) which they felt they needed to address although they recognised their options were restricted. Private and insurance based systems of payment would undoubtedly be rejected so "... if neither private enterprise market-oriented health care nor insurance-based pre-paid systems could solve the problems of the NHS, it is clearly time to examine other avenues." (ibid. p.5)

Box 1.1: Problems with the 1946 NHS Act

- The NHS was planned to deal with acute disease like Tuberculosis and other infectious diseases which prevailed at the time.
- The NHS was to be primarily hospital based.
- It was a development of the earlier 'poor law' or 'panel' health insurance schemes.
- It was planned to be acceptable to a relatively non-affluent society.
- It was assumed the NHS health care priorities would be self selecting.
- It was based on relatively low technology medicine in the 1930s.
- It assumed professional dedication to the cause of caring for the sick. (Teeling Smith, 1984)

Whilst acknowledging some need for additional NHS funding, the group sought to consider "new economic principles in relation to its organisation" and "to stimulate economic experiments within Britain to test some of the new approaches which economists and others have recently suggested to try and tackle the urgent problems of the National Health Service" (Teeling Smith 1986c:3). Previous administrative reforms had, in Teeling Smith's view, failed to improve efficiency so three new approaches were proposed:-

1. greater efficiency
2. better allocation of resources
3. possibility of attracting alternative sources of funds for health care

To this end, group members brought various ideas to the meeting and in his account of the discussions, Teeling Smith drew attention to two in particular which the group had favoured. The first was that competition might be injected into the system:

"*Competition versus control*

A great deal of discussion centred on the role of competition in improving the quality and efficiency within the NHS. Although competitive sources of

> funding (ie multiple insurance funds) were agreed to be irrelevant, this was by no means the case in respect of a multiplicity of providers ... If some form of effective competition could be introduced between different parts of the Health Service it could introduce the best features of a market system ..." (p34)

The second idea was that the role of general practitioners be augmented particularly by way of budget holding:

> *"Developments in general practice*
>
> The most important and interesting part of the discussion dealt with the future role of the General Practitioner ... For the future, it was predicted that General Practice would become even more important ... However, there will need to be changes if General Practitioners are to exploit to the full their potential role in improving the quality of care in Britain. First, it was emphasised that the General Practitioners' contract must be made more meaningful. At present it was largely a description of how they should be paid; it devoted too little attention to what their objectives should be. In connection with their contract, there was some suggestion that General Practitioners should in future be salaried employees of the NHS ...
>
> *The General Practitioner as a 'budget holder'*
>
> Within the discussions on general practice another speculative and fascinating idea emerged. This was that the GP should in a very real sense become a 'Budget Holder' for the whole of the health service. That is, funds for health care should be channelled through the General Practitioner instead of being distributed downwards from the DHSS, through Regional and District Authorities ..." (Teeling Smith 1984b:34-36)

The importance of general practice was further reflected in the fact that the second of the OHE meetings (in October 1985) concentrated specifically on general practice. The groups' membership altered to suit the emphasis on general practice and included members of the Royal College of General Practitioners and the Department of Health and Social Security, practising GPs, university academics and journal editors. Their

discussions ranged from the role of primary health care teams, health promotion and GPs as micro-epidemiologists to the future of training in general practice and the nature of illness. Crucially though, it was at this meeting that Alan Maynard proposed the idea of budget holding GPs (Maynard 1986; Teeling Smith 1986a).

Maynard suggested that general practitioners should become the 'budget holders' for the NHS on the basis that:

> " ..when a general practitioner sent a patient to hospital, the practitioner would at the same time be allocating part of his budget to cover the cost of the hospital treatment ... the more efficient hospital departments would attract extra patients, and, at the same time, extra funds. Less efficient units would attract fewer patients and would decline and eventually be closed. There would still need to be some central overall control to ensure a fair geographical distribution of resources, but within a much looser central planning system market forces would again stimulate efficiency and improve the quality of care ..." (Teeling Smith 1984a:13-14)

Maynard also proposed that GPs be encouraged to compete with one another and that additional income be used to "'buy-in' hospital and other services as needed. Such services could be bought in from the private or the public sector whichever is cheapest." (Maynard 1986). Maynard also believed that there would be sufficient incentives to ensure that GPs would manage resources efficiently. For example, careless use of drugs, diagnostic tests or hospital care would impose direct opportunity costs on the GP by reducing the resources available for alternative uses.

1.2.2 Alain Enthoven's Reflections on the NHS

That some form of health care purchaser be created was also the conclusion reached by Alain Enthoven following his review of the NHS. Rather than GP budget holding, however, he recommended large district purchasers based on the American Health Maintenance Organisation (HMO) model (Enthoven 1985) . HMOs cater for a population of around 500,000 patients providing them with a comprehensive list of medical services on a per capita basis. HMOs prosper by keeping their patients

healthy and satisfied and if any patients are dissatisfied, they can move to an alternative HMO (Newman 1995). Enthoven proposed that the DHAs operate in the same way as HMOs, receiving a per capita allocation of resources. They would then be free to provide or to purchase the care for their population from other (public or private) organisations and more efficient districts could sell services to less efficient districts. He believed that the market would mean "... managers would be able to use resources more effectively; they could buy services from producers who offered good value and use the possibility of buying outside as bargaining leverage to get better performance from their own providers" (Hudson 1994). (Chapters 2 and 3 discuss fundholding and HA/HB purchasing in more detail.)

1.2.3 Improving NHS Efficiency - The Introduction of Market Forces

Both the OHE and Enthoven's recommendations included the introduction of market forces in order to improve NHS efficiency and to do so, as Glennerster later pointed out, within a spending limit (Glennerster 1995),

> "... The UK health reforms were not concerned with halting the rise in health costs. Cost control had already been achieved. Rather, the reforms were aimed at coping with the consequences of imposing limits to the growth in health spending."

Teeling-Smith was all too aware of the social context of the NHS and the likely opposition to market forces. He considered that market solutions were unpopular because they were seen on the one hand as a challenge to the independence of the medical profession and on the other as a threat to the integrity of the National Health Service (Teeling Smith 1986b) As the following excerpt demonstrates, after discussion, a specific type of market was regarded as the optimal solution:-

> "It has often been pointed out that there are in principle only two ways of allocating resources. One is through the market, where people buy what they want provided they can afford it. The other is through a bureaucracy, in which resources are allocated centrally, usually in the belief that in that way they will be more equitably distributed.

Unfortunately, it seems to be inevitable that any large bureaucracy should contain pockets of inefficiency. Things are done according to the rule book rather than according to common sense: outdated practices continue because no one has the entrepreneurial initiative to challenge them: and without local ways of measuring efficiency and performance personnel may sometimes be poorly motivated to do what is best for the organisation as a whole.

On the other hand, the market mechanism on its own is wholly inappropriate for the allocation of health care resources. Those most in need are usually those least able to pay for treatment or care. For this reason, almost all of the advanced countries in the world have comprehensive pre-payment schemes for the provision of health services. The British National Health Service is just one variant of the schemes which exist in other countries.

It has recently been suggested that the conflict between the unfairness of a market system for purchasing health care and the inefficiency of a bureaucratic system of central allocation can be resolved. The proposed solution has been referred to as an internal market within the National Health Service." (ibid. p12)

1.2.4 A Market for Health Care

It was not long before the proposed internal market solution was adopted. In 1989, the government published its proposals for the internal market (Department of Health 1989b) in which it created a purchaser-provider split, introduced purchasing agents and established independent hospital trusts.

Key features of the market were:-

- NHS hospitals could volunteer to become independent of the Health Authority, and to adopt Trust Status. In so doing, Trusts became directly accountable to the NHSME.

- DHAs and HBs were to focus on purchasing, from the public or private sector, the services needed for their patient population and ceased to have responsibility for managing those NHS hospitals which became Trusts[4].
- General Practitioners could volunteer to become budget-holders and purchase a limited range of secondary care services for their patients.

The reforms introduced both types of purchasing agent proposed by the OHE and by Enthoven: GP budget holders and large district purchasers. The adoption of the former was, however, something of a last minute decision since the fundholding model proposed by Maynard had been unpopular with the government (Glennerster et al. 1994).

Having created a split between providers and purchasers of health care, an annual contracting system was developed as the vehicle by which GP fundholders (GPFHs) and HAs would purchase care from NHS or private sector providers (see Figures 1.3 and 1.4). The contracting mechanism is discussed fully in Chapters 2 and 3.

Figure 1.3 The NHS Market Structure in England: 1990 - 1999

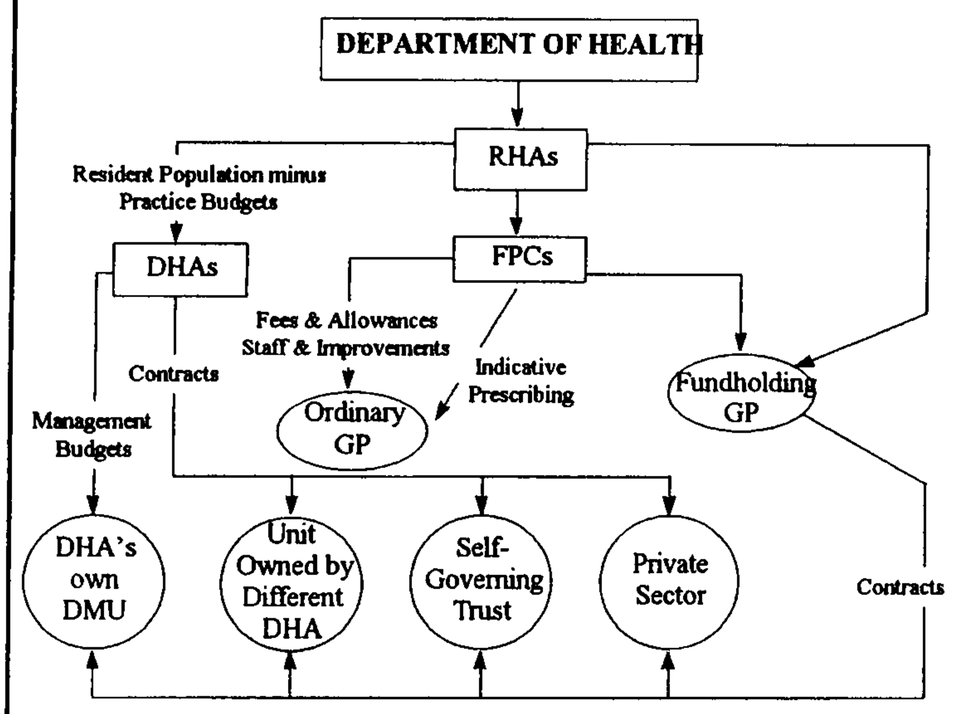
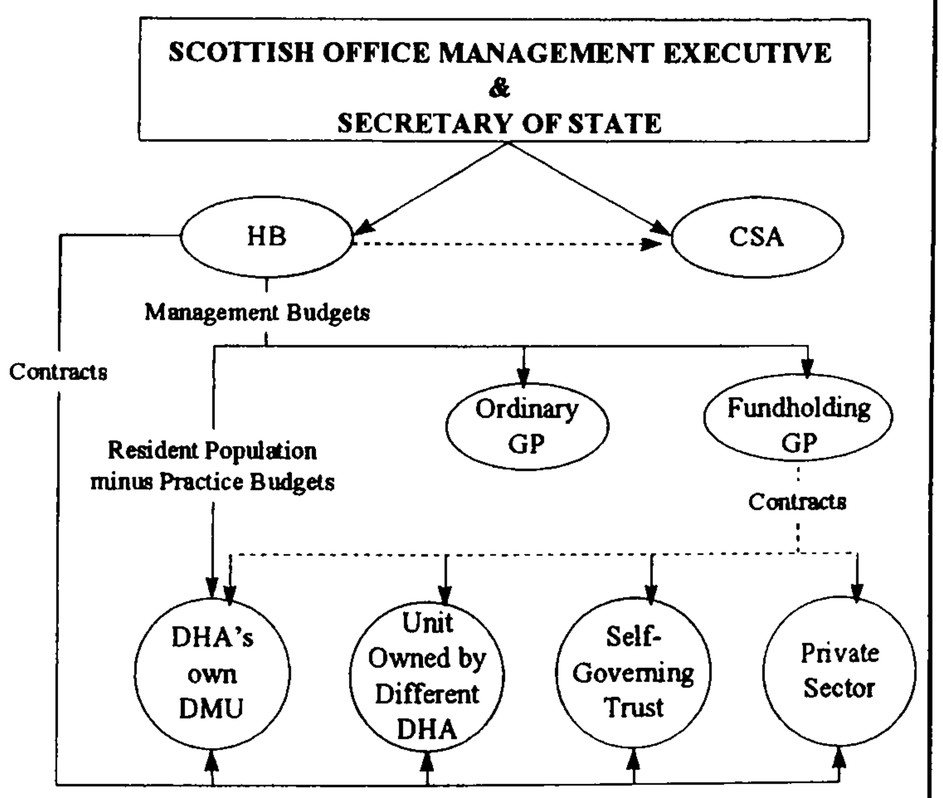


Figure 1.4 The NHS Market Structure in Scotland: 1990 - 1999



1.3 GP Fundholding

The introduction of fundholding heralded the beginning of a purchasing role for GPs which was to serve as one of the most fundamental changes ever to the 'business' of

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[4] Hospitals converted to Trust status over a period of time. In the meantime, non-Trust status providers were known as DMUs (Directly Managed Units).

general practice (Bevan and Marinker 1989; Duggan 1995; Meads 1996b). The scheme offered GPs the opportunity to have a greater say in the treatment of their patients and the costs and conditions of primary and secondary care services.

Practices who could demonstrate to their HA/HB that they were able to manage a budget and who had at least 11,000 patients[5], were invited to apply for fundholding status. The scheme offered practices decision making authority over a range of expenditures relating to staff costs, prescribing, investigative procedures, elective procedures and certain community services (see Box 1.2 for details). Having decided on their purchasing priorities, practices would then negotiate contracts with providers (see box 1.3 for contract types).

Box 1.2: The Scope of the Fundholding Budget

- "all practice team staff costs and practice accommodation costs…
- all expenses incurred during management of the fund and other costs associated with participation in the fundholding initiative
- all drugs prescribed and dispensed
- any diagnostic investigation of patients or specimens ordered or performed by the GP…
- initial and continuing out-patient services delivered by hospital-based staff
- costs relating to a defined group of surgical in-patient and day-case treatment - the list covers most elective procedures …Emergency admissions and medical admissions are excluded
- costs relating to direct access services - physiotherapy, speech therapy and occupational therapy, dietetics and chiropody
- health visiting and community nursing, elements of mental health and learning disabilities services."

(Pirie 1994)

Box 1.3: Fundholding Contract Types

1. "**Block contracts** will cover the provision of a defined block of services in return for an annual fee
2. **Cost and volume contracts** - providers will receive a defined sum for the provision of a baseline level of activity. Beyond that level, payment will be on a cost per case basis
3. **Limited volume contracts** - payment for a defined volume of cases
4. **Cost per case contracts** will be payments on the basis of a sum for each case treated."

(Pirie 1994)

In financial terms, the average annual budget in 1994/95 (in England and Wales) was £1.7mil (or £160 per patient for around 10,600 patients) (Audit Commission 1995). Hospital and community services accounted for approximately 55% (£940,000) of the

[5] The entry level was amended incrementally from the original minimum list size of 11,000 to 9,000 (April 1992), then 7,000 (April 1993) to 4,000 (April 1995).

budget whilst the remaining 45% was split between prescribing (38%/£660,000) and practice staff (7%/£115,000)[6]. This equates to a sizeable amount of public finance. For example, in 1996 there were 2,221 fundholders in England and Wales who, if the average of £1.7mil per practice is assumed, controlled in excess of £3775mil.

1.3.1 GPs as Drivers of Efficiency

One important assumption underpinning the reforms was that GPs would respond to the opportunity to have some control over the costs of hospital treatment (Department of Health 1989b:51) and would "negotiate the best deals they can" (Department of Health 1989b:52). Although HA/HB purchasing represents the majority 70%-75% of NHS purchases (Burnett 1994) GPs had a significant contribution to make to service improvements and efficiency gains:

> "[GPs] will move money to where the work is best done, and will make maximum waiting times an important feature of contracts and management budgets. [Fundholders] ... will seek to buy where waiting times are shortest, and hospitals will have a stronger incentive to reduce their waiting times in order to attract funds." (ibid. p37)

By building in the flexibility for practices to make savings from their deals, there was an added incentive for GPs. Savings could be reinvested in the practice to improve existing services, introduce new services and improve practice premises thereby creating competitive advantage over neighbouring practices. Attracting new patients increases the GPs' per capita income and thus the GPs individual wealth as a partner in the business.

The benefits from an increase in the range of activities within primary care does not only favour the practice. More minor surgery, and specialist clinics etc within the primary care setting should mean concomitantly fewer in the more expensive

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[6] Hospital and community services can be further broken down as follows: mental health and learning disabilities - 6%; diagnostic tests - 6%; direct access - 3%; outpatients - 40%; inpatients and day cases - 29%; and community nursing - 16% (Audit Commission 1995).

secondary care setting because, the direct costs to the health service are lowered[7] and because secondly, if GPs do more within the practice they can reduce the value of their secondary care contracts (this represents a transfer of resources from secondary to primary care).

In summary, GP fundholders were to make an important contribution to Teeling Smith's aims of stimulating improved efficiencies and ensuring better allocation of resources by;

- selecting the cheapest source of supply and switching contracts where appropriate, and
- instigating the transfer of financial and staffing resources from secondary care settings into the primary care setting by investing practice savings in new service developments.

1.4 Developing GPs as Purchasers and Providers

Although fundholding heralded the GP purchasing role, there have been a number of related policy instruments which have further contributed to the changing general practice environment (see Box 1.4). Two of the policies are of particular relevance to this study: the 1990 contract and the extension of the GP purchasing role in 1994 (NHS Executive 1994).

1.4.1 The 1990 GP Contract

In 1990 the government introduced its new GP contract. At the OHE meetings, Alan Maynard argued that it was unclear what GPs' contractual obligations were and that GPs could too easily interpret their remit (within the constraints of their existing HB/FPC contract) according to their own interests and the influence of the payment system (Maynard 1986). Consequently, some practices would offer, for example, hypertension and diabetes clinics but others would not. However, because practices were not allowed to advertise their services, patients could not make informed choices

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[7] The assumption is that primary care provision is less costly than secondary care provision but questions have been raised as to whether this assumption does actually hold. For example, Corney (1994) raises questions about the efficiency of outreach clinics.

about which GP practice to register with. Maynard also felt that there were insufficient pressures on GPs to contain their costs and that they were not sufficiently accountable to their employers, the FPC/HB.

Box 1.4: Changes in Primary Care

- 1988 Griffiths review of community care - formalised the responsibility of GPs to inform the social services authority (SSA) about patients' community care needs. In turn, the SSA must confirm receipt of the GP referral and inform the GP of proposed action. The GP needed, therefore, to ensure a systematic way of identifying expected community care needs and to use practice resources most effectively.
- "Working for Patients" - introduced the market and the fundholding/commissioning roles for GPs.
- "Caring for People" (Department of Health 1989a) - focused on community care provision and acknowledged the central role of GPs in identifying health (and social) care needs and working with health and social work colleagues to ensure quality services are provided.
- The 1990 contract for GPs - greater financial incentives for specific services (eg, clinics, immunisation).
- 1990 establishment of FHSAs (in England) which developed and monitored primary care.

The 1990 contract contained five key measures aimed at increasing accountability and improving the quality and quantity of information flowing from the practice to the FPC/HB and the patient:-

1. Giving patients better choice through issuing practice information and thereby stimulating competition between GPs.
2. Making the terms of service more specific to raise standards and reduce variability of service.
3. Amending the Statement of Fees and Allowances (SFA) (commonly known as the Red Book) so that remuneration is linked to performance, thereby rewarding quality service providers.
4. Strengthening the contractual relationship between the FPC (Health Board in Scotland) and the GP.
5. Ensuring greater value for money in general medical services.

Given that the market reforms aimed to encourage inter-practice competition, promote consumer (patient) choice, improve the efficiency of service provision and reallocate scarce resources, the 1990 contract was an important means for supporting these goals. These measures mainly addressed the role of the GP as a provider rather than as a purchaser, but in 1994, the purchasing role was to receive further policy attention.

1.4.2 Fundholding & Commissioning

In 1994 the MEL[8] "Developing NHS Purchasing and GP Fundholding Towards a Primary Care-led NHS" was issued. It marked an important step in augmenting the purchasing role of both fundholders and non-fundholders as fundholding was extended and HBs/HAs were instructed to embrace non-fundholders more fully in their commissioning[9] activities.

The extension to fundholding was as follows:-

- *Community fundholding* (known in Scotland as Primary Care Purchasing (PCP)) was introduced as a fundholding option for practices with a minimum of 3,000 patients. The scheme included a budget for staff, drugs, diagnostic tests and community health services, but excluded all hospital treatments. It was also seen as a first step for those not ready to take on standard fundholding.
- *Standard Fundholding* was expanded to include almost all elective surgery and outpatient services and specialist nursing services. The limit was also reduced from a minimum of 7,000 to a minimum of 5,000 patients.
- *Total purchasing pilots* were also introduced. These were open to GPs (normally within a consortium) to purchase all hospital and community health services for their patients including accident and emergency (A&E) services. By forming a consortium they could spread financial risks.

The involvement of non-fundholders in purchasing was also addressed. HAs/HBs were instructed to "continue their leading role in the development and implementation of a local health strategy, working in collaboration with GPs, NHS trusts, local agencies and local people ...." on the basis that "In many parts of the country, health authorities and GPs - fundholding and non-fundholding - are already working closely

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[8] MELs (Management Executive Letters) are a means of formal communication from central NHS executives to HAs/HBs and Trusts. They are used to issue instructions for policy developments, policy implementation and other such guidelines.

[9] Commissioning is a 'broader', more long term process than purchasing denotes. For a discussion of these concepts, see Chapter 2.

to ensure they meet the needs both of individual patients and of the local community." (NHS Executive 1994).

These moves were considered by the government to be "important steps in the evolution to a **primary care-led NHS**." (ibid.p1, emphasis added). The aim was for decisions about purchasing and providing health care "to be taken as close to the patient as possible ... More decision making on patient care will be placed in the hands of GPs, both through the extension of fundholding and through a stronger partnership between all GPs and health authorities." (ibid. p3)

1.4.3 A Primary Care-Led NHS

The 1994 MEL also made use of the term primary care-led, a fact which should not be over-looked, as it relates very much to the need for a good primary care foundation and it takes the role of the GP beyond that of simply a gatekeeper. As Peter Littlejohns (1996) noted,

> "Good quality primary care is being recognised throughout the world as the basis of a cost-effective health service. In the UK this approach has been adopted by the government with the emphasis on the National Health Service becoming a 'primary care-led service'. Rather than being considered merely a gatekeeper to expensive secondary care, the provision of health care by general practitioners, nurses and others is now recognised in its own right. Furthermore as general practitioners become more involved in the commissioning and purchasing of secondary care, the balance of management of the health service is shifting away from hospital based consultants and general managers to general practitioners." (p1)

This vision of cost-effective care within a well supported primary care service fits with a broader World Health Organisation (WHO) declaration agreed by the UK government and all other WHO member countries at an International Conference of Primary Health Care in 1978. The declaration, known as the Alma-Ata declaration, states that primary care should be "universally available" and that it is the "first level of

contact of individuals, the family and community with the national health system." (Faculty of Community Medicine 1986).

The declaration includes an overall goal of 'Health for All by the Year 2000'[10] and lists thirty-eight wide-ranging targets for its achievement[11]. Three of these targets related specifically to primary care and endorsed the importance of primary care providers as co-ordinators of services.

In real terms, the notion of a primary care-led service implies a different locus for decision making, a locus where there is a convergence of clinical referral powers, financial controls and service planning (Littlejohns and Victor 1996) although not necessarily strategic planning (Meads 1996a). It also implies a close relationship with public health and other members of the HA with GPs as key decision makers (Meads 1996b).

However, although this notion is compatible with the Alma Ata declaration and with fundholding/commissioning policies, a primary care-led service could end up being the "sleeping beauty of health policy" (Bosanquet 1995). Bosanquet argued that advances in technology which offer the opportunity to reduce bureaucracy and provide more information and diagnosis close to the patient could change a primary care-led service from being a "weak aspiration" to being a "core concept". However, a long term strategy which addressed investment in technology, research and development, skills and team development in primary care was essential for this to occur.

The language of a 'primary care-led' service did not remain in policy documentation for very long[12] but the general philosophy of the centrality of GPs as purchasers, priority setters, decision makers and a body of practitioners who ought to be involved in strategic decisions and service planning has been reflected *to varying degrees* in

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[10] WHO Regional Office for Europe, 1985 *Targets for Health for All 2000*; Copenhagen.

[11] Targets addressed specific illnesses (such as poliomyelitis and cancer), mortality rates, policy, educational programmes and environmental hazards.

[12] In 1996 reference was made to a primary care-centred rather than primary care-led NHS (The Scottish Office 1996). This was symbolic of an emphasis on primary care as co-ordinators rather than as leaders and was partly a counter to interpretations of primary care-led meaning GP-led.

ongoing NHS policy developments (The Department of Health 1997; The Scottish Office Department of Health 1997).

1.5 Post-Market Policy - From Competition to Collaboration

As was stated in the introduction to this thesis, during this study, there was a change of government, one consequence of which was the disbanding of the NHS market. Under the new policy, GPs continue to play a role in shaping future NHS services and stimulating efficient, cost-effective, quality care. The mechanism for their doing so has, however, changed. Efforts were made during the fieldwork to gauge what implications there might be for the non-market role of GPs in light of their behaviour as purchasers. This section outlines the new role of GPs within the non-market structure in order to contextualise the research findings (Chapters 6-8), discussions (Chapter 9) and conclusions (Chapter 10).

1.5.1 "Designed to Care"

In 1997, the Labour Government published its white papers (The Department of Health 1997; The Scottish Office Department of Health 1997) on the way forward for the NHS which included as a central tenet, the removal of the market and the creation of a "third way … based on partnership and driven by performance." (The Department of Health 1997:10) Although policies for Scotland and England differ, the common principles are:

- the separation of planning and hospital care provision
- the retention of NHS trust status;
- the abandonment of GP fundholding in favour of locality-based co-operative groups;
- new co-ordinated planning processes at Trust and HA/HB levels; and
- national bodies to evaluate new technologies and measure performance

Although the financial pressures facing the government of the late 1980s have not relented (both the Scottish and the English white papers stress the need for efficiency, performance measurement, cost-effectiveness and quality) the mechanism for achieving these ends has now changed. Rather than stimulating competition between providers

and between purchasers, the emphasis is on collaboration and partnerships at all levels of the system. Acute hospitals will not compete with one another, instead, GPs will refer patients on the basis of geographical locality.

1.5.2 Primary Care Trusts & Local Health Care Co-operatives

Of particular relevance to this study are the new arrangements for general practice, especially changes to their purchasing role. In Scotland a new type of NHS Trust has been established, the Primary Care Trust (PCT). PCTs are responsible for primary, community and mental health services within the geographical boundary of their individual Health Board. Within the PCT are primary care collectives known as Local Health Care Co-operatives (LHCCs). These groups are locality-based, and have responsibilities for service design and service commissioning:

> "The funding of primary care under PCTs reflects the move away from the individual practice model towards a collective arrangement managed through the Local Health Care Co-operatives. Co-operatives will have the right to hold a budget for primary and community health services if they wish ... The fundholding management allowance will be re-directed to support the work of the new Co-operatives, which will require access to specialist expertise providing a range of skills and support across the practices. These arrangements are designed to empower all GPs, working collectively, to ensure that they have flexibility to invest in services which optimise the health gain to their local communities." (The Scottish Office Department of Health 1997)

GPs, who will become employed by the Trusts rather than having a contract with the HB, will have the option to hold a budget within their LHCC for primary and community services and prescribing (ie those services covered by the PCP scheme). (A summary of LHCC objectives is given in Box 1.5) This differs from the English model, however, where GP groups (known as Primary Care Groups) can have financial control over the full range of hospital services previously covered under the total fundholding scheme. There are a range of options available to PCGs. At a minimum they can act as advisors to the Health Authority when commissioning care. Alternatively, they can take devolved responsibility for managing the budget for their

area, can become free-standing, accountable bodies and commission care, or ultimately, they can become free-standing bodies responsible for the provision of community health services and commissioning of care for their population (The Department of Health 1997). (See Figure 1.5 below for the new structure).

Box 1.5: LHCC Objectives

- provide services to their patients within an identified level of resources, including expenditure on prescribing;
- work with the support of public health medicine to develop plans which reflect the clinical priorities for the area, whilst taking into account specific health needs of the registered patient population covered by the Co-operative;
- support the development of population-wide approaches to health improvement and disease prevention which require lifestyle and behavioural change;
- improve the quality and standards of clinical care within practices and to support clinical and professional development through education, training, research and audit; and
- support the development of extended primary care teams which are formed around the practice structure, and promote the development of clinical expertise and the emergence of specialisms within primary care.

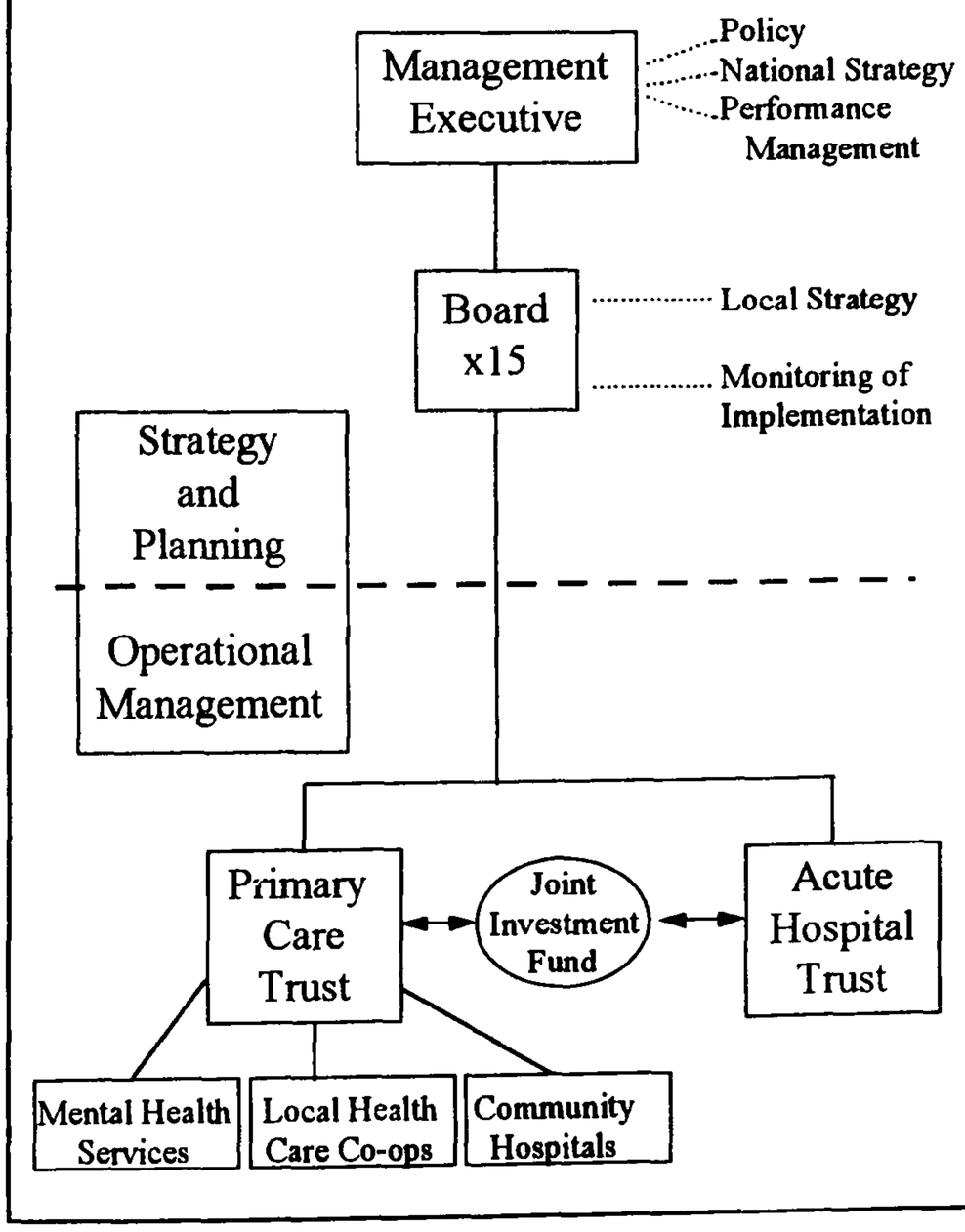
Source: The Scottish Office Department of Health 1997

In many respects the policy fits well with the 'vision' set out by Littlejohns and Victor (1996) and by Meads (1996b). There is provision for IT investment, locally based service design and some financial control. However, there are substantial limits to this financial control in Scotland.

1.5.3 The Primary-Secondary Interface

Instead of contracting as a mechanism for organising service delivery, Designed to Care represents a wholehearted return to *planning*. Health Improvement Programmes (HIPs) will be formulated through discussions between Health Boards and Trusts. HIPs are 5-year service and financial plans which include proposals for emergency planning, health promotion and service changes and developments (including those in primary care), human resource strategies and information technology strategies.

Figure 1.5: The Collaborative Structure in Scotland from 1st April 1999



Taking the HIP as a strategic framework, NHS Trusts then prepare Trust Implementation Plans (TIPs). TIPs must be consistent with the HIP and should set out the means by which services will be delivered to the local population. The primary vehicle for service design and development is the Joint Investment Fund (JIF). Each health board will have a JIF, the spend of which will be guided by the HIP, TIPs and collaborations between primary and secondary care with PCTs taking the lead in discussions.

These changes represent a new set of relationships between general practices and between practices and trusts. The discussions in Chapters 9 and 10 reflect on the market and non-market structures in light of the data considered in Chapters 6-8.

1.6 Summary

This chapter has explained the progression of ideas underpinning the NHS market and has emphasised the importance of GP fundholding, and latterly GP involvement in commissioning, as mechanisms for stimulating efficiencies in the NHS. It is clear from the account of the theoretical development of the market that improving efficiency was a central tenet of the reforms and has been so throughout the history of the NHS. The 1990 market reforms, the most radical to date, placed GPs in a position of considerable influence over large sums of NHS resource and expected them to negotiate low-price deals with providers, to move contracts in order to obtain these lower prices and thereby to stimulate competition in the marketplace.

As Chapter 2 now goes on to discuss, the creation of a market within a national, social service has created many analytical and pragmatic challenges for academics and practitioners. Understanding the structures and behaviours within the market are important not only for the UK but for continuing market and non-market policy here and abroad where market-based solutions have also been adopted. Chapter 2 discusses central structural and process issues relating to competition, and more specifically to the purchasing mechanism, which have arisen in the course of implementing the market during the 1990s.

Chapter 2

Purchasing Issues in the NHS Market

Introduction

Establishing a market within the NHS led to a wide range of debates of concern to academics and health service practitioners. The relative merits of alternative purchasing models, the nature of, and scope for, competition and the relative abilities of GPs and HAs/HBs to become effective purchasers were key issues tackled within the disciplines of health services research, social policy, economics, management, finance and accounting.

Chapter 2 discusses key issues of ***NHS market structure*** dealt with in the literature during the 1990s. It highlights the broader importance of these issues by reflecting on selected ***international*** market-based reforms and recognises the ***social context*** of the reforms by considering ethical concerns regarding the market system and the response to the market by the medical profession. The chapter also explains the nature and scope of ***purchasing and commissioning***, clarifying distinctions between the two concepts.

2.1 Implementing Reform

Gaining an understanding of the market structure and inter-organisational relations offers challenges at a macro level whereas the detail of the impact of financial incentives on doctors, including the ethical dilemmas these may pose, has provided micro-level analytical challenges. These challenges are not unique, however, to the UK. Market-based health service reforms have been implemented on an international scale although as the following section discusses, systems vary in terms of financing and the degree of competition.

2.1.1 International Health Service Reform

It is worth noting similar patterns of health service organisation and finance that have occurred elsewhere and which can therefore benefit from the lessons learned in the UK. The differences between alternative systems can be considered in terms of the amount of supply-side and demand-side competition. Scandinavia and Eastern Europe, for example, have, like the UK, introduced an element of provider (supply-side) competition. County councils in Sweden and municipalities in Finland have become

the purchasers who buy from competing providers. Demand-side competition is limited, however, unlike in the US where HMOs compete for customers and then purchase health services (through insurance premiums).

Donaldson and Mooney (1997) have positioned a number of countries in terms of the degree of competition between providers and competition between insurers (see Figure 1.6 below). Some countries have injected an element of competition into the financing of health care. For example, New Zealand, who concentrated mainly on provider competition, also permitted people to opt out of regional health authority cover to a private sector Health Care plan. This is the main way in which the New Zealand reforms differ from those in the UK and puts it in quadrant 1.

Figure 1.6: Reforms in Financing and Provision
Source: Donaldson and Mooney 1997

FINANCE

PROVISION	*Competitive*	*Non-Competitive*
Competitive	(1) New Zealand The Netherlands HMOs	(2) UK California Medicaid Leningrad
Non-Competitive	(4)	(3) Italy Spain Denmark Eastern Europe

The Netherlands have traditionally financed health care through private insurers but have recently proposed that purchasers seek out sources of supply in the public, private and voluntary sector on the basis of cost and quality.

Provider competition is also characteristic of the Leningrad system in which hospital budgets were transferred to polyclinics (the main providers of primary care). Polyclinics also conduct some specialist out-patient investigations, treatment and rehabilitation. When polyclinics had a separate budget, there was an incentive for them to refer patients to hospital but the budgetary reforms removed that incentive.

The UK reforms have, therefore, paralleled international health service reforms which can be characterised by the degree of supply-side and/or demand-side competition. The scale and pace of change, however, varies across these countries and Bevan and

Marinker (1989) have noted that, "even against this background, the scale and pace of change in the UK stands out...".

2.1.2 Health Service Reform in the UK

From the preceding discussion it is clear that there are market issues on both the demand-side and the supply-side of the market, both of which may exhibit lessons for systems elsewhere. This chapter reviews the literature on key issues related to the demand-side of the market and is centred around the following:

- the purchasing function;
- fundholding leverage, purchasing information, skills and equity;
- the nature of competition; and
- the transactions costs of the market system.

2.2 Competition and Contestability in the UK Market

The UK market was never intended to be subject to free market competition in the sense that classical market models depict but, as the previous chapter explained, there was a belief that a measure of competition was needed in order to improve service efficiencies, responsiveness and quality (Teeling Smith 1986). The expectation was that purchasers would "act as the engine to drive the reforms and use their purchasing power to bring about improvements in both health and health services" (Ham and Maynard 1994), and that NHS trusts would compete for their custom. The challenge, however, was to allow a degree of competition through purchasing activities, but at the same time to safeguard the fundamental philosophy of free health care for all at the point of use[1]. Considerable emphasis had to be placed, therefore, on correctly managing the market and ministers needed to find a balance between intervening too much in the market (the risk of which would be to weaken the incentives for providers to cut costs and raise standards) and not intervening at all (which might mean the bankruptcy of some Trusts) (Ham 1994a; Ham and Maynard 1994).

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[1] This was one of the founding principles of the NHS which the 1980s Conservative government committed themselves to maintain.

Ham and Maynard have pointed out that "The purpose of the present NHS reforms is to introduce a managed market; developing some of the incentives for greater efficiency that are often found in markets while still being able to regulate proceedings to prevent market failures." Elsewhere Ham (1994a) stated that the "underlying rationale for market management is that competition may run counter to the principles and values of a publicly funded healthcare system. Safeguards are therefore needed to protect the principles on which the NHS is based and to prevent behaviour which is anti-competitive." In order to achieve this balance, Ham and Maynard proposed eight core elements for managing the market (see Box 2.1)

That any market might be able to enjoy the benefits and not the disadvantages of competition was, however, regarded by Hunter (1995) as being unrealistic: "Managed competition's appeal lies in the promise it holds of perfect convergence between a managed system of healthcare on the one hand, but one that is not sheltered from the salutary discipline of competition on the other. This is known as having your cake and eating it."

Box 2.1: Core Elements for Management of the NHS Market

- Openness of information
- Control of labour and capital markets
- Regulation of mergers and take-overs
- Arbitrating in disputes
- Protection of non-profit making functions
- Overseeing provision of health services
- Protection of basic principles of the NHS
- Dealing with closures and redundancies

Source: Ham and Maynard, 1994

The need to carefully manage competition, and the difficulties envisaged in allowing competitive forces to prevail, led Chris Ham to question whether the exercise of competition was in fact important or whether "it is the psychology of competition that matters more". Ham advocated the notion of a contestable market[2] where "it is the threat of contracts being moved that stimulates providers to respond to the demands of purchasers rather than the reality of moving contracts." There are clear advantages to this philosophy. Firstly, it allows parties to work together over the longer term rather than working on a short-term/annual basis. This reduces the likelihood of bankruptcy

[2] The notion of contestability was developed by Robert Willig and William Baumol (Baumol, Panzar, and Willig 1982).

for any one provider, a particularly important criteria given that in some rural areas there is only one hospital. This in turn avoids the high entry and exit costs associated with the health care market each of which are borne by the taxpayer. Secondly, the efficiency gains that result from competitive tendering may not outweigh the transactions costs involved in the process. Ham supported this view by drawing on experience elsewhere and proposed that "Evidence from several industries illustrates that the most effective relationships are those where purchasers and providers work together in long-term, collaborative arrangements rather than relationships in which purchasers seek continual short-term gains by switching contracts between providers" (Ham 1994a). Contestability is based on purchasers and providers recognising areas where they have a shared interest and collaborating to pursue this interest (Ham 1994a) and emphasises partnerships rather than costly monitoring systems associated with contracting relationships.

Nevertheless, it is important that there are credible threats and perhaps occasional switching to alternative providers. There also needs to be a structure to facilitate this behaviour. In other words, there need to be alternative sources of supply and multiple purchasers. It also presupposes that GPs will respond to economic incentives. As Hunter observed, "managed competition forces providers into a way of behaving in which it is assumed that economic incentives dominate all others". This dominance of economic incentives, whilst disputed to a degree by Le Grand and Bartlett (1993) was quite clearly presented in Maynard's original design of the fundholding model (see Chapter 1). As Chapters 4 and 6 of this thesis discuss, these economic incentives prove to have been over-emphasised in relation to non-economic incentives.

2.2.1 Supply Side Competition

That there will be alternative sources of supply within the marketplace cannot be assumed because as Propper (1993) notes, in certain areas, there may be insufficient population to support more than one hospital, either because there are economies of scale in hospital production or because patients are unwilling to travel for treatment." In Scotland, for example, there are areas such as the Highlands and Islands, which are served by only one major hospital. Accessing an alternative provider would involve

travelling considerable distances. In contrast, other areas (such as Glasgow) are in a position to choose from a number of public and private sector providers.

2.2.2 Competition between Purchasers

As well as supply side competition, there needs to be competition on the purchasing side. Le Grand and Bartlett (1993) point out that if the purchaser is large, whilst it may be able to exercise some power to offset the powers of large suppliers, the danger is that the authority will be too large to be sufficiently sensitive to health needs. Furthermore, if it has a monopoly position (monopsony) and exploits that position, patients may suffer because in the long run the provider may become demoralised, poorly motivated and ultimately go out of business (op cit.). Another disadvantage of a single large purchaser and provider is that the relationship between the two may become "too intimate" (ibid.) which would cause difficulties in the bargaining process. In effect, there would be decentralised budgets and a management contract between the two parties but no real competition on either side.

As far as fundholding is concerned, the expectation was that practices would compete to improve patient service and would do so partly through the deals they made with providers (Department of Health 1989). There was an implicit assumption that fundholding would be taken up in sufficient numbers and that there would be multiple GP purchasers in any one HA/HB area. As the Scottish statistics in Appendix I show, however, the uptake of fundholding differed across the country,[3] and two health boards had no fundholders at all.

2.3 Fundholders - Purchasing Power, Information, Skills and Ethics

It is not only important that purchasing organisations exist, but that they have, and are motivated to exercise, a sufficient degree of buyer power, that they possess adequate purchasing information and that they acquire the requisite purchasing skills. There was concern, however, that GPs were weak in terms of buyer power[4] and lacked purchasing skills and information.

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[3] This was also the case in England - See Appendix I.

[4] See Chapter 3 for detailed discussion of buyer power.

2.3.1 Purchasing Power

Glennerster (1994) suggested that GPFHs were more suitable purchasers than HAs. (His argument is discussed in detail in the next chapter so is only summarised here). Glennerster suggested that GPs have better information about the needs and preferences of their patients, and can form opinions about service quality because they see patients after discharge from hospital. If care provided to patients is slow or inefficient, GPs suffer because visits to the GP will rise, draining resources, energy and time. There is, therefore, an incentive for them to seek more efficient hospital services. They can take marginal decisions to buy or not to buy services which signal to the provider a dissatisfaction with quality and thus there are no inhibitions on exercising powers of exit. However, whilst the model is favourable in terms of information and incentives, it is weaker in terms of the overall contribution fundholders might make. Relative to HAs/HBs, GPFHs purchase only a small (25%-30%) proportion of overall health services so providers may see little reason to be sensitive to GPFHs compared with HAs/HBs. GPFHs may have very few (if any) alternative sources of provision and are therefore reliant on the provider. Limited information about prices and costs with which to bargain, and the limited ability of GPs to conduct secondary care activities themselves (ie vertical integration) further restrict their power as buyers rendering them rather weak.

2.3.2 Purchasing Information

The availability of information upon which to base purchasing decisions is central to the economic model and to the exercise of buyer power. Propper (1993) considers that GPFHs have more discretion about how and when their patients are treated than HA/HB purchasers, that they have better access to patient and hospital service information[5] and that they will incur lower costs than HAs/HBs when gathering this information. This renders them more efficient purchasers than HAs/HBs. Others,

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[5] Glennerster (1994) notes that GPs see patients after discharge from hospital as well as prior to hospital referral. This gives them access to information about patient needs and service quality which is not codified and made available to HAs/HBs.

however, raise more general questions about the availability and asymmetry of information. Deakin and Walsh (1996), for example, argue that "The purchaser is often dependent on the provider for knowledge of what has been done, or even what should be done." Because of the importance of the availability of appropriate information, this issue is discussed in detail in Chapter 3.

2.3.4 Purchasing Skills

A third area of concern as regards the fundholding model was whether GPs had the requisite skills and information for purchasing relative to HAs/HBs (May and Robinson 1995; Oakley and Greaves 1995b; Pollock and Majeed 1995; Exworthy 1996). Bowie and Harris (1994) for example, claimed that GPFHs have neither the skills nor the expertise to contract for services and claimed that it was the general managers, accountants and public health physicians based at the HA/HB who possess the necessary skills. McKee and Clarke (1995), however, felt that clinicians (GPs) mystify business/contract managers and moreover, that HAs/HBs are unable to keep up to date "with the minutiae of change in clinical practice". Taking something of a middle ground, Alderslade and Hunter (1994) advocated that some combination of both sets of skills, rather than either one, was required and that GPs and HAs/HBs needed to work together. As this Chapter goes on to discuss, this approach is an important underlying principle of joint HA/HB and GP commissioning.

2.3.5 Purchasing Ethics

The size of fundholding practices was of particular concern because their relatively small budget would be financially vulnerable if patients were 'expensive'. Although the fundholding model does not stem directly from the HMO (see Chapter 1), Glennerster (1994) identifies an important, transferable principle: "American experience suggested that small HMOs were financially vulnerable. An unfortunately large number of expensive patients needing emergency treatment in any one year could bankrupt a small HMO." (p22). As a result, Glennerster et al. argue that the risk pool needs to be larger than 50,000. This, however, is more than any one practice can achieve. In the UK only around 40% of practices had more than 7,000 patients at the

time fundholding was introduced[6]. It is worth bearing in mind, however, that it was only total fundholders whose budget covered the full range of services (including expensive accident and emergency services) that an HMO would cover.

One potential problem, caused by a small risk pool, is that of 'cream skimming' or biased selection (Bartlett et al. 1994). Bartlett and Le Grand (1994) and Glennerster (op cit.) argued that because GPs had a fixed, per capita, income, there was an incentive for fundholders to avoid accepting patients with a huge risk of being expensive. Fears of a two-tier system also arose in relation to fundholding. Hospitals may offer preferential treatment to fundholders because of the opportunity to boost their incomes. This is particularly so if/when hospitals have a waiting list initiative (Audit Commission 1996). Enthoven contested this on the basis that in his view, the UK NHS already has a system with various tiers in terms of service quality although they are not measured and documented (Smith 1989) a conclusion to which Bartlett and Le Grand also came.

2.4 Transactions Costs of the Market System

The third market-related area of concern in terms of this study, was that of the transactions costs associated with the purchasing mechanism, a subject which is discussed in depth in the following chapter. When the market reforms were launched, many expressed concern about the transactions costs (see for example Ham 1994b; Benton 1995). However, transactions costs are not readily defined and calculated so little more was done than to discuss their potential scale.

Transactions costs are the costs associated with market contracts such as setting up contracts, monitoring and ensuring compliance to them and renewing them. They arise under particular conditions[7] in which parties are engaged in formal contracts and

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[6] Note that by 1994 the entry level for fundholding was 5,000 patients, and for community/PCP fundholding was only 3,000 patients.

[7] Transactions costs arise in circumstances of uncertainty and where there are small numbers of buyers and suppliers and where humans are boundedly rational and potentially opportunistic (Williamson 1975). These concepts are discussed in sec. 3.7-3.8.

where those contracts strictly specify products/services, payment systems are precisely defined with accurate orders, invoices and other records, and where some form of arbitration mechanism is required (Deakin and Walsh 1996). Ham signalled transactions costs as being of considerable importance to the NHS:

> "Perhaps the most important is the increase in management costs that has occurred. There is little doubt that a health service based on contracts between purchasers and providers is more expensive to administer than one in which health authorities manage hospitals directly. The increase in transaction costs is compounded by the fragmentation of purchasing ... Management in the NHS has come to resemble a paper chase as NHS trusts seek to secure their income by negotiating contracts with different purchasers and as all players in the market invest in information systems to monitor contract compliance. This has put at risk one of the greatest strengths of the NHS, its tradition of low administrative costs."

Ham believed that the market system was more expensive to administer than the pre-market model and that the transactions costs involved in the market were "likely to be considerable" (ibid) due, not least, to fundholding. Benton (1995) was equally concerned about the "exponential" rise in transactions costs due to fundholding, an increase which he said would result in "a large chunk of the healthcare pound being spent on the cost of developing, setting and monitoring contracts...". McKee and Clarke (1995) took the situation further and suggested that as purchasing is likely to develop on the basis of clinical protocols and guidelines that "calculations of costs and benefits should include the cost of developing, implementing, and monitoring the guidelines".

It is important to bear in mind that a further reason for the expected high level of transactions costs is due to the complexity of the product being exchanged (Petchey 1993; Thomas 1995). Petchey argues that "When the product or service being exchanged is complex ... it is either impossible or extremely costly to specify in advance, in a written contract, every contingency that might affect the transaction. An elderly, unstable diabetic patient admitted for surgery, for instance, is obviously going

to require more hospital treatment than a young, fitter patient. Because it is difficult to incorporate contingencies of this kind contracts will inevitably be incomplete specifications of the rights and obligations of the contracting parties. Incompleteness creates scope for opportunism." Writing more elaborate contracts or intensifying the monitoring process to cope with such complexities only adds to the transactions costs (op. cit.).

2.5 Market Reforms: The Views of the Medical Profession

The concerns expressed so far in this chapter were echoed by the medical profession who exhibited considerable opposition to the reforms. Teeling Smith had anticipated that the OHE solution would be unpopular with the medical profession because it challenged their independence and because a market would be regarded as a threat to the integrity of the NHS (see Chapter 1).

> "Greater efficiency, a more rational allocation of resources, the introduction of alternative sources of finance and extra taxes all seem to be potential ways of helping to tackle the short fall of health care in Britain ... The problem is that each of these approaches has its potential opponents, both within the Health Service and outside it ...many doctors and other health professionals resent the suggestion that their pattern of behaviour should be modified in order to provide better value for money in the Health Service. The opposition in some quarters to any form of financial incentive for improved performance in general practice is an example of the resistance to change from amongst the professions ...politicians face an unenviable dilemma. If they attempt to improve the quality of health care in Britain by other means in addition to better public funding they are likely to face problems. Governments have to work within the time-scale of a maximum of five years between elections. If they attempt to introduce politically unpopular moves within this time period, they may well lose office at the next election, and find that a politically more timid alternative government reverses their health care policies ..." (Teeling Smith 1986:18-19).

Teeling Smith's expectations were realised. The British Medical Association (BMA) regarded the document in which they stated their objections as being "...probably the most important document that the [British Medical] Council has issued in the last forty years." (British Medical Association 1989). The Association did accept the general aims of Working for Patients, but disputed the measures for achieving them, considering that "many of the proposals would cause serious damage to NHS patient care, lead to a fragmented service and destroy the comprehensive nature of the existing service." (ibid.). Clearly, as it was important to the government that the medical profession perform according to the incentives designed into the system, this was a troubling response. As the analysis in Chapter 6 shows, professionalism is an important dynamic within the service and is strongly valued by GPs.

2.6 From Purchasing to Commissioning

As Chapter 1 discussed, purchasing policy developed in a way which extended the fundholding scheme and which also placed importance on the involvement of non-fundholding GPs in commissioning activities. This meant that the entire GP population of the UK was to have an opportunity to influence purchasing priorities and decisions about local hospital services. Commissioning, however, was not only an important development as far as embracing more GPs in the decision making process. The term commissioning evolved from being a somewhat "mysterious" (Opit 1990) and nebulous concept, one often used interchangeably with purchasing (Hunter 1997), to become understood to mean a higher level process than purchasing was considered to be.

2.6.1 The Commissioning Concept

Although purchasing was viewed as being the "engine for change" (Hunter 1997), there were criticisms that the role had been much underdeveloped (Prowle 1992). Furthermore, that *"Working for Patients"* made reference to HA/HB commissioning but provided no explanation of the term and that subsequent working documents did not develop the concept either (Opit 1990) led to the emergence and use of the two equally undefined, ambiguous terms purchasing and commissioning.

Subsequent attempts to clarify the nature of the purchasing role, however, identified both long and short term issues plus a range of purchasing activities (Prowle 1992). The long term issues were later understood as commissioning activities (Alderslade and Hunter 1994). Prowle specified three key purchasing roles: (1) identifying the health needs of the population; (2) purchasing selectively those health services likely to bring the greatest benefit for the resources available; and (3) promoting efficiency in service provision. He went on to define a number of short term and long term issues related to these roles (see Box 2.2) and in so doing, placed particular emphasis on the need for careful attention to what services are needed and from whom, otherwise purchasers would be "purchasing what providers wish to supply rather than what the population really needs." (ibid. pp10).

Box 2.2: Short and Long Term Issues in Purchasing
Source: Prowle 1992

Short/Medium Term Issues

- "defining more precisely the current range of services;
- introducing a greater degree of specification into contracts;
- promoting further efficiency within provider units;
- promoting alternative treatment patterns (eg in-patient to day patient surgery)'
- looking for ways of reducing waiting lists."

Long Term Issues

- "what services should the DHA be purchasing (including what is the health care need and how do we weigh competing priorities, eg unmet demand or health gain)?
- how and from whom should the DHA purchase those services?

Prowle's distinctions were reflected in subsequent attempts to move towards a greater understanding of the purchasing and commissioning roles (Alderslade and Hunter 1994; Ovretveit 1995; Hunter 1997). Hunter and Alderslade note the distinction as follows:

"**Commissioning** is the process of gathering and analysing the wants and needs of the population, and identifying the services required to meet those needs. **Purchasing** is the interpretation of commissioning plans, and the construction and implementation of time-related purchasing plans."

Elsewhere, Alderslade and Hunter (1994) refer to commissioning as a "strategic process by which health improvement is sought and a vision of the service market is created and implemented. Within that wider process, a series of purchasing/contracting decisions about specific service elements are taken by individual purchasers..." (Alternative distinctions are provided in Box 2.2).

Box 2.2: Definition of Commissioning / Purchasing Terms

Public Health Commissioning:-
"To maximise the health of the population and minimise illness, by purchasing health services and by influencing other organisations to create conditions which will enhance people's health."

Health Purchasing:-
"...buying the best value for money services to achieve the maximum health gain for those most in need."

Health Contracting:-
"involves selecting a provider and negotiating an agreement with them about the services they will provide in return for payment. It includes the activities of defining service specification for tendering, specifying a contract, monitoring the contract and reviewing contract performance."

Source: Ovretveit 1995:18

2.6.2 Commissioning Skills & Information

Consideration of the longer-term, broader purchasing issues raises the importance of needs assessment, epidemiological analysis, priority setting and planning, disciplines in which public health clinicians receive training but GPs do not.

Commissioning has been viewed as being a means of combining the strengths of primary care with those of public health (Brown 1994). As Bowie and Harris (1994) explain, the skills of public health physicians are made available to all GPs "leaving the general practitioner free simply to make choices". Commissioning also brings together two sets of information. Shanks et al (1995) argue that there is a need for services to be commissioned following population wide needs analysis (the work of public health clinicians), rather than only practice-based decisions otherwise "General practitioners may ... find themselves limited to their unaided judgement of which services would most benefit the health of local people." (ibid). On the other hand, practices know their patients and as Glennerster et al. (1994) pointed out, they see the patient prior to and following a hospital visit so are ideally placed to make judgements about service quality and patient needs.

2.6.3 Locality Perspective

The importance of involving GPs in commissioning so as to ensure a local perspective can be further extended to involving the local population (consumers). "Health needs are not simple epidemiological variables" argue Alderslade and Hunter (op cit.), they are "complex social constructs which must be analysed, interpreted and given meaning and priority in conversation with the population served ..." and HAs/HBs have a responsibility to involve the local population directly in commissioning decisions (NHS Management Executive 1992). HAs/HBs must, therefore, rise to the challenge of 'thinking globally but acting locally' and need to give careful consideration to the mechanisms for gaining consumer views. Various methods were suggested in "Local Voices" (NHS Management Executive 1992) (for example public meetings, focus groups, health forums, telephone hotlines and complaints procedures), many of which have been adopted by HAs/HBs.

2.6.4 Commissioning Structures

By 1994, when HAs/HBs were given a directive to involve non-fundholders in their activities, a number of DHAs had already merged with one another and formed much larger purchasing authorities (Exworthy 1993). They had simultaneously sought to ensure a local perspective in their purchasing in order to identify and reflect the potential diversity of health needs within their catchment area (Exworthy 1993)[8]. The various ways in which they established their purchasing structures so that they were locality sensitive are many and varied (see for example Carruthers et al. 1995; Balogh 1996; Smith, Butler, and Powell 1996) and have depended in part upon local fundholding activities (Graffy and Williams 1994). The variability in approach is because "some health authorities have undertaken all the contracting and purchasing themselves while others ...have delegated substantial purchasing capacity and funding to GP practice groups. In between, various models and degrees of GP purchasing input, practice-sensitive and locality-based purchasing have emerged." (Hunter 1997).

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[8] The term locality can represent anything from a population of 13,000 (eg, in a GP practice), to 35,000 (a neighbourhood patch or area) and to 100,000 throughout a sector within the health authority. When discussing particular models it is necessary to define the size of a locality but for the purposes of this discussion, the term locality is used generally to mean an area larger than that of an individual GP practice, but smaller than that of a health authority.

2.6.5 Integrated Activities for Health Gain

One of the criticisms of fundholding was that with practices developing their own strategies, the overall HA/HB area strategy would become fragmented (Hegginbotham 1994; Benton 1995) resulting in a "patchwork of services ... which is not responding to the needs of the wider community" (Oakley and Greaves 1995a). A commissioning process in which needs assessment precedes purchasing objectives is believed to overcome this fragmentation (Ovretveit 1995). This in turn is argued to facilitate the move towards concentrating on health gain rather than health services (especially acute services) (Hunter 1997). The WHO declaration discussed in Chapter 1 places great importance on health promotion and health gain but, according to Hunter (op cit.) whilst purchasing was viewed as being the vehicle for achieving health again for local populations, "For many, purchasing has been about maintaining the status quo, resisting change and, at best, tinkering at the margins of current delivery systems and patterns of care ..." (ibid).

2.6.7 Commissioning - No Panacea

Whilst it is clearly in the mutual interests of GPs and HAs/HBs to find ways of working together to commission services (Graffy and Williams 1994), and although commissioning appears to counter many of the 'problems' with fundholding, it is no panacea for purchasing ills (Ham 1994b; Hudson 1995). Hudson identified various potential areas of difficulty relating to degrees of localisation and budgetary devolution, coterminosity of purchasing levels, maintaining diversity and comprehensiveness, compatibility of purchasing objectives and structures for managerial approaches to managing the commissioning process. If, for example, purchasing budgets are not devolved then the locality model is weakened and where budgets are devolved, decisions must be made about responsibility, accountability and the degree of flexibility any one locality has within the overall commissioning priorities and objectives for the area (see also Exworthy 1993).

2.6.8 Commissioning, Efficiencies, and Resource Allocation

There are many models of locality commissioning (Carruthers et al. 1995) as well as a number of alternatives, for example that of community oriented primary care[9] (Pollock and Majeed 1995). It is interesting to note, however, that discussions about commissioning generally address organisational structures and consultation processes but not mechanisms for stimulating efficiency and improved resource allocation. According to Donaldson and Mooney (1997), where HAs/HBs take account of collective consumer choice this may affect resource allocation but the impact is likely to be small[10]. Whilst the mechanisms for stimulating efficiencies within the competitive environment through discretionary purchases by fundholders and HA/HB purchasers have been more thoroughly explored, this is not the case with commissioning arrangements.

2.7 Summary

Chapter 2 has reviewed the key market issues concerning the demand-or purchasing-side of the NHS market. The literature covers a range of economic and social issues which are of importance not only to the UK, but to international governments who are in the throes of market reform, in particular countries like New Zealand which are experimenting with GP budget-holding.

This chapter has illuminated a number of aspects which require further discussion. These concern the structures and mechanisms for stimulating efficiencies, transactions costs, the degree of purchasing power and information available to GPs and the extent to which purchasers may wish to collaborate with their providers. It is to these matters that Chapter 3 now turns.

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[9] Community Oriented Primary Care originates from Israel and was proposed in the UK by the King's Fund. It is a method of teaching and applying public health skills in a primary care setting. It has several requirements: community-based primary care; identifiable population/community for which the practice assumes responsibility for improving health status; a planning, monitoring and evaluation process for identifying and resolving health problems; and liaison and collaboration with local community leaders.

[10] Donaldson and Mooney consider that the mechanisms for identifying consumer need and for differentiating between what is 'good' on the basis of individual patient choice and what is socially 'good' are highly problematic and thus will limit the impact of consumer views on resource allocation.

Chapter 3

Markets, Hierarchies and Networks in the NHS

Introduction

Chapter 1 introduced the politician's problem - that of improving NHS efficiency - and the politician's choice - that of market versus hierarchy[1]. Having set out the underlying theory for the NHS market, key market-related issues arising from its implementation were discussed in Chapter 2. As Chapter 2 noted, certain of those key issues (structures and mechanisms for stimulating efficiencies, transactions costs, purchasing power and information and the extent of collaboration between parties) require further analysis in light of existing organisation theory.

This chapter draws on and ***integrates economic and social theories*** concerning market structures, market costs and inter-organisational relationships. It places particular emphasis on ***transactions cost theory*** as a means of analysing the transactions and contracts between GPs and their providers and then introduces a ***network perspective*** on purchasing, to analyse the nature of the ***inter-organisational relationships*** that can arise between purchasers and providers.

3.1 Organising Health Services: The Politician's Choice

3.1.1 Allocating Resources

The Government during the 1980s faced continual pressure to commit more public money to the NHS to meet the increasing demands placed on the NHS from the costs of new technology, the burden of a growing elderly population and the groundswell of consumerism in health care. Believing that comprehensive primary health care services were not only cheaper to provide but could prevent/reduce the likelihood of hospital admission or could serve as an alternative and more cost-effective venue for certain procedures, it became a policy goal to transfer financial and staffing resources from secondary to primary care health services (Department of Health 1989). This transfer or reallocation of resources between secondary and primary care is not easy to achieve.

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[1]Teeling-Smith talks about bureaucracy not hierarchy (Teeling Smith 1986). The terms bureaucracy and hierarchy are used by different disciplines. Sociologists refer to bureaucracy and address one set of issues. Economists refer to hierarchies and address a different set of issues. The differences will be discussed later.

An ideal situation would be to transfer resources in such a way that one set of patients gains but no other set loses out - this would be the condition economists refer to as Pareto-efficiency.[2] This could mean, for example, transferring minor operative procedures and occupational therapy, from being delivered within a secondary care setting to delivery within primary care but doing so in such a way that resources are not taken from other areas of secondary care provision, for example intensive care or accident and emergency services. Alternatively, and perhaps more realistically, there may be trade-offs to consider when transferring resources. For example, it may be that resources can be channelled into the provision of inpatient rheumatology beds *or* into the upgrading and expansion of a community health centre *or* the provision of hydro-therapy[3].

3.1.2 Resource Utilisation: Reducing Waste and Improving Efficiency

The second resource issue addressed within Working for Patients was that of resource usage. As Chapter 1 discussed, there was thought to be a considerable degree of waste in the NHS and that competitive forces would provide the incentives for hospitals to operate more efficiently and so reduce their costs. According to Leibenstein (1966, 1987) this includes improving X-efficiency, ie, the motivation of management and staff to improve performance. As Chapter 1 also explained, the move towards a market represented a particular view that the competitive market is a more efficient way of allocating resources (ie ensuring that consumer tastes are met for a given level of resources and technology) than the inefficient hierarchical form of organisation that prevailed.

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[2]Pareto-efficiency was named after the economist Vilfredo Pareto whose *Manuel D'Economie Politique* was published in 1909. An allocation is said to be Pareto-efficient for a set of consumer tastes, resources and technology, "if it is impossible to move to another allocation which would make some people better off and nobody worse off" (Begg, Fischer, and Dornbusch 1987) (p314)

[3]This is an example from discussions at a civic forum in my own health board.

3.2 Resource Allocation and Utilisation in Hierarchies, Markets and Networks

In any system, resources need to be allocated and activities co-ordinated. As Daems (1983) writes, "Co-ordination of activities, allocation of resources and monitoring of performance require communication of information about opportunities and actions. It is also necessary that compliance with contracts be enforceable to assure effective co-ordination."

The market "works through the price mechanism, to send appropriate signals to economic actors about what they should be doing" (Jarillo 1990) whilst in the firm (or hierarchy), "the organising principle is hierarchical: actors are simply told what to do, in order to deliver the final, complex product or service." (Jarillo 1990). There is, however, a third alternative, the network. In the network "the mechanism is not quite complete integration into a single firm, but not quite exchange between two separate firms in markets either. Firms may form links or bonds of a long term, 'relational' nature, through which they become interdependent for business." (Sako 1992:23)[4] In reality, competitive and non-competitive environments display a range or "myriad" (Williamson 1985) of arrangements along the spectrum from market through network to hierarchy, so these distinct forms are rarely (if ever) found in their pure form. Nevertheless, their respective bearing on efficiency and resource allocation is important to the study of the NHS market.

3.3 Hierarchies

The hierarchy is the form in which a single administrative entity spans both sides of a transaction (Williamson 1975). Prior to 1990, health authorities decided on the allocation of resources within the health service, both in cash terms and in terms of which services were to be provided. Within this framework, resource allocation was governed by managerial authority which cascaded down through the tiers of NHS administration from the Department of Health to Regional/Area Health Authorities,

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[4] There are two views of networks. One view is that networks are a form of organisation somewhere between market and hierarchy. The other view is that the network is a distinct form of organisation characterised by social ties and socio-economic motives. See later discussion on networks.

District Health Authorities, Family Health Services Authorities, Hospitals and General Practices and within hospitals, to areas, for example, of medical specialty, research, and pharmacy.

The theoretical hierarchy model which is closely associated with Max Weber[5], has four key characteristics: hierarchy, continuity, expertise and impersonality (Beetham 1991). Decisions are made by supervisors who tell their staff what to do and tasks are divided up among employees who are accountable to their supervisor for the work that they do. The work is conducted according to prescribed rules and is done without arbitrariness or favouritism. Generally, there is the prospect of full time occupation with a clear career structure and regular advancement. Promotion within the hierarchy is based on merit and training for a particular functional expertise.

Beetham suggests that there are 3 classifications of staff within this model: chiefs, administrators and front-line workers. Chiefs are responsible for formulating policy, and administrators interpreting policy directives and translating them into action. Action (or service delivery) is the responsibility of the front-line workers. Max Weber[6] claimed that the more an organisation adhered to this model the more efficient it was likely to be. By efficient, he meant a complex of values which included performance (eg, speed, predictability), expansion of scope and cost effectiveness of operation.

There are a number of advantages to hierarchy (Jaques 1991; McGuinness 1991). According to Beetham (1991), the central feature of bureaucracy is its *systematic* division of labour. Complex administrative problems are broken down into manageable and repetitive tasks which are co-ordinated by a command structure. This can allow enormous expansion of scope, a high degree of precision and cost effectiveness.

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[5] Max Weber offered his discussions of bureaucracy as an 'ideal' type of organisation.
[6]Max Weber is most closely associated with discussions of bureaucracy as an ideal type of organisation.

Williamson (1975) claimed that organising transactions internally within a hierarchy has three particular advantages over the market. Firstly, it minimises the opportunity for sub-groups to pursue their own goals at the expense of the organisation (or *system*) as a whole. Although there may be divisions within an organisation which trade with one another, they do not have pre-emptive claims on their respective profits even although they may have a profit centre status. The prices which departments charge one another are likely to be constrained by organisational policy and rules so that no division can set monopolistic prices. Williamson also claims that within the hierarchy, managers within each trading division are more prone to co-operating with one another because "the aggressive pursuit of individual interests redounds to the disadvantage of the system and as present and prospective compensation (including promotions) can be easily varied by the general office to reflect non-co-operation, simple requests to adopt a co-operative mode are apt to be heeded. Altogether a more nearly joint profit maximising attitude and result is to be expected." (Williamson 1975:29)

A second distinct advantage of the hierarchy is that it can be more effectively audited. Whereas an external auditor is constrained to review written records and documents and his/her investigation is restricted to pertinent matters, an internal auditor has greater freedom to explore less formal evidence and to pursue any byways which his/her investigation may discover. An internal auditor is not thought to be partisan but instrumental whereas an external auditor is perceived as being 'on the other side' and as such, potential informants are unlikely to volunteer information for fear of being branded as disloyal.

The third advantage emphasised by Williamson is the fact that disputes are generally settled out of court thereby avoiding expensive legal costs. Resolution is achieved by exercising fiat which is "an enormously efficient way to settle instrumental differences". (Williamson 1975:30)

Criticisms of bureaucracies, however, are well known and have been food for the proponents of market mechanisms. One principal criticism is that of excessive layering, ie too many rungs on the organisational ladder. Multiple layers mean that information and decisions need to pass through a great many people and levels which

can cause inefficient delays and distortion and loss of information. The rules which govern work can become burdensome and constrain initiative, innovation and render the organisation inflexible and unresponsive to changes in the internal and/or external environment. As Beetham states "Adherence to rules can become inflexibility and 'red tape'. Impersonality produces bureaucratic indifference and insensitivity. Hierarchy discourages individual responsibility and initiative." (Beetham 1991:133) That organisations are divided into functional areas with staff who are rewarded for functional expertise, can mean that functional departments pursue their own goals which are not consistent with overall organisational goals and which may be incompatible with sub-goals of other departments - ie, the problem of sub-optimisation.

Beetham goes on to say that if one views an organisation as a social system of interpersonal relations then there are weaknesses in Weber's assumptions that the bureaucracy is efficient. "Weber's model of organisational efficiency assumes that all aspects of the individual personality which are not relevant to the strict performance of his or her duties will be cast off as the individual enters the organisation, or suppressed through effective socialisation." (ibid. p133,) In practice, people are individuals with personal needs and expectations for which they seek satisfaction and the way in which they interact socially can be crucial to the effectiveness of their performance. If social interaction is suppressed then it can lead to resistance. "People can be compelled to work upon command, but not to work efficiently or with commitment. That requires their active co-operation which is as much a matter of informal negotiation as of authoritative command." (ibid. p134,)

Beetham's point illustrates one of the prime difficulties within the hierarchy, the problem of motivation and its relationship to incomplete labour contracts. As mentioned earlier, Leibenstein proposed the notion of X-efficiency (Leibenstein 1966, 1987). Leibenstein acknowledged that specialisation gives rise to efficiencies because activities can be allocated to the person or equipment to which they are best suited. There are dexterity advantages to specialisation as well as improvements in the pace and quality of activity. There may also be training advantages because training can be shorter and more directed and effective. However, he identified what he termed

invisible elements in co-ordinating specialised activities because work which has been broken up must be recombined and here inefficiencies can be incurred. This he considers is the central internal efficiency question. Firms comprise many people and groups who have differing motivations, levels of trust, commitment to the firm and to one another and different levels of information on objectives which Leibenstein terms "natural attributes of the self-contained individual" (1986:159). These need to be "fostered and created in a hierarchy" (ibid. pp159) such that they are in the best interests of the firm. As Sako (1992) explains though:-

> "There is no reason why the level of effort chosen by individuals in a firm should result in working practices most productive for the firm: hence the possibility of X-inefficiency. Moreover, increasing X-efficiency may not be easily achieved because of inertia to maintain the existing routine. Inertial behaviour has a basic psychological foundation in comfort felt due to familiarity of habit and to predictability of other people's behaviour."

It may be that poor motivation, conflicting goals, a lack of trust, suspicion of superior organisational levels in the hierarchy may result in inefficiencies (X-inefficiencies) in recombining specialised work.

It is difficult to specify *ex ante* in the employment contract, all future contingencies which relate to future performance. As Williamson (1975) notes, even if they could be specified this would be a lengthy and complex process which would be of questionable value to both the employee and the employer. It is inevitable therefore, that all standards of performance cannot be specified within the contract. In a hierarchical form of organisation, therefore, although the owner or managers rely on some combination of authority and the forms of co-ordination identified by Mintzberg (1989), to ensure a desired level of worker effort, the quote above from Sako indicates that there are factors which prevent full worker compliance to the level desired by the organisation.

3.4 Markets

In the 'ideal' market, resource allocation is co-ordinated through the price mechanism. Purchasers exercise choice between producers on the basis of price and other product and related information[7]. Due to the fact that there are a large number of buyers and suppliers, the price is regulated both by their relative bargaining powers and the fact that there are many alternative sources of supply (Begg, Fischer, and Dornbusch 1987; Douma and Schreuder 1991).

The NHS market, however, operated within certain constraints in order to safeguard the social values of equity and access to NHS services. In other words, it was a managed or quasi market. Within the quasi-market framework, funding is not allocated solely through planning or formula funding but also through "competitive bidding, or an earmarked budget which can be given to users, or agents acting on their behalf, who can allocate the budget between competing providers." (Ferlie 1992) This form of market altered the resource allocation among service providers[8] and the organisational form of the economic actors within the market. For example, GP practices went from non-budget holding to budget holding status whilst hospitals came under pressure "to adopt many of the characteristics of a 'quasi firm'" meaning that "they have to attract business in order to maximise revenue; they may need to market their services ... to reduce costs and raise quality ... they may also collude with other providers .. to find ways of reducing purchaser pressure on them." (ibid)

Nevertheless, although the NHS market differed from a fully competitive market, the competitive model underpinning it suggested that there would be "adversarial relationships between purchasers and providers, with individual providers competing with each other to attract purchasers, with individual purchasers competing with each other to obtain the lowers possible prices, and with purchasers and providers vying

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[7]Purchasers may draw on information about product quality and reputation, brand name, the availability of components required for repair, service guarantees, the availability of alternative or substitute products on the market and so forth.

[8]Note here that GPs are also providers of services.

directly with each other to get the best possible deal". (Croxson 1997:2)

Chapter 2 provided an overview of some of the market-related issues which arose following the implementation of the NHS market. Particular issues reserved for more comprehensive discussion were those of GP purchasing leverage, the contracting process, the availability of purchasing information, and contestability. It is to these issues that the discussion now turns.

3.5 Buyer and Supplier Power

As the previous chapter identified, one of the key market assumptions was that buyers would be able to exercise purchasing leverage. Porter's (1980) treatment of the competitive conditions under which enterprises attempt to make strategic decisions, identifies buyer power as one of five competitive forces, the others being barriers to entry, supplier power, the threat of substitute products and the intensity of competitor rivalry. Of particular relevance to the healthcare market is the degree of buyer power which a GPFH or health authority might have relative to the NHS Trust with whom it is dealing. For GPFHs and HAs, the degree to which they can exercise buyer power within the market is a crucial aspect of their role. If they have little or no influence over suppliers, then they will be unable to influence what happens within secondary care and there will be no improvement in the efficiency of Trust hospitals' service provision. Porter argues that suppliers can exert bargaining power by raising prices or by reducing the quality of purchased goods and services. Customers on the other hand can drive down the prices, demand higher quality or more service and can play the competing suppliers off against each other (Porter 1980; Grant 1998).

Buyer power is determined by the degree to which buyers are price sensitive and their relative bargaining power, in other words, via some combination of the factors listed below:-

3.5.1 Buyers' Price Sensitivity

The extent to which buyers are sensitive to the prices charged by the firms in an industry depends upon four major factors.

- "The greater the importance of an item as a proportion of total cost, the more sensitive buyers will be about the price they pay ...
- The less differentiated the products of the supplying industry, the more willing the buyer is to switch suppliers on the basis of price ...
- The more intense the competition among buyers, the greater their eagerness for price reductions from their suppliers ...
- The greater the importance of the industry's product to the quality of the buyer's product or service, the less sensitive are buyers to the prices they are charged..." (Grant 1998)

3.5.2 Relative Bargaining Power

"Bargaining power rests, ultimately, on refusal to deal with the other party. The balance of power between the two parties to a transaction depends on the credibility and effectiveness with which each makes this threat. The key issue is the relative cost that each party sustains as a result of the transaction not being consummated. A second issue is each party's expertise in leveraging its position through gamesmanship. Several factors influence the bargaining power of buyers relative to that of sellers.

- *Size and concentration of buyers relative to suppliers.* The smaller the number of buyers and the bigger their purchases, the greater the cost of losing one...
- *Buyers' information.* The better informed buyers are about suppliers and their prices and costs, the better they are able to bargain...
- *Ability to integrate vertically.* In refusing to deal with the other party, the alternative to finding another supplier or buyer is to do-it-yourself..." (Grant 1998)

Chapter 2 indicated that GPFHs were thought to have relatively little bargaining power and that this was problematic in the face of large, possibly monopolistic suppliers. In order to consider GPFH buyer power in some detail, the following analysis was conducted drawing on the literature reviewed in Chapters 2 and 4, combined with some characteristics specific to the Scottish health service. The analysis confirms the fears expressed in Chapter 2, ie that *GPFHs as buyers are indeed **weak*** although they

can be considered to have a ***medium*** *degree of price sensitivity.*

Price Sensitivity - Medium	
Products as a Proportion of Buyers' Total Cost: Secondary care services can represent a significant fraction (55%) of the GPFH's standard fundholding budget. For total fundholders it is a greater percentage and for PCP fundholders, it is lower. On this criteria GPFHs are likely to be price sensitive.	Strong - Medium
Product Differentiation: Hospitals have to offer certain core services, so in a sense products could be regarded as standard. This increases buyer sensitivity because they can, in theory, find an alternative source of provision. Technically, GPs are not locked into particular providers due to, for example, complex, integrated production processes, so switching costs are in that respect low. However, health services are complex. They are largely intangible and heterogeneous, and they are difficult to define, cost, quantify and specify in contracts. Furthermore, service quality is known to differ between hospitals and hospital departments. Studies reviewed in the following chapter have identified difficulties in comparing procedures between providers. In reality, therefore, to suggest that all products are standard is inappropriate[9]. Accordingly such differentiation weakens buyer power.	Medium - Weak
Competition among Buyers: Fundholding designers intended that the incentives within the scheme coupled with those in the 1990 contract would stimulate buyer competition. That being the case, GPFHs would have been highly price sensitive, eager to negotiate better deals for their patients in order to attract new patients. As research evidence has shown, however, the response has been somewhat different. Amid fears of creating preferential services for fundholding patients, practices have not competed in this way thus weakening their price sensitivity.	Weak
Importance of Industry Service to Buyers' Service: Secondary care services form a component of the primary care service in that primary and secondary care should be integrated and thus viewed by the patient as a single health service. It may be the case that if a patient receives poor hospital treatment that it reflects badly on the referrer (GP). Moreover, if the patient receives poor hospital services then it will increase his/her attendance in the GP practice and the patient may not be able to distinguish what components of the care they receive ought to be primary or ought to be secondary care. This increases price sensitivity.	Strong
Buyer Power - Weak	
Size & Concentration of Buyers & Suppliers: In the main cities there is generally a choice of provider. GPs therefore, have the option of sourcing services without having to travel too great a distance. This gives buyers some power over providers. However, access (and therefore real choice) is a limiting factor to this power. In areas of poverty, high unemployment and/or deprivation, patients often do not have access to private cars and must rely on public transport to travel to hospital. For example, patients in Hamilton (Lanarkshire) may have difficulty in travelling into Glasgow even although there are only a few miles between the two locations. Patients are thus restricted to the 2 Lanarkshire acute providers. In rural and remote areas, GPs are often faced with more restricted choices. This may be because there are fewer providers compared with the large cities. It is also affected by access. Travelling from rural areas can be problematic because public transport is often inadequately provided. In remote areas, patients may have to travel considerable	Strong - Weak

[9] As Chapter 4 goes on to show, some services are more readily defined and specified (eg, laboratory services) but they are in the minority. Non comparability derives for difficulties in defining, costing and measuring the quality of the procedure.

distances by land, air or sea. Clearly these factors strengthen the position of the supplier. Technically, therefore, in the cities, GPs have greater buyer power than those in rural or remote areas.	
Buyer Information: One of the arguments in support of fundholding was that GPs had better access to information about hospital services. (See also Box 3.1 below). In theory, GPs could use this information, coupled with prices and league tables as their basis for provider choice. However, as this chapter discusses more fully later on, and as Chapters 4 and 8 discuss, GPs and HAs/HBs have had to make do with very little formal information and that which they do have is often ambiguous, incomplete, noncomparable and sometimes unreliable. This reduces their ability to bargain.	Weak
Scope for Vertical Integration: There is limited scope for backward integration. Although GPs have to offer certain general medical services they can now offer minor operative procedures and other services previously offered within the hospital. There are limitations however. Only a small minority of secondary care services can be provided without specialist skills and equipment. GPs may lack sufficient funds to buy the required specialist equipment or may not have the capacity or demand to offer services on the scale necessary to achieve the necessary economies. The size of the practice premises is often a constraint. The range of areas in which GPs may experience vertical integration are, however, limited relative to the overall proportion of secondary services.	Medium - Weak

Although GPFHs appear to have a medium degree of price sensitivity and are weak in terms of buyer power, it is important to bear in mind that they operate in an environment which is politically driven and highly politically sensitive. Given that there is an onus on Trusts to be responsive to purchasers there may be a degree to which buyer power is enhanced because of political power, an element not accounted for in Porter's framework. Moreover, relative to health authorities, GPs were thought to have a number of advantages as purchasers (see Maynard 1986; Glennerster et al. 1994). These were discussed in Chapter 2 but are presented in Box 3.1 as a reminder.

Box 3.1 Advantages of the Fundholding Model

- GPs have better information than Health Authorities about the needs and preferences of their patients. They can form opinions as to the level of service obtained from hospitals and consultants because they see patients before and after hospital attendance.
- GPs suffer if the care given to their patients is slow or inefficient because the frequency of visits by the patient to the GP increases, taking time and resources and draining the GPs energy. There is, therefore, an incentive to seek more efficient hospital services.
- GPs could take marginal decisions to buy or not to buy services from a hospital or community trust, signalling a dissatisfaction with quality. There would be no inhibitions about using their power of exit compared with HA/HBs who because of the scale of impact, would find it politically difficult to remove contracts from local hospitals.
- Although it is limited, GPs do face some competition for patients from other GPs.
- By being responsible for drugs spending, there's an incentive to give thought to how money should be allocated. GPs can think holistically and economically about the uses for the money - eg, less drugs and more therapy. This argument also applies to the purchase of hospital care.

3.6 Governing Market Transactions

As Chapters 1 and 2 have already discussed, the mechanism for expressing and realising purchasing intentions in the NHS market is the contracting mechanism. It is important to now consider the characteristics of the contracting mechanisms and the GPFH transactions with their providers.

There are three theoretical types of contract which can govern market exchanges: classical, neoclassical and relational (Ferlie 1992; Williamson 1996b)[10]. As the following discussion will show, NHS contracts[11] were expected to be neoclassical but were in fact relational.

3.6.1 Classical Contracts

Classical contracts are best suited to an environment where there are many buyers and suppliers and where good product information is available. Classical contracts suit the exchange of homogeneous products for which price is the basis for selecting the product, the market environment is relatively stable and the identity of the supplier is of no consequence to the exchange. The classical contract is seen as discrete and clear and the parties to the contract are irrelevant. It is also formal, carefully delimited, emphasises legal rules and formal documentation, and accounts for some anticipated future events. Since market alternatives are available, efforts to sustain any relationship between the parties are irrelevant and disputes are resolved in a court of law.

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[10]These are not the only terms used. Sako (Sako 1992) for example distinguishes between Arm's length Contractual Relations (ACRs) which are similar to classical contracts, and Obligational Contractual Relations (OCRs) which are similar to relational contracts. Kay (1993) refers to perfunctory contracts (classical) and consummate (relational).

[11] Chapter 1 described four types of NHS contract: block, cost and volume, limited volume and cost-per-case.

3.6.2 Neoclassical Contracts

When contracts are long-term, conditions uncertain, products complex and difficult to define or where there is a transaction-specific investment[12], classical contracts are unsuitable. Under these conditions, it is either extremely costly or impossible to anticipate at the outset all future contingencies for which adaptations need to be stipulated. Consequently, an alternative form - the neoclassical contract - has evolved. Neoclassical contracts are long-term contracts, characterised by gaps in planning which allow parties to be more flexible in their agreements. Where there are gaps in the planning, parties expect to adapt to the circumstance prevailing at the time, a flexibility which creates pressure on parties to maintain a social relationship. In the event of any dispute, parties do not turn to a court of law for a resolution but to arbitration by a higher administrative tier. This type of contract dominates the building industry and was expected to dominate health services.

3.6.3 Relational Contracts

A third form - the relational contract - has evolved to cope with the increasing duration and complexity of contracts as well as the increasing degree to which transactions are asset-specific[13]. Contracts are relational where "discreteness is fully displaced as the relation takes on properties of a minisociety with a vast array of norms beyond those centred on the exchange and its immediate processes."[14] (Williamson 1996b). Ferlie adds that, "the contract is increasingly embedded in a social relation with its own history and norms ...The reference point may not be the initial contract document, but rather the history of the relation as it has developed through time." (Ferlie 1992). For relational contracts, sanctions are more informal than formal.

It was expected that NHS contracts would be neoclassical and *Working for Patients*

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[12] Transaction-specific investments are discussed below.

[13] See later discussion.

[14] R Macneil "Contracts: Adjustment of Long-Term Economic Relations under Classical, Neoclassical and Relational Contract Law" **72** Nw. U. L. Rev 854 (1978) quoted in Williamson (Williamson 1996b)

proposed the set up of an internal (administrative) arbitration function to handle contract disputes. Given the complexity of health care services, however, neoclassical contracts have proved inappropriate. Flynn et al (1996) make this point very clearly following a longitudinal study of contracting in three health authorities in England:

> "In order to create a contract, certain minimal conditions or prerequisites are necessary: the objective or service to be bought must be defined, the amount to be bought and sold must be agreed, the price for the exchange must be agreed, any conditions about the transaction and about quality must be set out, and terms agreed for the parties to cancel or withdraw from the contract. In the NHS quasi-market there are fundamental problems at each stage of this process, and this is compounded by the enormous complexity of, and variation between, specialties and procedures. We argue that, *comparatively*, acute medical and surgical specialties are *relatively* easier to define, codify and calculate for contracting purposes than those elements of health service which are more continuous and comprise 'care' rather than 'cure' ... However, even within the acute sector there are difficulties in agreeing standardised systems for coding: there are 13,000 different diseases and procedures. Consequently, 'there is not, as yet, an accepted consistent way of grouping diagnoses for treatment into useful categories for contracting' (National Audit Office 1995: 12)[15]. In community health services, the range of different nursing and other para-professional staff involved, the variety of forms of treatment and settings, and the heterogeneity of clients and conditions all combine to exacerbate these inherent difficulties. Nevertheless, purchasers and providers are required to make contracts which agree activity (the volume of service), price and quality." (pp12-13)

Flynn et al (1996) point out that information was poor and in their study, activity statistics (based on FCEs (Finished Consultant Episodes) in the acute sector and

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[15]National Audit Office (1995) *Contracting for Acute Health Care in England.* Report by the Comptroller and Auditor General. London: HMSO

community contacts in the community sector) were frequently regarded as crude and unreliable. Contracts based on these quantifications of activity tended to underestimate workload. For example, a note through the door to a patient could not be differentiated from a 4-hour counselling session with a family experiencing terminal illness. Moreover, purchasers were continually needing to request more consistent and reliable cost information. Although policy required that "provider prices should be the same as actual costs, that costs should be full cost and that providers must not cross-subsidise different contracts, procedures or specialities." (ibid. pp14-15), Trusts found it very difficult to calculate and apportion costs associated with every component of health service diagnostic treatment and associated overhead costs.

3.7 Transactions Costs

As Chapter 2 pointed out, the introduction of the market system led to concerns about transactions costs, ie, costs associated with market contracts. These costs arise with all 3 contract types as Blois (1990) (quoting from Coase[16]) explains:-

> " ...Coase's statements that 'The most obvious cost of "organising" production through the price mechanism is that of discovering what the relevant prices are' and 'the costs of negotiating and concluding a separate contract for each exchange transaction which takes place on a market must also be taken into account' indicate that these costs do arise from a variety of activities."

Williamson further developed the concept of transactions costs when trying to understand the conditions under which it was more efficient to internalise costs through vertical integration. He developed a framework to explain the circumstances within which markets fail (the 'organisational failures framework') and went on to identify the cost bearing and cost economising dimensions of transactions. Having done so, Williamson combined these frameworks into one overall framework to identify the most efficient forms of governance given certain market conditions and transaction characteristics.

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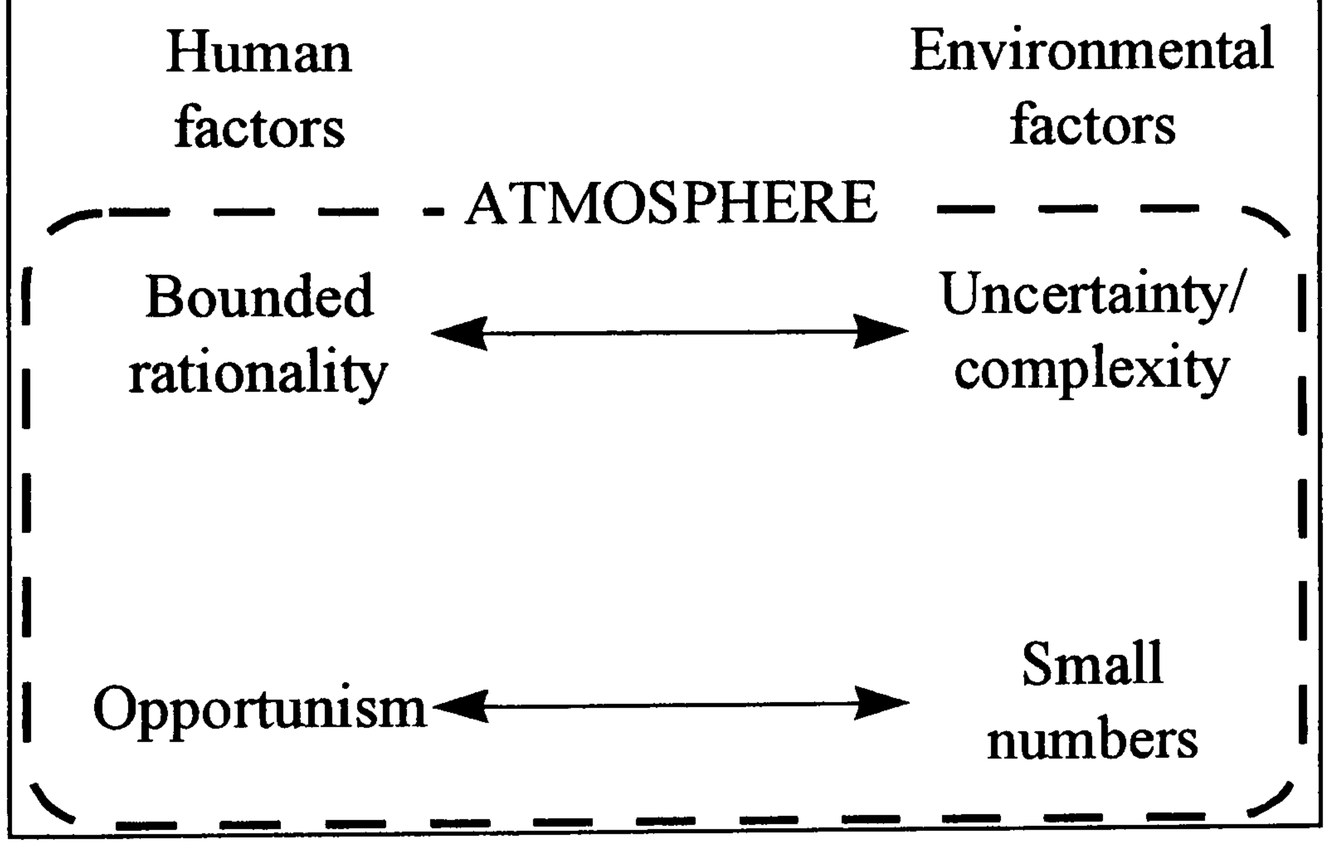
[16]Coase, R. H. "The nature of the firm", *Economica*, **4**, 1937, pp. 386-405

3.8 The Organisational Failures Framework

Williamson brought together the conditions in which transactions costs were thought to arise. The framework incorporates not only market/economic conditions but also human conditions (see Figure 3.1). Williamson argued that whilst branches of economics have tended to treat the theory of firms on the basis of the transaction, price and so forth, they have omitted "the elementary attributes of human decision makers - of which opportunism is one, and bounded rationality is another" (Williamson 1975:24).

Figure 3.1: The Organisational Failures or Transactions Cost Framework
Source: Douma and Schreuder 1991



In a perfect market, transactions are carried out without transactions costs. Information is freely available, decision making is characterised as being rational, there are alternative buyers and suppliers "and there are no carry-over effects from one period to the other of a specific transaction between two parties in the market." (Johanson and Mattsson 1991) When these conditions do not prevail, however, efforts are required to organise, carry out, control and enforce transactions. Faced with the risk of such costs, firms may decide to bypass the market and organise the transactions internally (Williamson 1975). In other words, the market arrangement fails and transactions are internalised.

3.8.1 Bounded Rationality & Opportunism

The framework includes two aspects of human behaviour: bounded rationality and opportunism. Bounded rationality, first explained by Herbert Simon[17] proposes that "The capacity of the human mind for formulating and solving complex problems is said to be very small compared with the size of the problems whose solution is required for objectively rational behaviour in the real world." (Williamson 1975:9) Human rationality is bounded by neurophysiological and language limits. The former refers to the ability to receive, store, retrieve, and process information without error. The latter refers to the inability of individuals to articulate their language and feelings in words, numbers or graphics in such a way that they are fully understood by others. In conditions of complexity and uncertainty then the limits on human rationality create a problem for buyers and suppliers because it is impossible to anticipate all possible contingencies for any one set of decisions.

The second human condition Williamson allows for is opportunism. Williamson defines opportunism not as strategic self-interest but as "self-interest seeking with guile", which "has profound implications for choosing between alternative contractual relationships." (Williamson 1975:26). Opportunism involves making "false or empty, that is, self-disbelieved, threats and promises" in order to realise some individual advantage (ibid. p26) and may be manifest in the manipulation of information or the misrepresentation of intentions (eg. making false promises regarding future conduct). Although Williamson acknowledges that one need not assume economic agents are opportunistic most of the time, he asserts that it is " important is to be alert to potential contractual hazards and, if and as these arise, to make provision for cost-effective safeguards." (Williamson 1996a) However, it is impossible to distinguish *ex ante* (prior to the exchange) or *ex post* (after the exchange or contract has occurred) who is honest and who is dishonest (Douma and Schreuder 1991), so contract monitoring is required.

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[17]Simon, Herbert A. 1957 *Models of Man*. New York: John Wiley & Sons.

3.8.2 Small Numbers & Information Impactedness

In addition to the two human conditions, the organisational failures framework accounts for two market/economic conditions: small numbers and information impactedness. Where there are only a few sellers, the supplier may not have to worry about his/her reputation because the buyer has no alternative source of supply. Small numbers situations can arise *ex ante*, where there is, for example, only one buyer and one supplier (bilateral monopoly). Both parties will want to exchange a quantity of the good/service which is profit maximising but will need to expend considerable resources in negotiating over price. Small numbers may also arise *ex post* at the stage of contract renewal: "Although a large-numbers exchange condition obtains at the outset, it is transformed during contract execution into a small-numbers exchange relation on account of (1) idiosyncratic experience associated with contract execution, and (2) failures in the human and nonhuman capital markets." (Williamson 1975:29).

Information impactedness derives from the combined conditions of uncertainty and opportunism. It occurs when some circumstances relevant to the transaction are known to one or some of the parties, but cannot be made known to the other party or parties without costs being incurred. One party may, for example, have specific task or transaction experience which is not available to a competing firm and so can be used strategically to win the contract. Alternatively winners of initial contracts may gain advantages over future competitors because of the experience, information and know-how[18] acquired during the contract period. Consequently, ex ante multiple supplier conditions are altered and disparity arises. This may ultimately give way to firms integrating vertically.

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[18]The distinction between know-how and information is made clearly by Kogut and Zander (Kogut and Zander 1997). Information here is taken to mean facts, axiomatic propositions and symbols, which do not lose their integrity when transmitted because the rules for deciphering it are known. Know-how implies knowing what something means and knowing how to do it. Quoting from Von Hippel's definition in *The Sources of Innovation* (1998), the definition Kogut and Zander adopt is that "know-how is the accumulated practical skill or expertise that allows one to do something smoothly and efficiently" (312).

3.8.3 Atmosphere

The final element of Williamson's framework is atmosphere, a condition which makes "allowance for attitudinal interactions and the systems consequences that are associated therewith." (Williamson 1975:37) He critiques standard economic models for ignoring attitudinal intentions and considering individuals as only neutral or instrumental whereas "it may be more accurate, and sometimes even essential, to regard the exchange process itself as an object of value" (ibid. p38). Here Williamson introduces the exchange relation into the model and "*...supplying a satisfying exchange relation* is made part of the economic problem .." Taking blood donation as an example, Williamson argues that there is intrinsic value in the act of donating blood which is altered or perhaps lost if the transaction is commercialised. "It seems reasonable to believe that voluntary donors derive satisfaction partly from their sense of indispensability." (ibid. p38) If donation is commercialised, donors' sense of being essential may be impaired because they know the system can adjust to blood shortages by increasing the price of blood.

3.9 Transaction Specificity

Whilst the organisational failures framework suggests conditions under which markets may fail, Williamson went on to identify specific characteristics of transactions which incur costs or yield economies. He proposed that there are 3 critical dimensions for characterising transactions: uncertainty, frequency of occurrence and the degree of transaction specific investment. Williamson maintained that "...the most critical dimension for describing transactions is the condition of asset specificity." (Williamson 1985:30) because it can be a source of economic value:

> "Parties engaged in a trade that is supported by nontrivial investments in transaction-specific assets are effectively operating in a bilateral trading relation with one another. Harmonising the contractual interface that joins the parties, thereby to effect adaptability and promote continuity, becomes the source of real economic value." (Williamson 1985:30)

Where products are unspecialised, there are few hazards and there are likely to be

several alternative sources of supply and custom. However, difficulties arise when the **specific identity** of one of the parties has important cost-bearing consequences. These transactions are termed ***idiosyncratic*** (Williamson 1996b). If, for example, a buyer induces a supplier to invest in specialised capital, specific to that transaction (eg highly specialised production equipment), then the supplier becomes 'locked into' that buyer to a significant degree. The buyer too may be locked in if alternative sources of supply are costly and/or use unspecialised capital.

More commonly, however, the investment is not in specialised physical capital but **human capital**. Economies in production arise, for example, because of specialised training and learning-by-doing. These cannot often be transferred to alternative suppliers at a low cost and the benefits to the buyer and the supplier are only realised if their relationship is maintained.

A further set of economies can also be transaction specific - communication economies: "specialised language develops as experience accumulates and nuances are signalled and received in a sensitive way. Both institutional and personal trust relations evolve." (Williamson 1996b:173) That these types of transactions evolve into relational contracts is influenced by the fact that:-

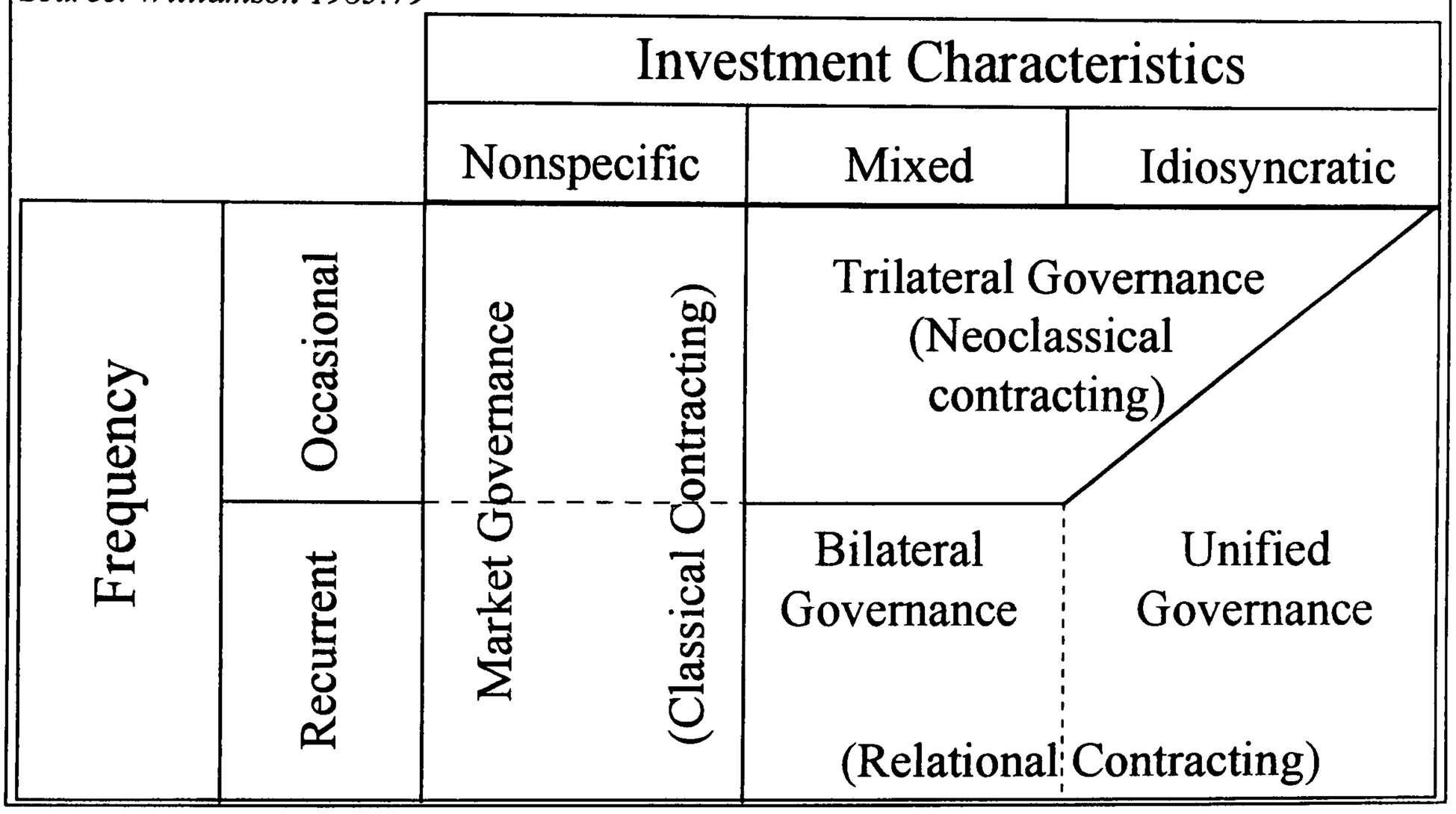
> "Although large-numbers competition is frequently feasible at the initial award stage for recurring contracts of all kinds, idiosyncratic transactions are ones for which the relationship between buyer and supplier is quickly thereafter *transformed* into one of bilateral monopoly - on account of the transaction-specific costs ..." (Williamson 1996b:174)

3.10 Contracts Types and Forms of Governance

In 1985, Williamson developed his transactions cost approach to incorporate bounded rationality, small numbers etc, into 2 key dimensions which he proposed would determine the most efficient form of governance; these dimensions were the frequency of transactions and the degree to which they were asset specific (Williamson 1985). Figure 3.2 identifies the types of transactions and the most efficient governance with

which they are associated. Market governance was deemed by Williamson to be the most efficient for non-specific transactions which were either occasional or recurrent since "both parties need only consult their own experience in deciding to continue a trading relationship or, at little transitional expense, turn elsewhere. Being standardised, alternative purchase and supply arrangements are presumably easy to work out." (ibid, p74) The relation between buyer and supplier is not valued and litigation is only a means of settling claims.

Figure 3.2: Efficient Governance
Source: Williamson 1985:79



Where transactions involve mixed or highly transaction specific investments, Williamson believes that trilateral governance is required. Where these transactions are occasional though, it is difficult for parties to recover the costs incurred in setting up the governance structure so unified governance (a single firm) may prove more efficient. Bilateral governance is appropriate where transactions are mixed and recurrent. The parties to the exchange maintain their autonomy but engage in a relationship where the relation is of greater importance than the contract. Where transactions are idiosyncratic and recurrent, unified governance is appropriate and may be achieved through vertical integration of buyer and supplier. Williamson writes,

> "Highly idiosyncratic transactions are ones where the human and physical

assets required for production are extensively specialised, so there are no obvious economies to be realised through interfirm trading that the buyer (or seller) is unable to realise himself (through vertical integration). In the case, however, of mixed transactions, the degree of asset specialisation is less complete. Accordingly, outside procurement for those components may be favoured by scale economy considerations. As compared with vertical integration, outside procurement also maintains high-powered incentives and limits bureaucratic distortions." (ibid, p76)

As transactions become progressively more idiosyncratic, according to Williamson, the incentives for trading weaken. This is because assets (human and physical) become more specialised to the point of having a single use and are therefore less transferable to other uses. The key issue then becomes one of which mode of governance allows for adaptations. Williamson writes that "The advantage of vertical integration is that adaptations can be made in a sequential way without the need to consult, complete, or revise interfirm agreements." (ibid, p78) Williamson's argument is that "market contracting gives way to bilateral contracting, which in turn is supplanted by unified contracting (internal organisation) as asset specificity progressively deepens." (ibid, p78)

3.11 Transactions Costs in the NHS

The emphasis on efficiency within the government's 1990 policy makes the transactions costs perspective particularly appropriate to any discussion about the NHS market. Williamson states that the "criterion for organising commercial transactions is assumed to be the strictly instrumental one of cost economising. Essentially this takes two parts: economising on production expense and economising on transaction costs. To the degree that transaction costs are negligible ... [the market] ... will be the most cost-effective means of procurement" (Williamson 1996b:177)

Earlier in this chapter, it was noted that GP purchasing takes place within an environment characterised by bounded rationality, information impactedness and small numbers, conditions which, according to Williamson, when combined with

opportunism would give rise to transactions costs. In Chapter 2 it was shown that there is information asymmetry between purchasers and providers and there is little information upon which purchasers can base purchasing decisions. Because of poor provider information, it becomes difficult for GPFHs to switch provider on the basis that they cannot compare like with like, and have limited knowledge about the service quality. It is likely, therefore, that information impactedness will characterise the contracting environment and, as Williamson indicates, initial providers will learn from their experience and gain information and know-how giving them an advantage over other providers and further reducing the likelihood of provider switching. Products are complex and difficult to delineate within a contract and there is considerable uncertainty within the market environment.

Two crucial dimensions though were presented in Figure 3.2 - frequency of occurrence and transaction specificity - as the dimensions which Williamson proposes would determine the most efficient form of governance for NHS transactions. The UK government originally envisaged a market in which GPFHs and Trusts would engage in annual contracts (short-term contracts), for defined services. In Williamsonian terms these would be recurrent contracts as opposed to occasional. The degree to which GPFH contracts are, or might be, asset specific is, however, difficult to ascertain. Studies show that GPFHs have been purchasing from local providers or hospitals where they know the consultant to whom they refer their patients. Local knowledge, experience with the hospital, and social contacts have been important determinants in placing contracts (see Chapter 4). GPFHs have, on occasion, removed their contracts and sought provision elsewhere. This has usually been when waiting times/lists have become intolerably long, or because practices have failed to negotiate an open/direct access service from their provider or where they can obtain more rapid diagnostic/investigative services. More infrequently, patients have travelled (sometimes considerable distances) for private sector treatment to alleviate pressure on waiting lists.

This evidence would suggest that GPFH contracts are not highly asset specific. Indeed, there are certain factors which are likely to reduce the scope for asset-specificity. Human investments are likely to be constrained by the fact that clinical

staff receive nationally governed, standard training and experience to treat the general population whose health needs are likely to be relatively similar across the GP population. GPs are, therefore, unlikely to be in need of customised technical skills from hospital staff and hospital staff are, therefore, unlikely to develop skills/expertise unique to any (set of) customers. Human asset specificity is also likely to be constrained by the fact that hospital doctors are a mobile cohort and often stay for very short periods of time in one Trust.

A further constraint on asset specificity is the fact that Trusts are required to provide a set of core services. They are, therefore, likely to require standard, not customised, equipment. This reduces the likelihood of capital asset specificity.

Despite these constraining factors, there may nevertheless be certain communication economies which are transaction specific. Williamson (1985) notes that parties can develop a specialised language as experience accumulates and evolves. It is possible, therefore, that because GPFHs and Trusts have had to learn to operate in a new market environment and have had to do so as partners in a contracting process, they may have developed a common language and a shared trust and understanding which represents a non-marketable investment.

It would seem, therefore, that GPFH contracts are mixed, rather than non-specific or idiosyncratic. As they are also recurrent, according to Williamson's schema, they are most efficiently conducted under a bilateral form of governance through relational contracting. This form of governance does not require third party arbitration as neoclassical contracting does and so saves on the costs of setting up a governance body to monitor performance and resolve disputes. Bilateral governance also limits the bureaucratic distortions associated with the single firm (Williamson, 1985). However, Williamson suggests that "Problems with market procurement arise ... when adaptability and contractual expense are considered. Whereas internal adaptations can be effected by fiat, outside procurement involves effecting adaptations across a market interface." (Ibid., p76) In other words, the buyer and supplier need to consult, complete or revise their agreements which restricts sequential adaptation to changing circumstances and incurs contract-related costs.

3.12 A Relational Perspective

Williamson's TCE theory focuses on the transaction as the unit of analysis. Williamson proposes, however, that different contracts are suited to different forms of governance or inter-organisational relationship. This brings the discussion to a different level, the relational level. In relational contracting, the identity of the parties is significant and there is pressure for the relationship to continue over time. Such relationships go beyond simply the content of the material transaction: "... empirical observations ... demonstrate that the relationship interaction between suppliers and customers that are important to each other is not only - and in many cases not even primarily - a matter of buying and selling." (Blankenburg Holm, Erriksson, and Johanson 1999). Their interaction can be described as a process of social exchange between the actors (op cit.). Such relationships are socially embedded[19] (Ferlie 1994; Ferlie and Pettigrew 1996) and each relationship "is at every point in time a result of its history." (Blankenburg Holm, Erriksson, and Johanson 1999)[20].

Not only should relational contracts be considered within a social and historical context, but as Blankenburg et al (1999) go on to suggest, although business relationships are distinctive entities that can be analysed (as TCE theory treats them) they can be better understood if they are considered in the context of the transacting firms' co-operation in relationships with other parties. Thus, "...the dyadic relation should be considered within the context of the direct exchange network surrounding the dyad." (ibid). (See also Harland 1996).

3.13 Networks

There has been a growing interest in the subject of networks during recent years. On one hand, it has been noted that relational contracts require an alternative form of governance somewhere between markets and hierarchies (Jones, Hesterly, and Borgatti 1997). This form has frequently been described as a network (Barney and Hesterly

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[19] See later discussion on social embeddedness.

[20] Levinthal, Daniel A. & Mark Fichman. 1988. Dynamics of interorganisational attachments: Auditor-client relationships. *Administrative Science Quarterly*. 33:345-69

1999) and is increasingly common in a range of industries (for example in the semiconductor, bio-technology, film, music, financial services and fashion industries (Jones, Hesterly, and Borgatti 1997)). On the other hand, interest in networks has grown from the recognition that in business relationships "the pursuit of economic goals is normally accompanied by that of such non-economic ones as sociability, approval, status and power and economic action (like all action) is socially situated, and cannot be explained by individual motives alone; it is embedded in ongoing networks of personal relations rather than carried out by atomised actors ..." (Granovetter 1992)[21].

Whilst there is general agreement on the characteristics of networks, the term lacks an agreed definition (Jarillo 1990). Jones et al (1997) identify a number of terms and definitions used under the umbrella of "interfirm co-ordination that is characterised by organic or informal social systems, in contrast to bureaucratic structures within firms and formal contractual relationships between them". For example, 'interorganisational networks' (Alter and Hage 1993); 'alliance capitalism' (Gerlach & Lincon, 1992[22]); 'business groups' (Granovetter, 1995[23]) and 'network organisations' (Miles & Snow, 1992[24]). From the definitions they identify, Jones et al developed an integrated definition and termed it 'network governance':

> "... a select, persistent, and structured set of autonomous firms (as well as nonprofit agencies) engaged in creating products or services based on implicit

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[21] Earlier in the chapter, reference was made to two opposing views of networks. On the one hand some regard the network as a hybrid form of organisation somewhere between market and hierarchy (see for example (Williamson 1985; Jarillo 1990; Miles and Snow 1996). On the other hand, some regard it as a distinct form of organisation (see for example (Ouchi 1991; Powell 1991)) which is "neither a market transaction nor a hierarchical governance structure, but a separate, different mode of exchange, one with its own logic" (Powell 1991) (p269).

[22] Gerlach, M.L. & Lincon, J.R. 1992. The organisation of business networks in the United States and Japan. In N. Nohria & R.G. Eccles (Eds.) *Networks and organisations: Structure, form, and action:* 491-520. Boston: Harvard Business School Press

[23] Granovetter, M. 1995. Coase revisited: Business groups in the modern economy. *Industrial and Corporate Change.* 1: 93:130

[24] Miles, R.E., & Snow, C.C. 1992. Causes of failures in network organisations. *California Management Review.* 28(3): 62-73.

and open-ended contracts to adapt to environmental contingencies and to co-ordinate and safeguard exchanges. These contracts are socially - not legally - binding." (ibid).

3.14 Network Characteristics

Although definitions of networks differ considerably, there is a greater consensus about network characteristics. Network characteristics include, for example, mutuality, complementarity, reciprocity, conflict and collaboration and these exist within the totality of connections between various actors (or nodes) (Knoke and Kuklinski 1991). These connections extend to include buyers, suppliers, suppliers' suppliers and the customers of buyers, competing companies and many others with whom the actors are connected directly and indirectly. There are potentially four levels of network analysis (Knoke and Kuklinski 1991): (1) egocentric - the simplest form which looks at an individual node, it's connections and the relations among them; (2) dyad - a relationship formed by a pair of nodes; (3) triad - formed by selecting each possible subset of three nodes and their linkages; (4) the complete network - all the possible connections between the nodes. The discussion which follows applies to each of these levels.

3.14.1 Co-operation and Competition

Firms within the network are considered to be interdependent relying on open-ended relational contracts (Powell 1991) and because market conditions continue to prevail, both competitive and co-operative forces are combined as Johanson and Mattsson describe (Johanson and Mattsson 1991):

> "We stress complementarity in the network. There are also, of course, important competitive relations. Other firms want to get access to specific exchange possibilities, either as sellers or buyers, and co-operating firms also have partly conflicting objectives. The relationships imply that there are *specific interfirm dependence* relations ... this model of industrial markets implies that a firm's activities in industrial markets are *cumulative processes* in the sense the relationships are constantly being established, maintained,

developed and broken ... through its activities in the network the firm develops the relationships that secure its *access to important resources* and the sale of its products and services." (p257)

"The exchange implies some kind of mutuality - that is, the involved actors give to and receive from one another ..." (Hakansson and Johanson 1993:39) thereby making them interdependent. This interdependence extends not only to the network actors, but to the *activities and resources*; all three are interdependent. Hakansson and Johanson argue that "each actor controls certain activities and resources directly, but because the dependencies to some extent mean control, the actor has indirect control over the counterparts' activities and resources." (p36). What is more, each activity is dependent to some extent on the performance of other activities and so the activities of the other actors are themselves interrelated in what Hakansson and Johanson term a chain of activities[25]. The actors, activities and resources form a web of "relatively interdependent activities" in an industrial network. This web and the connections which form it will change continuously because actors will acquire new knowledge, may alter their intentions or may have different resources available to them over time.

It is important to note before going further in the discussion that three assumptions can be made about network actors:-

1. All actors control certain resources/activities.
2. They are purposeful in their action and act in order to make economic gain in a general sense.
3. They have bounded knowledge and they are well aware of this. Thus, much of their action and interaction aims at gaining knowledge. (Hakansson and Johanson 1993:39)

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[25]Hakansson and Johansson stress that they are not referring to generic value chains suggested by Porter (*Competitive Advantage: Creating and Sustaining Superior Performance*, New York: Free Press, 1985). Instead, they are referring to activities which are "enacted; they are emergent phenomena that are formed and modified through interaction among the actors."

3.14.2 Co-ordination, Price & Reputation

Co-ordination and mutual interest is achieved in part through "... a set of more or less implicit rules, which are related to the exchange in the same way as language is related to communication. The rules are formed, reinforced, and modified through exchange ... They view one another as specific counterparts, they have some knowledge about one another; they have some trust in one another; and they are aware of and may even share one another's interests ..." (Hakansson and Johanson 1993:39) Having recognised their common interests, the need for adjustments among the interdependent firms concerning quantity and quality of goods and services exchanged, and the timing of such exchange, call for more or less explicit co-ordination through *joint planning*, or through power exercised by one party over the other..." (ibid, p256, emphasis added).

The role of price in the network differs from the market. Croxson (1997) points out that opportunities for short term gain are foregone in the interest of sustaining an integrated buyer-supplier relationship: "These opportunities appear if one part is offered a more favourable price by a third party, or if one party could extract economic rent from the other by acting opportunistically. Co-operative relationships will therefore be characterised by some degree of expected longevity ... and by the use of information other than prices to allocate resources."

Reputation plays an important part in network relationships. Granovetter (1985) argues that:

> "The widespread preference for transacting with individuals of known reputation implies that few are actually content to rely on either generalised morality *or* institutional arrangements to guard against trouble ... Better than the statement that someone is known to be reliable is information from a trusted informant that he has dealt with that individual and found him so. Even better is information from one's own past dealings with that person. This is better information for four reasons: (1) it is cheap; (2) one trusts one's own information best - it is richer, more detailed, and known to be accurate; (3) individuals with whom one has a continuing relation have an economic

motivation to be trustworthy, so as not to discourage future transactions; and (4) departing from pure economic motives, continuing economic relations often become overlaid with social content that carries strong expectations of trust and abstention from opportunism."

3.14.3 Information

Powell (1991) proposes that networks are particularly apt for circumstances in which there is a need for efficient, reliable information. "The most useful information is rarely that which flows down the formal chain of command in an organisation or that which can be inferred from shifting price signals. Rather, it is that which is obtained from someone whom you have dealt with in the past and found to be reliable. You trust best information that comes from someone you know well." (p272) As a result, networks are especially useful where the value of commodities is not easily measured. Know-how, technological capability, production styles and innovative approaches to production are just some characteristics which are difficult to cost within a contractual relationship. Therefore, "the open-ended, relational features of networks, with their relative absence of explicit *quid pro quo* behaviour, greatly enhance the ability to transmit and learn new knowledge and skills." (p272)

3.14.4 Reciprocity & Trust

Reciprocity is central to networks but is difficult to define because it may not be readily visible as equal value exchanges but may involve indebtedness and obligation over the long term (Powell 1991). Integral to long-term reciprocity is trust which, in Powell's words, is "a remarkably efficient lubricant to economic exchange ... Trust reduces complex realities far more quickly and economically than prediction, authority or bargaining." (p273) For trust to be engendered, however, parties must have mutual interests and behave according to standards that neither can determine individually (op cit.).

Sako (1992) defines three types of inter-organisational trust:

- *Contract Trust* - characterises all contracts, even arm's length (spot)

contracts where parties retain their independence. They still trust one another to behave in a mutually acceptable manner, ie, to uphold universalistic ethical standards of keeping promises - agreeing to produce and deliver goods on the basis of written orders, obeying the law, expecting payment within a given period of time after delivery etc.

- *Competence Trust* - concerns the expectation of a trading partner performing its role competently in terms of technical and managerial competence - "... a buyer may either entrust a supplier to carry out a task which the buyer itself has the ability to carry out, or it may entrust a specialist to carry out tasks whose technicalities are outside of his capability." (Sako 1992:37-38) This may or may not involve inspection of quality on delivery (much of this having been mitigated by the increase in quality assurance by suppliers).
- *Goodwill Trust* - exists only within what Sako terms Obligational Relational Contracts (ORCs) which are akin to the relational contract. It refers to mutual expectations and open commitment between parties and "may be defined as the willingness to do more than is formally expected " (ibid. p38) There are no explicit promises to fulfil as with 'contractual trust', nor fixed professional standards to be reached, as with case of 'competence trust'. Someone worthy of 'goodwill trust' is dependable, endowed with discretion, and can be trusted to take initiative without taking unfair advantage.

Buyer and supplier reputation is important for the development of trust. At the outset when economic actors are perhaps unfamiliar with one another trust may be 'fragile' (Smith Ring 1997). A good reputation may be sufficient to permit reliance on fragile trust until more 'resilient' trust can be developed. Network relationships will be important sources of information regarding each party's reputation (ibid.).

3.14.5 Knowledge Sharing, Research & Innovation

Relational interaction promotes the development of knowledge (Johanson and Mattsson 1991; Harland 1996; Stuart 1997) which means that the network is an important source of knowledge for individual firms. As Hakansson and Snehota

(1989) explain, "The interaction between the parties in a relationship entails more than just passive adaptation. While the two parties are interacting, their problems are confronted with solutions, their abilities with needs etc. Reciprocal knowledge and capabilities are revealed and developed jointly and in mutual dependence by the two parties ...". Alter and Hage (1993) suggest that ongoing development of inter-organisational networks is perpetuated because of "the growth in knowledge, produced by steadily increasing investments in research and the rapid technological changes that result." (p20) Moreover, networks can "integrate diverse and disparate pieces of new knowledge ... [and] ... allow the combination of different kinds of expertise." (ibid. p28)

Choi and Lee (1997) argue that networks may be more efficient than markets for knowledge integration and transfer. This in turn has a significant impact on the opportunities for investment, research and innovation. Whilst short-run price-competition improves efficiency by encouraging one-off cost reductions (Croxson 1997), it may also impede investment in innovation which would yield sustained cost reductions. Croxson writes, "It is important to remember that the benefits of vying over prices are generated by a static model which does not recognise that, in a dynamic context, 'vying' over *given* resources may stifle growth-promoting innovation." (ibid).

Grabher (1993b) warns, however, that if relationships are over- or under-socialised, "Too little embeddedness may expose networks to an erosion of their supportive tissue of social practices ... Too much embeddedness, however, may promote a petrification of this supportive tissue and ... pervert networks into cohesive coalitions against more radical innovations." (Grabher 1993a)

3.14.6 Learning & Adaptation

Through inter-firm exchange, parties test how well they fit together in a process that is "not only a learning process but also an *adaptation process*." (Johanson and Mattsson 1991:258) Adaptations may for example, be technical (eg, modifying products or production processes), logistical (eg, adjusting stock levels), administrative (eg, modifying planning or scheduling systems) or financial (eg, handling payments in special ways).

Attitudes and knowledge are also the subject of adaptations (eg, by working together in some technical development matter). This, Johanson and Mattsson suggest, results in a common language regarding technical matters, contracting rules and the standardisation of processes, products and routines. "A most important aspect of mutual orientation is mutual knowledge, knowledge which the parties assume each has about the other and upon which they draw in communicating with each other. This mutual knowledge may refer to resources, strategies, needs and capabilities of the parties and, in particular, to their relationships with other firms. It is a subtle knowledge based on personal experience, and takes time to develop." (p259)

As a consequence of adaptation, firms "utilise and strengthen the interdependencies of their activities." (Hakansson and Johanson 1993:40), and through learning, adapt their activities in a way which increases joint productivity and strengthens interdependence (op cit.)

3.14.7 Conflict, Power and Control

Networks are co-operative but are not characterised solely by collaboration, harmony and concord (Granovetter 1985; Powell 1991; Hakansson and Johanson 1993) - "In every relation there are both common and conflicting interests between the actors. Thus, relations can be viewed as a co-operative mode of handling conflicts." (Hakansson and Johanson 1993:39-40) and each point of contact in the network is a potential source of conflict.. Each point of contact in a network is a potential source of conflict.

Quoting Keohane[26], Powell notes that reciprocity or co-operation in no way "insulate[s] practitioners from considerations of power." (p273) Moreover, "Power is not only rooted in individuals ... It also stems from the interactions of individuals with and between firms, and from the control of information and resources in these interactions." (Besanko, Dranove, and Shanley 1996:711). Besanko et al identify four key sources from which power stems: "(1) the relative dependence of an actor on

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[26]Keohane, R (1986) "Reciprocity in International Relations", *International Organisation* **40(1)**: 1-27

others in a set of interrelated jobs and tasks...; (2)the centrality of an actor within an organisation's communication network; (3) the degree to which the individual is substitutable within a relationship; and (4) the dependence of a firm, or a unit within a firm, on the ability of key individuals to cope with uncertainties that affect performance." (p711) Clearly, these sources relate to the power of an individual within a firm but when one considers that firms within a network are mutually interdependent, this introduces further levels of power.

Bates and Slack (1998) point out that much of the literature on integrated buyer-supplier (or supply-chain) relationships assumes that buyers have sufficient power to influence their suppliers. Bates and Slack, however, note that this is not necessarily the case. They support Thorelli's (1986)[27] contention that power is never held unilaterally in such relationships neither is any participant powerless, and make the distinction between dependence and commitment in relationships. Dependence arises when the buyer needs the supplier whether they like it or not (perhaps due to limited supply options or a power imbalance). Commitment, however, "arises from mutual trust and an exhibited willingness by both parties to invest resources in the relationship, and to be tolerant in the face of problems." (Bates and Slack 1998)

Control is a further important structural dimension of networks (Hakansson and Johanson 1993). Actors have some, although incomplete, direct control over their own activities and have indirect control over other activities via their relations with other actors. "The overall indirect control over other actors' activities in the network is based on the position within the network, the strength of the relations, and the relative importance of the actors to one another." (p42). It is not shared equally among the actors and as such its distribution shapes not only the direct consequences for actors, but the future shape of the network.

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[27]Thorelli, H.B., 1986 Networks: between markets and hierarchies. Strategic Management Journal 7, 37-51

3.14.8 Barriers to Entry

Interfirm relationships which develop in a network can be difficult to intercept. To get established in a new market and enter any networks, a firm has to build relationships that are new to it and to its counterparts. Due to mutual adaptation, "'voice' is better as a conflict resolution mechanism than 'exit', since exit is not easy or attractive." (Johanson and Mattsson 1991:259) As Ferlie puts is "There is a tendency to 'keep things in the family' so that buyers - once locked into a set of relationships - may be relatively inert in seeking new sources of supply." (Ferlie 1994) Penetrating these relationships becomes extremely difficult for a new firm to do.

3.14.9 Production Costs & Quality

Firms may experience reduced production costs. If, or example, individual providers specialise but form co-operative relationships with providers of complementary services, then as a group they can offer a full range of services. Each firm can respond quickly to changes which affect only part of the overall production process but which benefit the group as a whole. Moreover, "within a cluster of specialised firms, each firm has access to a wider variety of 'capabilities' than if they each had to internalise all aspects of production." (Croxson 1997) Firms may also make use of integrated buyer-supplier relations to improve product and process quality (Sako 1992; Dubois and Hakansson 1997) by streamlining production processes, jointly investing in equipment and by focusing on long term quality improvements.

3.14.10 The Individual Organisational Unit

Network effectiveness is not only dependent on the ability of firms to relate to one another, but also on individual firms' effectiveness, specifically that of its resource deployment capabilities (Hakansson and Snehota 1989).

Within the supply chain, a firm's purchasing function becomes particularly important. Studies of supply-chain management (Cousins 1995; Harland 1996; Stuart 1997), emphasise the extent to which firms engaged in integrated buyer-supplier relationships have reorganised their individual internal activities so that combined inter-firm activities are effectively streamlined, adding value to the chain of their activities.

The deployment of knowledge resources is also important. Nonaka et al (1996) write:-

> "In recent years, the vital importance of knowledge to business has been highlighted. Quinn[28], for example, observed that a company's competitive advantage increasingly depends on such 'knowledge-based intangibles' as technological know-how and deep understandings of customers. Drucker[29] argued that knowledge is "*the only meaningful resource*" in business today." (italics added)

The capacity of firms to accrue and exploit new knowledge is particularly important. Cohen and Levinthal (1990) suggest that the scope for innovation and learning is not automatically accrued through collaborating, but is dependent upon an individual firm's absorptive capacity: "...the ability of a firm to recognise the value of new, external information, assimilate it, and apply it to commercial ends is critical to its innovative capabilities. We label this capability a firm's absorptive capacity ..." Whilst they do not constrain their discussion to knowledge within the firm, their attention to the ability of the firm to assimilate and use new knowledge is consistent with the views taken by proponents of the resource based view of the firm (see for example Wernerfelt 1984; Penrose 1997). Penrose (1997), for example suggests that the growth of the firm is constrained by internal resources, more particularly the productive services available to a firm from its own resources, and specifically its management resources[30].

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[28]Quinn, J.B. (1992) *Intelligent Enterprise: A Knowledge and Service Based Paradigm or Industry.* New York: The Free Press

[29]Drucker, P. (1993) *Post-Capitalist Society.* London: Butterworth Heinemann.

[30]Penrose makes an important distinction between resources and the services rendered by resources - "Strictly speaking, it is never *resources* themselves that are the 'inputs' in the production process, but only the *services* that the resource can render. The services yielded by resources are a function of the way in which they are used - exactly the same resource when used for different purposes or in different ways and in combination with different types or amounts of other resources provide a different service or set of services ... resources consist of a bundle of potential services and can, for the part be defined independently of their use, while services cannot be so defined." (pp30)

3.14.11 Organisational Knowledge and Learning

Cohen and Levinthal's (1990) attention to absorptive capacity proves particularly important in the context of the preceding discussion about networks. Networks are believed by many to offer particular advantages for knowledge sharing and innovation. However, papers cited in earlier discussions place little emphasis on limitations to innovation and knowledge sharing that may exist within *individual* firms. Absorptive capacity requires that prior, related knowledge exists within the organisation for new knowledge is to be assimilated and used (Cohen and Levinthal 1990). This knowledge may be technical, scientific or may include learning skills: "experience or performance on one learning task may influence and improve performance on some subsequent learning task". (ibid).

That prior knowledge exists is extremely important:

> "... learning is cumulative, and learning performance is greatest when the object of learning is related to what is already known. As a result, learning is more difficult in novel domains, and, more generally, an individual's expertise - what he or she knows well - will change only incrementally." (ibid)

It is also important that prior knowledge is diverse:

> "In a setting in which there is uncertainty about the knowledge domains from which potentially useful information may emerge, a diverse background provides a more robust basis for learning because it increases the prospect that incoming information will relate to what is already known. In addition to strengthening assimilative powers, knowledge diversity also facilitates the innovative process by enabling the individual to make novel associations and linkages." (ibid)

Nonaka et al (1996) stress that as well as transferring knowledge , organisations create knowledge by supporting creative individuals and providing contexts for them in which to create knowledge. (This is also said to be true for innovation, which also requires

the right organisational environment in which to flourish (Henry and Walker 1991; Nohria and Gulati 1996)) Indeed, Nonaka et al argue that "Organisational knowledge creation ... should be understood as a process that 'organisationally' amplifies the knowledge created by individuals and crystallises it as a part of the knowledge system of the organisation." Knowledge transfer and knowledge creation, they suggest, cross intra- and inter-organisational boundaries.

Also important is the ability to exploit new knowledge, a process which "depends on transfers of knowledge" across sub-units within the organisation and across it's interface with the external environment (Cohen and Levinthal 1990). This relies on critical knowledge, ie, the "awareness of where useful complementary expertise resides within and outside the organisation." (ibid) This may be knowledge of who knows what, who can help with what problem, or who can exploit new information. Critical knowledge therefore depends on both internal and external relationships.

It is important to recognise that individuals within co-operating firms also have a role within the network. Sometimes mutual orientation among firms is principally a mutual adaptation among individual actors (Johanson and Mattsson 1991), for example, between individual salesmen and purchasers. Knoke and Kuklinski (1991) argue that "The organisation of social relations ... becomes a central concept in analysing the structural properties of the networks within which individual actors are embedded, and for detecting emergent social phenomena that have no existence at the level of the individual actor." (ibid, p173) Actors may also belong to a number of networks within the firm. For example, an advice giving network may differ from a formal authority network and that again from a friendship network. Also of significance are the networks to which individuals do not belong because "*...the structure of relations among actors and the location of individual actors in the network have important behavioural, perceptual and attitudinal consequences both for individual units and for the system as a whole.*" (Knoke and Kuklinski 1991).

In summary, therefore,

> "To the extent that an organisation develops a broad and active network of internal and external relationships, individuals' awareness of others' capabilities and knowledge will be strengthened. As a result, individual absorptive capacities are leveraged all the more, and the organisation's absorptive capacity is strengthened." (Cohen and Levinthal 1990)

In summary, network theorists propose that the network form of organisation offers particular advantages over the hierarchy and market. It is more efficient due to the lowering of transactions costs, offers opportunities for jointly funded investments, learning, innovation and knowledge transfer, and achieves long-run efficiencies. Firms in the network adapt to one another on the basis of trust and pursue both economic and social goals. Networked firms engage in relationships which are reciprocal, collaborative (yet not devoid of conflict) and interdependent. It is, however, important to bear in mind that the extent to which networked firms can exploit the benefits associated with networks is dependent on individual firm capabilities.

3.15 Networks and the NHS

As this chapter noted earlier, research conducted in the years following the NHS reforms[31] (see for example Ferlie 1994; Bennett and Ferlie 1996; Deakin and Walsh 1996; Ferlie and Pettigrew 1996) suggested that contracts between buyers and suppliers in the NHS were of a relational not neoclassical nature, and that the NHS should be regarded as a network of organisations engaged in socially embedded relationships. Purchasing is not influenced solely by price, as Ferlie points out, but by a number of factors of which one important one is reputation. "In professional services (e.g. medicine), information on reputation is transmitted through organisational and occupational networks and is critical in establishing market position." (Ferlie 1994) Reputation plays a particularly important role in the NHS because of the dearth of information about health services and thus a high degree of information asymmetry between purchasers and providers (Mannion and Smith 1997). Mannion and Smith (1997) suggest why it is that reputation is particularly important in health care:-

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[31] See Chapter 4 for review of the empirical evidence.

"The concept of *reputation* is ... closely associated with qualitative aspects of a product which cannot be incorporated into a formal contract. Purchasers can observe the past and current quality of a producer, and may form judgements about the future quality of its products on the basis of such historical observations ... In contrast to status, which tends to be thought of as a public attribute, reputation is often treated as a private judgement regarding future quality - that is, reputation judgements may vary from consumer to consumer. Reputation is likely to be important where (a) qualitative aspects of the product are important, (b) there is a difficulty in writing complete contracts, (c) contracts are long term, and (d) the quality of the product can only be judged after it has been used."

There are a number of important implications which follow from seeing markets in more relational terms:-

"Unlike individual consumers, corporate buyers might often interact with sellers. The relationship between companies might display a complex history of adaptation, commitment, trust and conflict. Buyer-seller relationships are but one example of sets of relations which may shape a market, as buyer-buyer and seller-seller relations may also be important. The interaction process is not solely revolving around product/service exchange, but also includes important processes of social exchange, undertaken so as to reduce uncertainty and to build trust. The result may be a common value system which emphasises source loyalty. There is a tendency to 'keep things in the family', so that buyers - once locked into a set of relationships - may be relatively inert in seeking new sources of supply." (Ferlie 1994)

What might also be expected when viewing the NHS as a network of relational contracts, is that there will be evidence of mutual adaptation, knowledge sharing and innovation unless the parties are unable to acquire, assimilate and exploit new knowledge (Cohen and Levinthal 1990). In terms of knowledge transfer and learning, because GPFHs and hospital trusts have prior knowledge of services and diversity in their knowledge (a combination of specialist secondary and specialist primary care

knowledge) there should be significant scope for innovation and learning. It can also be expected that there will be some degree of conflict and that some individuals may have more prominent network positions than others.

As the network's effectiveness is dependent upon the organisational effectiveness of individual actors, at the end of the day, if a hospital is unable to organise itself internally and provide adequate services, good interorganisational relationships may be insufficient to sustain buyer-supplier relations. This is because the activities of, and service offered by, the GPFH are dependent to an extent on the activities of the hospital. Poorly performing hospital services may mean increased patient visits to the GP which ultimately drain GP resources.

It is important to bear in mind that the network model whilst based on collaboration, also assumes a degree of contestability. If there are no alternative sources of supply available to the GPFH then there remains a question mark over the extent to which buyers can effect any changes in the hospital. Barriers to communication may prevail and high levels of inefficiency may occur if there are no incentives for the hospital to improve their performance because they enjoy a monopoly position in their local market.

3.15.1 Networks: Resource Allocation and Organisational Efficiency

One of the crucial aspects of the network form of organisation in the NHS is whether it is an efficient mode of organising transactions; and whether it results in allocative and productive efficiency. This aspect is more problematic to consider because only Sako (1992)was found to deal with this aspect in any detail in the network context. Sako suggests that arms-length contractual relations (ACRs) (classical market contracts) and obligational contractual relations (OCR's) (socially embedded relational contracts) have different implications for the composition and level of costs[32].

Resource Allocation

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[32] Total costs include production costs and the transactions costs of negotiating, writing and monitoring contracts as well as building up trust etc.

Classical contract (ACR) trading has the advantage of flexibility in selecting trading partners and buyers can switch according to price whenever their contracts expire. Relational (or OCR) contracts, however, are more rigid due to moral obligations to sustain relationships. Sako suggests that "from this reasoning, allocative efficiency is more easily achievable under ACR then under OCR." (Ibid, p224). However, this argument does not hold if there are suitable incentives under OCR which effectively mimic market pressures for continuous productivity-enhancing improvements. What is more, information asymmetry exists to a lesser degree between the buyer and supplier in OCR than in ACR. This, Sako argues, potentially leads to pricing which is more allocatively efficient because prices reflect costs more accurately. "Price negotiations in ACR take on an air of hard commercial bargaining with importance attached to tactics and strategy, while OCR negotiations tend to centre more around engineering effort to lower costs. The contrast in approach becomes starker when prices are reviewed and renegotiated." (Ibid, p228)

Resource Utilisation

Relational contracts may reduce both production and transactions costs. Uncertainty is reduced through the development of trust and knowledge sharing (Johanson and Mattsson 1991) and parties may take a long term view of costs (Sako 1992). Sako found that prices of materials and components were higher under OCRs but parties believed that long run benefits would be accrued from building trust with their suppliers which would outweigh the benefits of being able to switch trading partners as prices dictate. Consequently,

> "...there are grounds for believing that OCR may achieve a lower total production cost than ACR. This is likely to occur if normative values governing OCR elicit greater work effort, and hence higher X-efficiency, thus reducing labour costs (or increasing labour productivity). It is plausible that in times of crisis, a buyer's appeal to 'goodwill trust' ... may give greater incentives for suppliers to reduce costs than impersonal market forces." (Sako 1992:22)

Transactions costs which arise from, for example, searching, negotiating and monitoring efforts are higher for ACR firms who deal with a greater number of trading

partners. Asset specificity (and thus the cost of non-marketability) is, according to Johanson and Mattsson (1991), the rule rather than the exception.

A further set of economies which may be achieved in the network are X-efficiency gains. Although the concept of X-efficiency is largely about what goes on inside the firm, Sako proposes that the concept can be extended to inter-firm relations. Inter-firm X-efficiency is about the efficiency of a pair of trading partners put together (Sako 1992). "...Inter-firm X-efficiency may increase over time in a trade relationship as tacit understanding emerges over the product specification and quality requirements, in price negotiation and in planning future production."

Sako's research found no conclusive causal links between ACR-OCR patterns and organisational efficiency: "It could be argued that ACR traders achieve allocative efficiency by reserving the right to switch their partners as prices dictate, but there are no sufficient grounds for thinking that ACR-type relations lead to X-efficiency also. Similarly there is no theoretical basis for asserting that the existence of 'goodwill trust' in OCR-type relations constitutes a sufficient condition for generating incentives to maintain efficient practices over time. It is quite possible that such trust, by diminishing the expectation of trading partners quitting, reduces the incentive to make an effort and hence coexists with X-inefficient practices." (ibid, p221). The contribution of OCRs to the reduction of transactions costs is also uncertain - "... if we concentrate on the current component of transaction costs, ACR firms are willing to trade off an increase in transaction costs in order to obtain lower materials costs through bargaining, while OCR firms typically face low current transaction costs (due to past investment in trust) but temporarily high material and component costs." (ibid, p22)

3.15.2 Networks & Incentives for Efficiency

Whilst there are uncertainties about the extent to which networks yield economies, there is some clarity about mechanisms or incentives for stimulating efficiencies. Sako identifies pricing and continuous improvement incentives which can be used to mimic market pressure and thereby improve efficiencies.

Price

The determination of price is usually partly a matter of norms (industry- or country-specific) and partly a matter of relative bargaining power. Under ACRs, suppliers generally do not disclose details of cost calculations to their customers for fear of weakening their bargaining power[33]. In OCR-relations, however, in the interests of openness and communication, greater levels of detail in costing/pricing can be disclosed. Because buyers exercise 'voice' rather than exit, parties can take a longer-term perspective on cost reduction. In Sako's study, firms had two mechanisms for such reductions: price-reduction targets or time path of price reduction targets and joint analysis of costs using value analysis and value engineering techniques. The benefits of this approach were mutual. Suppliers by rationalising their companies could save on material costs, increase capacity utilisation, cut internal costs and make quality and productivity improvements whereas buyers benefited from quality improvements and cost reduction over the longer term.

Continuous Improvement

A second mechanism/incentive is that of continuous improvement. In market relationships, the need to remain competitive serves as an incentive for product/process improvements. In network relationships, however, it is less clear what incentives exist to ensure concomitant levels of continuous improvement. Indeed, inefficiencies may be incurred where customers become locked-into particular suppliers (see earlier discussions). One incentive for ensuring continuous improvement is where suppliers are ranked according to (maintenance of) quality and delivery performance in published monthly lists. Suppliers who climb up the ladder are assured of increasing levels of desirable orders (Sako 1992). Sako argues that "Suppliers' incentives to make X-efficiency enhancing effort derive in part from inter-supplier rivalry but also from the customer company's reputation for integrity in keeping its promise to reward those suppliers making greater effort." (ibid. p237)

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[33] Disclosing profit margins or detailed cost levels might mean that their profit is negotiated away.

3.15.3 NHS Networks : Costs & Benefits

It is difficult to draw firm conclusions about the comparative efficiency of markets and networks. The efficiency of individual activities is difficult to ascertain because individual firms' economies are dependent in part upon their ability to achieve economies of scale and to work efficiently with other network members (Dubois and Hakansson 1997). The efficiency of the network is a function of the ability of actors to combine and integrate different resource elements needed to perform the activities and to create value for customers (Dubois and Hakansson 1997). It is likely that network activities, resources and complementarities will differ over time and between network members, and may not always need to be combined. Not only is this complex to analyse but as Ebers and Grandori (1997) point out, conceptual frameworks have not yet been developed for analysing internal and external network costs.

Nevertheless, from this discussion, it would seem that the NHS as a network organisation may benefit from the possible lowering of transactions costs and improved allocative and productive efficiency where it is able to create appropriate incentives. Innovations and learning ought to arise from the mutuality, reciprocity and creativity which characterises networks, although these benefits are limited by the degree to which NHS organisations can absorb and exploit new knowledge and asset specific investments may be non-marketable. NHS networks are also likely to be characterised by both conflict and collaboration, and should be seen from the point of view not only of buyer-supplier relations, but buyer-buyer and supplier-supplier relationships.

3.16 Summary

This chapter has integrated economic and social theories in order to analyse the likely impact of market and network forms of organisation upon allocative efficiency and resource utilisation within the NHS. It has discussed in detail the costs associated with market transactions and has considered the characteristics and dynamics of relational contracts. The chapter has concluded that NHS contracts are more akin to relational contracts and occur within a network of interconnected buyers and suppliers. It follows, therefore, that if the NHS is able to exploit individual firm capabilities, it

may benefit from knowledge transfer, organisational learning, joint investments and innovations. Parties may, however, become engaged in non-marketable investments thereby incurring losses if trading with those partners ceases. The thesis returns, in Chapters 9 and 10, to further reflect on to these issues in light of this study's findings.

Having so far discussed the historical and theoretical contexts of the NHS market in Chapters 1 to 3, Chapter 4 now goes on to review the empirical literature dealing with the behavioural and attitudinal responses GPs have made to their purchasing role and to the fundholding scheme. It also identifies the research gaps to which this study contributes.

Chapter 4

Review of Empirical Studies: GPs in the Marketplace

Introduction

Chapters 1 to 3 have discussed the NHS market in terms of its historical context and theoretical basis. These chapters showed that purchasing relationships in the NHS are best understood from a relational contracting and network perspective which assumes that network actors are motivated by both economic and social factors. The empirical evidence reviewed in Chapter 4 supports this view.

This chapter ***brings together published empirical evidence*** concerning GP purchasing behaviour and attitudes to the reforms. Two dimensions of purchasing are addressed, the **purchasing role** in the broad sense and the **fundholding scheme** in particular. Difficulties in interpreting research findings are highlighted before considering the published empirical material in detail after which the chapter ***concludes by highlighting the research gaps*** to which this study will contribute.

4.1 Evaluating the Reforms - A Cautionary Word

When the government launched the 1990 reforms, it resisted pressure and widespread criticism from practitioners and academics to scientifically evaluate pilot fundholding practices (Le Grand 1994; Robinson 1994; Coulter 1995b). The Secretary of State for Health, Kenneth Clarke, denied any requirement for formal monitoring and evaluation and said calling on the advice of academics was a "sign of weakness" (Robinson 1994) The lack of evaluation troubled even the pioneers of the NHS reforms (Smith 1989; Maynard 1994). Alain Enthoven called the decision "a mistake" (Smith 1989), suggesting that demonstration projects would have helped break down the resistance to change, and that much was at stake given the uncertainty of the policy innovations.

Although the government's approach meant that there would be no pilot studies, some evaluations of the reforms have been conducted. The Kings Fund quickly decided to fund its own research programme inviting research proposals in 1989. Seven projects were awarded funding for the period 1990-1993 covering a range of issues: market structure and managed competition, performance of NHS Trusts, GP fundholding, views of GPs and patients concerning hospital referral, medical audit, services for older people and the changing role of the personnel function. Reports from each of the

studies were brought together in a comprehensive review of the reforms (Robinson and Le Grand 1994). The Audit Commission's (1996) study of GP fundholding in England and Wales was the largest evaluation to be conducted.

In Scotland, the approach to evaluation was different. The BMA in Scotland persuaded the government to allow the proposals to be tested. They agreed to independently evaluate a shadow fundholding exercise to assess the effects on the care of patients and look at administrative structures, consulting patterns, and use of doctors' time. (Wisely 1993) Twelve practices (six in the north east of Scotland, five in Grampian and one in Tayside) were identified for a pilot study which was evaluated by Professor John Howie at the University of Edinburgh (Howie, Heaney, and Maxwell 1995).

The lack of formal reviews is, however, not the only factor hindering evaluation. Simultaneous changes and subsequent injections of resources into the NHS cause further difficulties (Le Grand 1994). Firstly, Le Grand identifies a number of changes occurring in parallel with market development. The 1990 GP contract, the Patients' Charter, and 1990 community care legislation, for example, have all had an effect on the NHS' systemic behaviour. Consequently, it is impossible to isolate changes due to market factors from other influences.

The second difficulty arises because of injections of resources into the NHS (see also Petchey 1993). Additional resources are likely to have enabled hospitals to reduce waiting lists and to improve the range of services they offer. Consequently, these changes cannot be considered as a direct or sole consequence of market measures.

When considering empirical findings, it is also important to bear in mind that for the first few years of the reforms, there was pressure from the government to restrain the pace of change, to maintain a steady state (Ferlie 1994; Kirkup and Donaldson 1994). GPFHs and HAs were obliged to maintain referral patterns to a level consistent with the pre-market environment. Such artificial constraints are particularly significant when interpreting studies conducted during the early 1990s.

4.2 The Fundholding Scheme

Despite the difficulties in evaluating the reforms, a number of empirical studies have been conducted. These studies have mainly concentrated on prescribing rates and hospital referral rates. Indeed, in a recent review of all the *quantitative* studies on UK fundholding, Gosden and Torgerson (1997) identified 17 published studies of which four were based on one original evaluation in Edinburgh and a further four were based on one original evaluation in Oxford. Although the studies reviewed by Gosden and Torgerson looked at the effect of fundholding on referral and prescribing costs aspects such as purchasing decision criteria and GP views of fundholding have also been addressed. The general conclusions from these studies can be summarised as follows:

- fundholders have not responded to financial incentives as expected;
- savings through changed prescribing practice have been only short term;
- hospital referrals have increased;
- formal sources of information have little influence on purchasing decisions when compared with the high value placed on local and personal knowledge and judgement;
- GPs are keen to support local hospitals rather than to switch to alternative providers; and
- buyer power was exercised only as a last resort.

This chapter goes on now to review these empirical studies in detail beginning with a brief reminder of the original objectives of the fundholding scheme.

4.2.1 Objectives & Assumptions of Fundholding

When considering the empirical evidence, it is important to bear in mind the original fundholding and purchasing objectives and assumptions.

> "[Fundholding] aims to make GPs aware of the financial consequences of their clinical decisions and, by giving them an incentive to make and spend audited savings, to encourage them to consider the costs of different courses of action. The expectation is that this will lead to more economic and efficient use of

hospital and community health services, and more rational prescribing. Giving GPs the power to contract with providers, and the freedom to choose between them, is intended to give providers - particularly hospitals and their consultants - an incentive to listen more carefully to what GPs have to say and to take steps to improve their quality of services." (Audit Commission 1996:6).

> "It is essential that practices are able to manage their total expenditure, without denying services to their patients. It is also important that they do so in a way which enables them to negotiate the best deals they can. ... GPs themselves will be responsible for deciding the best mix of budgeting and contractual arrangements for their practices..." (Department of Health 1989:51-52).

Clearly then, GPs had a dual responsibility to improve their own practice management and control their expenditure, and to negotiate improved services to patients, seek out the best deal thus stimulating improved efficiencies within secondary care. However, as Chapter 2 has already discussed, a number of concerns were raised about issues such as budget volatility, practice management skills, under-referral, 'cream skimming' and two-tier health services. The purchasing function was also called into question on the basis that GPs lacked purchasing skills and information (Pollock and Majeed 1995; Deakin and Walsh 1996), would not take a strategic perspective, but a 'parochial' one causing fragmentation (Hegginbotham 1994) and that the transactions costs of the contracting system would be high, possibly outweighing any benefits to patients (Ham 1994; Thomas 1995).

These issues generated a broad research agenda, covered at two levels: (1) the fundholding scheme and (2) the purchasing role. The following sections go on to discuss the research findings as they relate to these themes.

4.2.2 Prescribing

One of the most studied aspects of fundholding is prescribing. Early studies concluded that fundholders were more successful at reducing their prescribing costs than non-fundholders (Bradlow and Coulter 1993; Maxwell et al. 1993; Howie, Heaney, and Maxwell 1995). However, later evidence suggests that reductions are

only short term. The Audit Commission (1996) found that "In the early years of the scheme fundholders in general prescribed more rationally than GPs in non-fundholding practices." (p31) They made greater use of generic drugs, prescribed fewer drugs of limited clinical value and fewer antibiotics but "prescribed more drugs for preventing asthma attacks that, although expensive, reduce the need for hospital admissions and, hence, overall treatment costs." (p31) The main efficiency gains were found to be in the first year of fundholding, a finding consistent with other studies (Stewart-Brown et al. 1995; Whynes, Baines, and Tolley 1995, 1997; Whynes, Heron, and Avery 1997) indicating that in the early years of fundholding GPs are able to make initial savings through more efficient prescribing behaviour, but are unable to sustain this during later years when prescribing costs rise at the same rate as non-fundholders' (see also Gosden and Torgerson 1997). Whynes et al (1997) describe this as a "'sideways displacement' in the longer-term growth trend, by interpolating a year of 'less-than-normal' growth".

Although GPs could benefit from inflating prescribing costs during their shadow fundholding year and thus make savings as fundholders, Whynes et al (1997) found no evidence of artificial inflation. It would seem, therefore, that incentives for reducing prescribing have not had the effect predicted in 1990, and have not been sufficient to influence clinical practice (Stewart-Brown et al. 1995; Whynes, Baines, and Tolley 1997) although Stewart-Brown et al comment that "...maybe we are being premature in seeking to identify the effect of these incentives. The cultural change required of doctors to achieve any form of cost containment may take a long time to manifest itself."

4.2.3 Under-Referral

Chapter 2 identified the potential danger of under-referral due to the incentive for GPs to make practice savings but studies of referral patterns have not found evidence of under-referral (Corney 1994; Surender et al. 1995; Audit Commission 1996; Ellwood 1998). Surrender et al. (1995) conducted a study between June 1990 and January 1994 and hypothesised that two courses of action could be taken by GPFHs to save money. Firstly, they could decrease outpatient referrals and secondly, they could encourage patients who have private health insurance to be referred to private clinics

so insurance companies subsequently meet the costs. They looked at 38,682 referrals from 16 practices (including non-fundholders) to 11 specialties and found that NHS referral rates from fundholding practices did not decrease over the four year period but instead showed a small, steady increase. Howie et al. (1995) noted a similar increase in referrals but found that there had been a change in the pattern of usage; with "a downward trend in most areas of activity .. matched by an upward trend in the use of direct access services."(ibid)

The Audit Commission (1996) study showed that most GPFHs continued their pre-GPFH referral patterns. Where they did make changes, this was often temporary and in response to long waiting lists. They identified a gradual decrease in repeat out-patient attendances (some GPFHs set maximum levels in their contracts) but this trend began before fundholding so cannot be attributed entirely to its influence.

Surender et al's study (1995) concluded that financial pressures had little effect on general practitioners' referral decisions after entering the scheme, but suggested that there was an incentive for GPs to increase referrals during the preparatory year because fundholding budgets are based on historical activity and costs. They found a "steeper increase in rates among three of the four practices who were in their preparatory year for fundholding." (ibid)

Gosden and Torgerson (1997) point out that interpreting referral patterns is "always going to be more difficult...than prescribing behaviour..". This is because "if a fundholding practice succeeds in reducing its expenditure on drugs then it might quite reasonably spend some of the savings on increasing referrals thereby realising more health gain for its patients. Thus, the practice could be efficient in the sense that for no extra resources more patients are receiving effective procedures which improve health, but referrals actually increased."

4.2.4 Cream Skimming & A Two Tier System

Fewer studies have considered the 'cream skimming' and two-tier dimensions of fundholding. Although potential exists within the fundholding scheme for cream skimming, there has been no published evidence so far that it has occurred. Llewellyn

and Grant's (1996) sample of fundholders (from Grampian, Lothian and Tayside) did not think cream skimming was a potential moral hazard of fundholding because there is an allowance provided for expensive patients (see also Bartlett and Le Grand 1994). In Llewellyn and Grant's study GPs also countered fears of two-tierism on the basis that "the market is more muted in Scotland than in England."

Dowling (1997) conducted one of the few comprehensive studies on the impact of fundholding upon waiting times, in order to identify whether a two tier system was occurring. The study (covering 1992 - 1996) found that fundholding patients waiting for elective surgery had "significantly shorter waiting times" than patients of the non-fundholding practices. The Audit Commission (1996) though found similar waiting times for GPFHs and non-GPFHs. Dowling attributes the difference between these findings to the methodologies used, asserting that recalculation of the Audit Commission sample using Dowling's methodology identifies differential waiting times.

4.2.5 Management Skills

Fundholding received criticism because GPs did not have the managerial skills to engage in purchasing and would need to bring qualified managerial staff into the practice, but little has been written about this since the reforms were implemented. Most first and second wave practices appointed a dedicated fund manager in addition to their existing practice management staff. The smaller third and fourth wave practices though tended to appoint a combined practice and fund manager or to recruit a part-time fund manager who would work in one or two other practices as well (Laing et al. 1996). Laing et al. found, however, that of practice managers, only 37% had previously been employed outwith the NHS. Of the remaining 63%, most (46%) were from previous posts in general practice administration. Similarly, of the fund managers, 42% had held previous practice administration posts whilst 38% were drawn from outside the NHS. Consequently, only a minority of fund/practice managers with financial/managerial skills were recruited.

Some fundholding practices combined into multifunds both to pool their managerial resources and skills (Locock 1995) and to increase their buyer power (D'Souza 1995; Audit Commission 1996; Laing and Cotton 1997a). Multifunds are large groups of up

to 50 fundholders who collaborate voluntarily but maintain their separate identity. They have a decision making body of GPs who act on behalf of their colleagues and oversee central office staff. Around half have an executive group (including GPs) who take responsibility for particular areas of finance. Although this maximises their managerial resources, there are difficulties in organising multifunds. D'Souza (1995) notes that pooling management allowances "has always generated heated public debate. It remains to be seen how well they can agree on the expenditure of pooled public money for patient care." Not all GPs share the same philosophy - "Most doctors see themselves simply as professionals delivering ethical care, some feel they are entrepreneurial managers whose chief concern is to maximise their incomes, and a relative few are interested in doing clinical science. In the past, each of these types of doctor have practised in separate environments." (ibid)

Laing and Cotton (1997a, b) witnessed similar organisational difficulties within GPFH consortia[1]. There were power struggles (based on length of time as a fundholder and individual knowledge bases), problems with communication, disagreements as to who ought to be on the executive committee of the consortia, dominant individuals, sub-groups and divisions. Experience of consortia in Grampian though suggests that GPs are better able to influence quality, waiting times and communications and GPs responded enthusiastically to dialogue with, and changes within, secondary care (Wisely 1993).

None of the papers cited offered evidence as to whether multifunds were any better at purchasing than individual practices although they suggest that multifunds save on direct management costs.

4.2.6 Perceptions of the Fundholding Scheme

The fundholding scheme has proved "deeply divisive among GPs" (Petchey 1995) and response to the scheme has been mixed across the UK (Lapsley, Llewellyn, and Grant 1997). Fundholding was viewed by some GPs as an opportunity to be innovative. To others, it was an ugly, incongruent blot on the primary care landscape. There were

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[1]Laing and Cotton do not use the term multifund but rather consortia to mean the same thing.

deep divisions between GPs when the scheme was introduced and practitioner journals have been the forum for heated debate about its costs and benefits (Eve and Hodgkin 1991; Bowie and Harris 1994; Iliffe and Freudenstein 1994). However, despite public debates, little research has been conducted concerning GPs' views of fundholding (Leese and Bosanquet 1996). In the two studies presented below, researchers found that there was minority support for fundholding, even when fundholders were surveyed. Despite opposition to fundholding, a sizeable minority of fundholders thought that service quality had improved and contract switching had either occurred or was expected to occur in 53% of practices.

In 1993, Bunce (1993) published the biggest survey of GP opinion on fundholding which covered more than one third of GPFHs and included non-fundholders. Only two thirds of existing fundholders supported the fundholding scheme and there was a "significant difference in the level of support from lead fundholders and from their partners". Less than 50% of non-lead fundholders say they are in favour of the scheme, compared with 22% of lead fundholders and 66% said they were forced to join despite having reservations. Interestingly, 9% had switched community provider, 18% planned to do so the following year and 26% planned to move parts of their contracts to other providers, a factor attributed to GPs' frustration with providers who refused to negotiate. Community budget holding though was not highly valued: 22% said it helped improve patient care, 54% said it was introduced too quickly, 30% said it was too much work for too little gain, and 28% said that it was a welcome addition to the fund. Most GPs felt that practice savings were a short term phenomenon and that the capacity to save would diminish in future fundholding years.

Leese and Bosanquet's (1996) study in 1993 of GPs' views of the 1990 contract and fundholding found that more than half of their respondents were opposed or strongly opposed to both the 1990 contract and to fundholding. They write, however, that "despite this opposition, a sizeable minority of group practice practitioners (38%) agreed that the quality of services provided had improved or considerably improved since the 1990 contract" (ibid). (Views of the scheme are summarised in Figure 4.1). Of the group practices, 8% were strongly in favour of fundholding and 16% in favour,

a stark contrast to the single-handed practices of which none were strongly in favour of fundholding and 17% were in favour.

Figure 4.1: Views on the Fundholding Scheme
Source: Leese & Bosanquet, 1993

	Strongly in Favour		In Favour		Opposed		Strongly Opposed	
	GRP*	SH**	GRP	SH	GRP	SH	GRP	SH
Fundholding Scheme	8%	0%	26%	17%	32%	21%	28%	39%

*GRP = group practice ** SH = single handed practice

Fifteen percent of group and single-handed practices had no strong view and 2% did not know what they thought of the scheme. Less than half of the fundholders (45%) demonstrated support for the scheme and 22% voiced opposition. Nevertheless, "67% [of fundholders] reported that the quality of service provision had improved or considerably improved as a result of the practice controlling its own budget: there was almost unanimous agreement that the administrative workload of the practice had increased or considerably increased as a result of fundholding." They found that 69% of the fundholders in their study felt that to a large extent, or to some extent, fundholding had led to shorter waiting times for hospital outpatient appointments and hospital inpatient appointments (59%). Sixty-nine per cent felt that there had been an improvement in patient services.

Bunce (1993) and Leese and Bosanquet (1996) show the support for fundholding to be rather low among fundholders and non-fundholders, yet Tod (1995) asserted that "At a time when morale in the NHS is said to be low, the one area where it is seen to be high is in fundholding practices, where innovation is the name of the game, efficiency is the password and savings are being seen to benefit patients through more on-site services, modern equipment and improved services." Tod admits, however, that "translating the benefits of fundholding into health gain for patients will prove more difficult because it is the appropriate use of clinical skills which produces health gain, rather than new administrative systems involving purchasing." (ibid.) The challenge to which he believes general practice is beginning to rise, is to evaluate activity at the primary/secondary care interface and to think about the benefit of medical care.

These two studies show that support for the scheme is low yet only 3 published studies were found reporting data on why GPs decided to become fundholders in the first place (Bartlett and Le Grand 1994; Lapsley, Llewellyn, and Grant 1997; Ennew et al. 1998). Ennew et al. (1998) found that there were positive and negative reasons for becoming a fundholder. The most frequently cited positive motive was to improve patient choice and the quality of services and patient care. Others included reducing waiting lists, facilitating access to secondary care consultation and admissions, maintaining the good quality of services already being received and gaining control over their practice. The negative motives included not disadvantaging patients where neighbouring practices were fundholders, avoiding threats of restricted freedom for referral, pressure from the FHSA, and gaining additional funding for computers. Lapsley et al (1997) found that the primary reason for GPs becoming fundholders was to gain more control over their activities and to do so in a way which improved services to patients. The authors, however, offer only a limited comment on motivation for fundholding so their findings cannot be compared fully with Ennew et al. Bartlett and Le Grand found that GPs became fundholders in order to gain freedom over referrals and their budget, to improve service quality and to develop services, to benefit from additional financial and computing resources, and for some, it was partly to respond to the challenge.

4.3 The Purchasing Role

GPs have not, it would seem, responded to incentives at a practice level in the way they were expected to and GPs seem dissatisfied with the fundholding scheme. However, the studies which looked at GPs' perceptions suggest that fundholders had stimulated improvements in service quality. This chapter now goes on to review how GPs have behaved as purchasers, the extent to which they have fulfilled their anticipated purchasing role and how they have influenced resource utilisation/hospital efficiency and resource allocation.

4.3.1 Resource Utilisation / Hospital Efficiency

The anticipated changes in referrals were based on an assumption that GPs would actively choose between providers, would respond to price signals and would have the

information upon which to make decisions. Under the rules governing fundholding, GPFHs could buy a select list of outpatient, inpatient and day case procedures each defined by an OPCS4 (Office of Population Censuses and Surveys) code (Miller 1997). Every hospital procedure has a price tag per episode which must reflect the full cost of the referral. Low prices therefore reflect low hospital costs so by switching provider according to the lowest price, GPFHs reward the more efficient providers.

Two questions are important:

- firstly, 'to what extent are prices comparable and thus good signals of efficiency?',
- secondly, 'to what extent are GPs sensitive to prices?'.

4.3.2 Price as a Signal

Ellwood conducted a longitudinal study in the West Midlands which examined NHS prices (Ellwood 1995, 1996b, 1998). Her exploration of costing methods for 1991/92 contracts found imprecise definitions of services, non-consideration of variations in case-mix, and where procedure prices were compiled they were often based on inadequate data and cost methods therefore prices "were not a reliable indicator of resources consumed" (ibid). The study also showed that there were considerable variations between prices (based on consultant episodes) across one region. In obstetrics, for example, prices ranged from £350 to £1,353 for the same procedure and in dermatology from £469 to £3,417. There are a number of reasons for these differentials:

> "The choice of clinical specialty as the cost product is bound to give rise to distortions due to differences in specialty case-mix or complexity between hospitals. (Specialty case-mix refers to the frequency of patients falling into types according to some predetermined characteristic, for example diagnosis. Different hospitals may have different mixes of diagnosis within the clinical specialty and even if a similar mix of cases exists, the individual characteristic, for example diagnosis, may relate to more complex forms.)" (Ellwood 1995).

In 1993 the NHSME[2] set minimum costing standards (as guidelines) which were to be applied in calculating 1994/95 contracts. They established a minimum cost level by type (direct, indirect and overhead), and endorsed a more standardised approach to methods of apportionment for indirect costs and overheads. However, Ellwood found that despite the guidelines, 1994/95 prices still varied significantly (Ellwood 1996b). For a total colectomy, prices ranged from £558 to £3,616 and for a day case skin biopsy, from £69 to £224 (Ellwood 1998). Providers had attempted to apply the NHSME guidelines, but differed in their costing methods and procedure classifications. Despite moves towards bottom-up costing there is "still a dearth of departmental cost and activity systems" (ibid).

In a similar study, Miller (1997) analysed 1994-95 tariffs for all the NHS providers of five former NHS regions (Northern, South East Thames, Wessex, West Midlands and Yorkshire). He found significant price variations for the same procedure. "A two, three or four-fold difference in price for a procedure was common. Absolute differences in price are also large - a £5,500 difference, for example, in the published price of an inpatient lobectomy among the seven providers in the former Yorkshire region." Price variance identified by the Audit Commission (1996) was 2-fold.

Price Sensitivity

Given the non-comparability of prices and procedures, using price as a market signal is clearly problematic. Nevertheless, assuming that the accuracy of costing methods can improve, it remains important to establish whether GPs are price sensitive because stimulating provider efficiency through competition will "hinge on the role of price within the purchaser-provider relationship and, crucially, on how purchasers respond to price." (Miller 1997) . Miller developed a model to calculate potential[3] savings from shopping around which proposed that the maximum possible savings for fundholders, aggregated to district level, ranged from £700,000 in Wakefield to £7.2m in North Yorkshire. "If all fundholders within Yorkshire region purchased in accordance with

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[2]NHSME (1993), EL(93)26, 6 April, *Costing for Contracting*. This subsequently formed the basis of a manual on costing, NHSME (1993) FDL(93)59, *Costing for Contracting - The 1994/95 Contracting Round*.

[3]The model ignored feasibility and capacity.

their district 'price optimal' pattern, the maximum possible saving could be about £24.5m." Ellwood's (1996a) conclusion was that between £100,000 and £300,000 could be saved per practice for fundholders in the West Midlands had they purchased from the providers with the lowest prices.

Whilst potential savings are considerable, they are unlikely to be realised because studies show that the influence of price on GP decision making is relatively low. Figure 4.2 summarises the findings of 3 studies in which GPs were asked to rank their criteria for referral. The studies differed in research methodology, geographical location and samples (Ghiacy's study included the views of practice managers, Miller's study was aimed at fundholders and Mahon et all covered fundholders and non-fundholders), however, the results indicate similar relative rankings of factors in GP decision making.

Figure 4.2: Factors Which Influence GP Referrals

Miller 1997	Ghiacy 1995	Mahon et al 1993
Waiting time	Waiting time	Good clinical care
Reputation	Quality	Local and convenient
Distance to travel	Attitude of clinician	Waiting time for appointment
Price	Communication	Known consultant
Other	Courtesy to patient	Patient's preference
	Cost	Waiting time for surgery
	Distance	Good overall service
	Attitude of hospital	Patient's clinical needs
	Representative	Only hospital available
	Environmental	Consultant's manner towards patients
	Wait in hospital	Good communication at hospital
	Existing referral position	Patient's previous attendance
	Marketing	Patient's personality
		Sub-specialty available

Although price does not appear in Mahon et al's list of 14 criteria, elsewhere the full list of 17 criteria used in their study is provided (Mahon, Wilkin, and Whitehouse 1994). In each of the specialties studied during 1992 (general surgery, ophthalmology and orthopaedics), low costs as a decision criterion was ranked 17th. Ellwood (1996a) found that of 21 GPs studied, 12 ranked price as least important compared with location, waiting time and service quality. Of the remainder, 8 ranked price third most important and 1 ranked it second. In Miller's study, price entered the purchasing

process for less than half of those surveyed and none stated it as the most important factor.

Laing and Cotton (1996) found similar results among their sample of Grampian GPFHs. Waiting lists, followed by previous experience, reputation, patient interest, service range and loyalty were ranked as the most frequently mentioned decision criteria. Financial considerations and administration were the least frequently mentioned[4]. Price, as a decision criterion has thus been identified as being of low influence. This consistent rating of criteria is also supported by results from a pre-fundholding study in Northern Ireland (Kennedy and McConnell 1993) where GPs rated waiting times and knowledge of the consultants' expertise as being the most important referral criteria although costs and prices, did not come into this latter study because it predated the fundholding scheme.

Miller (1997) found, however, that GPs were willing to "shop around". Their purchasing is "not entirely restrained by geography" (ibid) but shopping was not based on price. In their choices, GPs most frequently cited the consultant's reputation as being the most important factor (38% of respondents). Although Miller's study showed a greater propensity for GPs shopping around than other studies have shown, their lack of sensitivity to price is a common factor.

Nevertheless, price is not entirely irrelevant. Ennew et al. (1998) found that although GPs emphasised quality and accessibility, there was often an "implicit or explicit use of a 'value for money concept'". However, the role of price within purchasing is sensitive as according to Ennew et al., there was "considerable resistance to the idea of price as a bargaining tool".

4.3.3 Switching Provider

There has been very little evidence of fundholders switching provider to any great extent (Audit Commission 1996; Bennett and Ferlie 1996; Ellwood 1998; Ennew et al.

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[4]Laing and Cotton differentiate between decisions by a GP consortia and individual fundholding practices. The difference in terms of results though was that for the consortia sample, service range was ranked as the second most frequently mentioned criteria after waiting lists.

1998)). Where GPFHs have switched provider, it is only when local provision is unsatisfactory and efforts to change local provision have failed (Ellwood 1998; Fischbacher and Francis 1998). Fundholders have found though that the threat of switching is a useful mechanism for negotiating the type of service they want (Ennew et al. 1998).

Strong and Hanmer Lloyd (1997) sought to identify factors which influenced GP practices to switch contracts and identified waiting times, followed by price, as being the most important reasons. Distance was the "final push" in deciding to switch. However, their sample, whilst it included GPs, focused mainly on practice managers who are administrators not clinicians so one cannot assume their priorities are the same as GPs' priorities.

Ennew et al (1998) proposed that an "improved price-quality configuration" led to switching. This is consistent with Ellwood's study in which "prices have rarely caused shifts in services, but if waiting times or service quality is unsatisfactory then price is considered when evaluating alternatives ..." (Ellwood 1998). In summary, therefore, although there is little evidence of contract shifting, where it does occur, it is likely to be due to some combination of long waiting lists, poor service quality and better alternative prices.

4.3.4 Non-Price Criteria in Purchasing Decisions

It is clear from the evidence presented so far that price has been of relatively low influence in both purchasing and switching. Instead, a number of other criteria have emerged as having a major influence: quality, location and waiting lists being the main ones.

Service Quality

Quality is a consistently highly ranked decision criterion. The term, however, has been used to cover a range of service attributes. Ellwood's (1998) definition included previous experience of outcomes, reputation of consultant, communication between consultant and GP, courtesy of consultant to patients, attitude of consultant to GP, communications between hospital and GP, hospital reputation, physical environment

and attitude of hospital management, each of which was ranked individually. Mahon et al (1993) did not use the term quality at all, but asked GPs to rank categories which were similar to Ellwood's, for example, good clinical care, good overall service, patient's previous attendance, consultant's manner towards patients and good communication at hospital so were clearly addressing quality issues. Miller (1997), however, rates reputation individually and has no general term for quality. This makes study comparisons difficult. Nevertheless, Figure 4.2 showed earlier that good clinical care, reputation and quality appear at, or near the top of the list.

Laing and Cotton (1996) helpfully differentiate two dimensions of quality; technical quality (what is delivered) and functional quality (how it is delivered)[5]. Recent published accounts (Laing and Cotton 1996; Llewellyn and Grant 1996; Lapsley, Llewellyn, and Grant 1997; Fischbacher and Francis 1998) have identified GPs as having influenced functional quality (care management) more than technical quality (clinical care). (Examples of functional quality include the quality of discharge letters, the speed with which laboratory and other test results are received, waiting times for outpatient appointments and the setting up of one-stop-shops[6].)

Location

The relative priority of location (distance to travel) differs in the studies cited in Figure 4.2. In Mahon et al's study (1993), when asked which factors *commonly* influenced GP decisions, 'local and convenient' received the highest score but was ranked as the second *most important* factor in decision making. In Ellwood's study (1998), location was not ranked as first by the majority of GPs, but previous experience of the consultant was considered an aspect of quality not location whereas in Mahon's study, previous experience of the consultant would possibly be considered within reputation although this is not stated. Thus, the two measures of location cannot readily be compared. In Ellwood's study, the pattern of referrals to traditional, local providers differed between areas covered in the study. Overall though, distance travelled

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[5] Classifications originally made by Gronroos, C. (1984) "A Service Quality Model and its Marketing Implications" *European Journal of Marketing* **18**. (4) pp315-334

[6]Waiting times are considered here as a measure of quality not efficiency.

remained fairly static with minor increases after the first year of fundholding for particular procedures such as cataracts and endoscopies.

The importance of location may also be influenced by a non-market factor. Where rationalisation of acute services is imminent, GPFHs' loyalty to their traditional, local providers may be higher (Ellwood 1996a). Switching provider for one type of service might conceivably jeopardise the future of the entire hospital, so GPs have been reluctant to move contracts "because one of their prime concerns was to keep a particular provider in business because it was geographically convenient." (Ennew et al. 1998). There is some evidence to suggest that where closure threats are not imminent, loyalty may not be consistent across services but was greater for services like diagnostic radiology where there is a higher degree of ongoing patient-provider interaction, than for laboratory services (Laing and Cotton 1996).

Waiting Lists & Waiting Times

Waiting times appeared to be the most or one of the most important referral criteria (see Figure 4.2) However, there are again difficulties in definition. Miller and Ghiacy (op cit) use the term waiting whereas Mahon et al (op cit) differentiate between waiting time for appointment and waiting list for surgery.

Waiting lists were considered important purchasing criteria but according to Mahon et al (1993) were "less influential than good clinical care and the proximity and convenience of the hospital". Ennew et al (1998) suggested that it was the more entrepreneurial GPs who used waiting times as the basis for their negotiations with providers whereas the less innovative GPs focused on keeping their main provider in business. The interpretation of waiting lists has been discussed as an issue not only in purchasing, but as a means of comparing hospital quality more broadly within National league tables. There are considerable difficulties interpreting waiting lists and, as the next section discusses, problems in acquiring waiting list information.

4.4 Service Contracting

It is clear from the studies reviewed so far that GPs have proven to be non-price sensitive and reluctant to change provider. This would suggest that there is little pressure on hospitals to reduce their costs albeit there may be pressure for them to improve their quality. One cannot assume, however, that concern for quality automatically translates into quality improvements. The contracting process is the opportunity for GPs to stipulate specific quality improvements and to enforce penalties where standards are not met.

Contracting is the vehicle for negotiating prices and agreeing performance standards. Establishing, monitoring and reviewing contracts gives purchasers an opportunity to influence provider performance. For example, standards can be set and, where providers fail to meet those standards, penalties enforced. This is important in terms of improving resource utilisation and X-efficiency. Research findings about the quality and types of contracts used however, is mixed.

Allen (1995) reviewed 12 GPFH contracts for 1993/94 and found that they bore little resemblance to well drafted commercial contracts, yet it is fundamental that parties clarify what services are to be provided in terms of tasks and standards of performance. They ought to specify inputs (staff, buildings etc), outputs (the service provided, eg, finished consultant episodes) , throughputs (eg number of patients to be seen, operations to be performed) and outcomes (the impact of services upon the recipient (eg health gain)) (Allen 1995). GPFH contracts contained some attempts to specify throughputs but "it is particularly difficult to specify ... services ...[like]... continuing care ... as opposed to discrete episodes of treatment." Specifications of levels of outputs and throughputs are incomplete as performance specifications but setting standards and measuring performance is complex. (See Chapters 2 and 3 for further discussion).

Allen's findings though have been contradicted by other studies. Locock (1995), found GPFHs favoured cost-per-case contracts because they were more effective when trying to sort out administrative problems, they invited hospital staff to visit the practice and

discuss information issues with practice staff. A similar preference was identified by Llewellyn and Grant (1996) and by the Audit Commission (1996) who found that most GPs used cost-per-case contracts (44% of sample), only 16% block contracts and 31% cost and volume contracts with their main provider. The remaining 10% used a combination of these types.

Again, in contrast to Allen's findings, Locock's sample imposed fines on providers if efficiency index targets were not met, set monitoring requirements and supplemented their monitoring by regularly issuing questionnaires to their patients. Whereas, Ennew et al (1998) identified GPFHs (albeit a minority) who were prepared to charge an invoice fee or withhold payment when invoices were issued late.

The Audit Commission (1996) reported that "Most fundholder contracts met at least half of the principles of good contract drafting." GPFHs were found to have included quality targets (see Box 4.1) based on the Patient's Charter standards although very few had included any outcome measurements. Three quarters of GPFHs surveyed set specific waiting list targets in their contracts. On a smaller scale, Oxley and Buchan (1997) discovered a total fundholding practice in Attleborough who employed a part-time nurse to monitor care given to patients and to ensure compliance with contracts and the multifund in Kingston-Upon-Thames has appointed members of its executive to monitor quality standards and health outcomes (D'Souza 1995).

Box 4.1: Standards detailed in GPFH contracts
Source: The Audit Commission 1996

- Patient's Charter standard for non-urgent inpatient waiting times - >90%
- Patient's Charter standard for waiting times in outpatient clinics to see the doctor - >90%
- Clauses covering withholding payment - >75%
- Standards for the speed and content of discharge letters - >75%
- Agreement that the GPFH would inspect quality - >40%
- Outcome measures (eg: re-admission rates, infection rates) - <20%
- Incentive bonus - <20%
- Penalty clauses if provider fails to meet contract requirements - ≅ 10%

Whilst some progress in monitoring quality is clearly being made, it remains that the simple 'classical' model of contracting is only applicable in practice under special

circumstances[7] (Bennett and Ferlie 1996) and neo-classical contracts are also inappropriate (see Chapters 2 and 3). The majority of contracts are much more complex and "the picture ... confusing" (Bennett and Ferlie 1996).

4.4.1 X-efficiency

The extent to which fundholders are able to improve X-efficiency "depends on how contract provisions translate into actual behaviour." (Ennew et al. 1998). Allen's (1995) findings that contracts were virtually devoid of detailed specifications about performance standards, performance monitoring and methods of pricing, have been shown to have been contested to an extent (Audit Commission 1996), but it remains the case that outcome measures and quality are ill defined in the NHS setting. Where peer review was occasionally mentioned, there was no mechanism by which it could stimulate better performance. Only three of the twelve contracts contained any financial methods to enforce performance and Ennew's study showed GPs' were reluctant to implement these kinds of measures.

Ennew et al. found though, that some practices had specified the number of outpatient attendances and who should see the patient, and practice managers had complained directly to hospitals where standards had not been met. The authors point out that, "While this places increased pressure on providers to deliver what they are supposed to deliver in an efficient way, the absence of formal mechanisms for enforcing the provision of the contracts raises questions about the extent to which organisational slack is reduced. Indeed, a closer examination of invoicing and payment arrangements highlights considerable inefficiencies and delays which, according to the contracts, should not occur."

Flynn et al (1996) found that GPs had not intended to use the contracting process as a means to 'drive' changes. "Contracting had enabled them to obtain improvements in information and to increase or modify particular services, but was not seen as a device to abandon current suppliers or even to coerce providers into changes. While there

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[7]For example, spot purchases of a discrete package of care from a private agency where there is no obligation to maintain a social relationship.

were some examples of 'adversarial' attitudes among some of the GP fundholders, they avoided bureaucratic or punitive styles of contracting in favour of much looser and more informal approaches."

Another way in which GPFHs can influence X-efficiency is through measures to reduce waiting lists. The Audit Commission (1996) found examples of a number of measures such as checking waiting lists carefully to ensure those waiting longest get called in before others with equal or fewer needs, and setting tight waiting time targets in contracts and switching provider if targets are not agreed/met. Implementing these measures would force the hospital to reduce the waiting list by changing the case mix, reorganising consultants' lists and checking the appropriateness of outpatient follow-ups. However, "Most fundholders do not apply [these] measures ... because they lack the relevant information about average waiting times or the number of patients waiting in particular specialties." (p21)

4.4.2 Resource Utilisation

That GPs appear to be non-price sensitive has "significant implications for efficiency and cost containment in the NHS ... Gains from the market system ... crucially depend on the price mechanism and on cost-effective purchasing ... purchasers must reward efficient provider units by strategic contracting and by responding to price signals." (Miller 1997)

Although GPs are non-price sensitive, Söderlund et al (1997) found that productivity improvements had been made in hospitals (ie, the cost per inpatient episode had reduced). They attributed this improvement to a change from DMU to Trust status although the exact forces for change were less clear. The authors suggest the possibility that hospitals were intentionally unproductive before becoming trusts so they could make gains when changing status. However, they write that "Analyses of the effect of trust status by trust wave sheds more light on the timing of productivity changes. For second and third wave trusts the largest gain in productivity was in the year of gaining trust status ... suggesting that whatever changes occurred, they were relatively immediate ... There is ... some evidence that hospitals who already had effective cost control mechanisms in place might have been more likely to become

trusts, so some of the trust productivity gains may well have happened anyway." The authors concluded that competition between hospitals had no significant effect on productivity most probably because hospitals were not competing on the basis of price but quality since GPFHs did not make price a priority. The implications of quality-based competition may actually be that prices increase as they have in the US (Ellwood 1996b; Soderlund et al. 1997)

4.4.3 Resource Transfer from Secondary to Primary Care

As well as stimulating efficiency improvements, GPs were also expected to encourage the transfer of resources from secondary to primary care, doing more within the primary care setting. The evidence suggests, however, that in this respect, the 1990 vision has not been realised. Surender et al (1995) write, "It may be disappointing, however, to those who hoped that the fundholders' scope for reinvesting savings in new practice based facilities would encourage a shift away from dependence on specialist hospital services. Our results show no such shift, at least in terms of initial outpatient referrals." (ibid). Fundholders did offer community health services from the practice (eg physiotherapy, dietetics, chiropody, psychology and acupuncture) (Audit Commission 1996). For example, in excess of 50% of GPFHs provide physiotherapy at the practice whereas for non-GPFHs the figure is less than 25% (of larger practices).

Although the Audit Commission report noted that such practice-based provision often pre-dated the practice's entry into fundholding, Corney (1994) found that there had been a general increase in facilities for investigations and treatment within practices. Eleven of the fifteen practices she studied had set up extra surgery facilities including facilities and equipment for, among others, audiology, sigmoidoscopy, cholesterol level investigations and pregnancy tests. Evans' (1996) study showed that GPs believed their workload had increased significantly, for example, they had greater demands for post-operative follow-up, although Trusts maintained that the workload increase in primary care was concomitant with the increase in GP referrals. GPs admitted that it was difficult to differentiate workload increases due to shifts from other factors like increased patient expectations.

One area where there has been some shift in the *locus* of activity is consultant outreach. Nine of the 15 GPFHs studied by Corney (1994) during 1992, had developed outreach consultant clinics directly as a result of fundholding. Others had set up physiotherapy clinics or audiology clinics and more clinics were being planned. Nineteen per cent of the practices in Leese and Bosanquet's (1996) study held outreach clinics although 46% of them were fundholders (23 practices). Outreach clinics were most common for psychiatry followed by dermatology. Clinics were advantageous because patients were seen in familiar surroundings, spent less time and money travelling and waiting times were reduced. Furthermore, fewer patients failed to keep their appointments and they saw a consultant. GPs were able to talk to the consultants about specific cases which resulted in more appropriate referrals and fewer follow ups. They also had more control over reviews and follow-up appointments. However, clinic initiatives were hampered by antagonism from providers, who felt practices lacked appropriate accommodation and facilities, and, in order to offer consultant clinics, providers required additional staff to make appointments, organise clinics etc. Moreover, consultants have at times been reluctant to participate because of the loss of economies of scale and the threat to centres of excellence (Corney 1994; Evans 1996). Leese and Bosanquet's (1996) study showed, though, that of the 42% of fundholders who had a budget surplus (27 practices), most of them expected to improve their practice premises (15) or to buy new equipment (14), compared with only 4 who wanted to introduce services for cataracts, physiotherapy (3) or chiropody (2) services in the practice. Bunce (1993) also found that the majority of fundholding savings were intended for equipment (>70%) and/or practice premises (>60%).

It would seem that although a shift in the locus of service provision is occurring, it may not be a priority to GPs who are already complaining of workload pressures (Petchey 1994; Leese and Bosanquet 1996). More broadly, the lack of resource transfer (eg. in terms of financial resources) may be because implementing a shift requires the strengthening and development of the primary care infrastructure. If more patients are to be treated (or to manage their own conditions) within primary care clinics or in the home, then community support needs to be strengthened (Lewis and de Bene 1994). Primary care centres need to develop (perhaps by increasing practice-based consultant sessions, by undertaking more minor surgery or diagnostic tests etc). This requires

financial and human resource investments and "clearly specified condition-based pathways of care, agreed between secondary and primary care providers. In particular, the respective roles and profiles of both primary and secondary care must be explicit and protocols must define thresholds for entry to and exit from secondary care." (Lewis and de Bene 1994) Importantly, problems of low morale in general practice and more evidence about appropriate and effective shifts need to be addressed (Corney 1994; Evans 1996)).

4.4.4 Information

GPs must continually make decisions about purchasing and health care provision, but as discussions have indicated they have little information to underpin their decisions. Activity transfers from secondary to primary care need clinical guidelines, protocols and pathways and defined thresholds for entry to and exit from secondary care (Lewis and de Bene 1994). Some sources of published information are available to GPs on a local and national scale and efforts have increasingly been made to produce objective measures of clinical effectiveness (eg, SIGN guidelines (Scottish Inter-collegiate Guidelines Network)) and organisations like SHPIC (the Scottish Health Purchasing Information Centre) were set up with the primary aim of providing information on effective health care.

Although considerable progress is needed regarding cost effectiveness more is known about the role and adequacy of purchasing information. Waiting lists have become more readily available and National league tables are now published. NHS Trusts also publish their price lists. As Ellwood found, there were a number of factors impeding the influence of published prices:-

"the need to look at the total package of care including out-patient prices;

the late publication of prices;

the lack of need to be receptive to price ...;

the effect of cost and volume contracts where marginal prices are paid for activity above target;

destabilising effect on local providers;
additional administrative work." (Ellwood 1996a)

"Most GPFHs were extremely dubious of the value of any league-table approach for assessing service quality. Many GPFHs said that if they were considering referring to a consultant for the first time they would ring another GP who had experience of the consultant." (Ellwood 1996a) Mahon et al (1993) though, found that waiting times did influence their referral decisions and that potential referrals outwith the district were hampered by the lack of information about comparative waiting times. Of the 254 GPs in their study, 95.8% received information about waiting times for outpatient appointments and 81.4% received information about waiting lists for surgery but this was only for hospitals in their district. For hospitals outwith the district the percentages were 53.4 and 40.5 respectively.

Another study explored the extent to which GPs used research evidence to support their purchasing activities (Farmer and Williams 1997; Farmer and Chesson 1998). GPs were given a list of 15 different personal, local and national information sources and asked to identify their degree of influence (see box 4.2 below).

Box 4.2: Sources of Information in GP Decision Making Listed in Order of Degree of Influence
Source: Farmer and Chesson 1998

Knowledge about local providers
Own professional experiences
Own intuition/hunch
Local priorities
Opinion of clinicians
Information about costs of treatment
Information about treatment of outcomes
Statistical information
Consumer opinion
Health economics
Evidence from the literature
Opinion of public health doctors
NHSME/Scottish Office Priorities
Opinion of local advisory bodies
National/local politics

Knowledge about local providers and the GPs' own professional experience were considered as having the greatest influence on purchasing decisions. The doctor's own intuition/hunch was identified by 39.4% of the 71 GPs who participated, whereas only 4.2% indicated that NHSME/Scottish Office priorities were of high influence. "Cost of treatments were highly rated by approximately a quarter of practices, but nearly two thirds saw them as having some influence." (Farmer and Chesson 1998). The most frequently stated source of information used was files kept within the practice. "Such files,

however, are likely to be idiosyncratic and may be particularly prone to personal bias..." (ibid). Local guidelines (eg, Effective Health Care Bulletins) were of little influence. Overall, the picture was one of "low and *ad hoc* use of nationally published information" (ibid) and a high reliance on personal intuition and hunch as the main sources of information (see also Shanks, Kheraj, and Fish 1995).

In another paper based on the same study, Farmer and Williams (1997) combine the influences on sources of information upon GP purchasing with the importance of these same sources upon Health Board purchasing. Sources used by the Health Board are in stark contrast to those used by GPs. The priority runs almost in reverse to the sequence in Figure 4.3.

When asked whether they thought that quality of information was poor, adequate or high quality, responses were 37%, 60% and 3% respectively. Most felt they needed improved health outcome measures and effectiveness information upon which to base decisions. More accurate waiting times were also thought desirable.

In Laing and Cotton's (1996) study of the main sources of information "The most striking feature of GP fundholder purchasing behaviour is the overwhelming reliance placed by GP fundholders on what may be described as informal or non-controllable sources of information." GPs were found to place "particular importance ... [on] direct personal knowledge or experience of the key professionals responsible for service delivery, rather than 'second hand' knowledge or experience." Like Farmer and Chesson (1998), Laing and Cotton found that fundholders placed "little or no weight on the more formal, largely impersonal sources of information." (See Figure 4.3)

Figure 4.3: Relative importance of source of information in GP decision making.
Source: Laing and Cotton 1996

1	Clinical outcome of previous referrals to consultant
2	Personal knowledge of consultant
3	"Word of Mouth" - patients
4	"Word of Mouth" information - other GPs
5	"Word of Mouth" - other health professionals
6	Professional publications
7=	Health board literature
7=	Promotional / contractual materials from providers
9	Seminars / presentations from providers

Farmer and Williams (1997), Ellwood (1996) and Laing and Cotton (1996) all note the influence of other GPs upon purchasing decisions. That GPs rely on their own views and the views of other GPs when referring patients is perhaps symptomatic not only of the lack of information but the nature of services. Laing and Cotton (1996) contend that,

> "Health care services are highly intangible, both physically and mentally; they are heterogeneous over time as well as per customer, ... and production and consumption are inseparable with customers taking an active part in the delivery process ... professional services consist primarily of **experience and credence** qualities. Such a characterisation of professional services is crucial, in that **evaluation and judgement of such services are based on experience and perception**." (emphasis added)

Hunter (1997) concurs with this view and suggests that even with the developments in knowledge bases, medicine remains an art/craft so clinicians will continue to rely on expert judgement.

4.5 What Kind of Market?

This chapter has presented a range of evidence about the NHS market which suggests that GPs are non-price sensitive and not seeking to drive efficiencies but that they are concerned with quality and local access and also the very nature of services is such that purchasers rely heavily upon experience and judgement in their decisions and less so upon formal or published information (Laing and Cotton 1996; Mannion and Smith 1997). Nevertheless, a number of studies have identified the primary/secondary interface as being where GPs can and have exercised considerable leverage (Wisely 1993; Glennerster et al. 1994a; Lapsley, Llewellyn, and Grant 1997). GPs do not need to make major contract switches, but need only move those contracts which are at the hospitals' margins for break even to generate a response. Furthermore, Glennerster et al (1994b) noted that where over half the practices in an area became fundholders, the impact on providers was considerable and conversely where numbers

are small, buyer power is weaker. This presence negated the need for contract switching.

Despite the lack of provider switching and contract penalties, negotiations between purchasing GPs and providers have yielded results. GPs have focused mainly on care management but have demonstrated a growing desire to influence clinical care (Llewellyn and Grant 1996). In the main they have stimulated direct/open/rapid access services and improved purchaser provider communications:-

- *Direct access* services in audiology, endoscopy, radiology and cardiac investigations have been a key area of progress (Corney 1994; Howie, Heaney, and Maxwell 1995; Evans 1996). They allow GPs to make more rapid assessments and provide more appropriate treatment.

- *Communications with the provider* have been identified as a main area of improvement since fundholding (Glennerster et al. 1994b; Audit Commission 1996; Evans 1996; Llewellyn and Grant 1996). In Evans' study, GPs reported a marked difference in the attitudes of trust managers and consultants "who now listened and took account of GP views". This was attributed to the consultant's awareness of the increased power of GPFHs within the market although Evans comments that "this perception of increased GP power was stronger in the trusts and the commission than among GPs themselves. One trust respondent commented that GPs had greater potential power, but had not yet worked out how to use it effectively." GPs though tended to be very aware of the limitations of their power.

Flynn et al (1996) proposed that the balance of power has swung in favour of the GPs and they were becoming involved in the design and specification of services, particularly service quality:

> "...contracts did not appear to be valued because they stimulated supplier competition or large-scale shifts in services *per se*. Rather, they were seen

(and used) as vehicles through which the fundholder could articulate a demand for information and influence quality in a way they were unable to do before holding their own budget, but which had been a long-held aim." (ibid).

4.5.1 Social Embeddedness

Buyers are enacting their role, exerting their influence, within a socially embedded market context. They are collaborating with providers (Bennett and Ferlie 1996) in a setting which is underpinned by close professional relationships which exist between clinicians across different sectors of the health service (Laing and Cotton 1996) . GPs and hospital clinicians share much of their educational and training experience and their relationships continue to exist across organisational boundaries within the healthcare market (Laing and Cotton 1996) or rather, "the market mechanism within the health service was effectively super-imposed on such existing relationships, and the resultant market relationships are viewed by many clinicians as secondary to these professional relationships."[8] (ibid)

Laing and Cotton contend that "It is almost inevitable within the context of services such as medical care, that the existence of these relationships will be relied on even by professional intermediaries, as the key source of information underpinning purchasing decisions." Interestingly, Laing and Cotton found that where there were no such relationships, the relative ranking of decision criteria changed. Priorities for purchasing laboratory services altered to: service range (most important), financial considerations, administration, loyalty, previous experience, reputation and least of all patient interest[9]. There are not the same strong, shared relationships between GPs and laboratory service providers because many of the latter come from a scientific rather than medical background[10] so loyalty became less important. Loyalty was a feature in

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[8]Laing and Cotton make reference at this point to Harrison S (1995) "Clinical Autonomy and Planned Markets: The British Case" in Saltman R and Von Otter C (Eds) *Implementing Planned Markets in Health Care*, Open University Press, Buckingham.

[9]Figure 4.4 shows the results for referrals to general surgery, orthopaedic surgery and gynaecology.

[10]Another factor is that laboratory services are more 'tangible' than other services and can more easily be standardised. Because of this, there is likely to be little variation between providers in terms of the actual service delivered. Past experience and reputation become less important decision criteria for GPs and thus heightens their willingness to switch provider.

the study by Flynn et al (1996) who found that "The possible threat of replacement by competitors from outside the locality was not seen as feasible or reasonable by most GPs and GP fundholders; instead, they appeared to endorse a network approach in which loyalty to colleagues ... was essential." (p136)

Despite their shared medical training and education, there are accounts of the deep division which has historically existed between these generalists and specialists (Honigsbaum 1979, 1993; Glennerster et al. 1994b). In a recent study Marshall (1998) acknowledged this history and expected to find it's legacy today but discovered instead that although "there might still be problems with mutual understanding and communication ..." that there is also a "high level of mutual respect and co-operation between the two branches .. and a strong desire to build a personal relationship over a long period of time." Marshall found that mutual support was more prevalent than conflict and that there were perceived benefits for patients where clinician relationships were based on trust and mutual respect. GP-consultant relationships are not devoid of conflict or tension, but the potential for continued good working relationships was found to be considerable.

Flynn et al (1996), found that inter-organisational trust was based on a perception that professionals delivering community services delivered high quality work and had knowledge of the locality. GPs were therefore willing to place a great deal of trust in providers "in a whole range of circumstances" (p136). That social relationships influence the maintenance of quality is particularly important given the deficiency of NHS contracts in specifying quality standards (Allen 1995).

4.5.2 Scotland and England - Two of a Kind?

Before concluding this chapter and clarifying the research gaps to which this thesis contributes, one last distinction must be made concerning fundholding and purchasing. As this chapter noted earlier, the enthusiasm with which fundholding was embraced differed between Scotland and England. It also differed across geographical regions within these two countries. In England, for example, on the 1st April 1995 there were 93 funds in Essex and 87 funds in Kent but only 3 in Sunderland and 1 in Camden and Islington (Audit Commission 1995).

Similar differences occurred in Scotland (see Appendix I) where the uptake in Grampian, Lothian and Tayside has been more rapid than elsewhere. In 1996[11], Grampian Health Board, followed by Borders Health Board had the highest number, and the greatest percentage, of the population covered by fundholders in Scotland. In both Boards more than 50% of the population were served by fundholding GPs. Greater Glasgow Health Board (GGHB), the location for this study, ranked 9th out of the 15 health boards in terms of both the number of fundholders and the percentage of the population covered by fundholding GPs. In GGHB there were 61 fundholders (compared with 163 non-fundholders) who between them covered 30.9% of the GGHB population.

Of particular significance to this research is the fact that by 1996, only 3 published studies had looked specifically at the Scottish market (Howie, Heaney, and Maxwel[l] 1995; Laing and Cotton 1996; Lapsley, Llewellyn, and Grant 1997) and of them only two (Laing and Cotton 1996; Lapsley, Llewellyn, and Grant 1997) concentrated on purchasing. Llewellyn and Grant's study focused on Grampian, Lothian and Tayside and included non-fundholders, whereas Laing and Cotton covered the whole of Scotland but sampled only fundholders[13]. Of further interest is the fact that Lapsley et al's (1997) study suggested that there are "distinctively Scottish aspects to GP fundholding" (p47) in terms of the motivation of GPs seeking to join the scheme; the degree to which GPs identified with the overall aims of the Scottish health service; and particularly as regards their desire to work with providers:

> "...predominantly, these fundholders have worked in close liaison, have sought to target specific issues, whether of care management or clinical practice, in their negotiations with hospital trusts and have sought to ensure such gains are available to patients of both fundholding and non fundholding GPs" (p48).

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[11] The fieldwork for this thesis began in 1996.

[12] The publication cited previously by Llewellyn and Grant (Llewellyn and Grant 1996) was from the same study as Lapsley et al (1997).

[13] Although Laing and Cotton's (1996) study was Scotland-wide, three of the health boards at that time had no fundholders and so were not included so the fundholding population but not the geographic patient population was covered.

As the following section goes on to conclude, whilst evidence concerning the reforms is limited, Scotland as a whole, and the west of Scotland in particular, are particularly under-researched.

4.6 Conclusions: What Does the Evidence Say & What are the Research Gaps?

A number of authors have reviewed the empirical studies of fundholding and purchasing and have agreed that the evidence is mixed, limited and ambiguous not to mention riddled with methodological difficulties (see for example Appleby 1994; Maynard 1994; Coulter 1995a). These and other authors (see for example Coulter 1995a, b; Petchey 1995; Baggott 1997; Gosden, Torgerson, and Maynard 1997; Smith and Wilton 1998) all warn of the difficulties in drawing firm conclusions too early, so offer cautious conclusions. With their warnings in mind, some general conclusions from this chapter are stated below.

4.6.1 Economic Incentives in Fundholding:

Evidence:

Studies have shown that GPs have not responded to financial incentives in the way they were expected to. More efficient prescribing did occur, but fundholders were unable to sustain the momentum over the long term whereupon costs increase at the same rate as fundholders. Referral patterns overall have not changed. Practices continue to refer according to traditional patterns although there has been some change in the type of referral - GPs are making greater use of direct access services for example although they have not achieved the anticipated targets for day surgery both of which would be cheaper services to purchase.

Research Gaps:

(1) Studies do not comment fully on why referral patterns have not changed. There are suggestions that it may be to do with loyalty to a provider, or an

unwillingness to make their patients travel, but more research is needed to identify the rationale behind GP behaviour.

4.6.2 Efficiency and Quality:

Evidence:

GPs have not been primarily engaged in stimulating improved efficiencies as was anticipated. Price is of less importance to them than service quality and access, and practices are reluctant to switch provider. This means that they are not putting pressure on hospitals to reduce costs although they are calling for improvements in functional quality (care management) and technical quality (clinical care). They have, improved x-efficiency (although this concept of efficiency has not been explored in empirical studies) although it is unclear how, as their emphasis on quality has not been translated into contracts with sanctions for non-compliance.

Research Gaps:

(2) It is not clear whether the lack of attention to efficiency is because GPs think hospital services are efficient, or whether there are other issues which are of greater importance; for example, there may be some social process (eg loyalty to hospital doctors) which causes GPs to avoid bringing pressures to bear on hospital costs.

(3) If GPs are claiming improved quality of hospital services but they do not set targets and standards or impose fines within contracts, how are they stimulating quality improvements? What are the factors which put sufficient pressure on Trusts to improve practice?

(4) To what extent are GPs actually seeking to improve x-efficiency or is it a by-product of other negotiations?

4.6.3 Resource Allocation:

Evidence:

Fundholding studies have identified a number of areas in which practices have developed primary care services (eg, outreach clinics, practice-based audiology) which suggests that there is a shift in the locus of service provision.

There are, however, limitations to transferring activity, for example, the cost effectiveness of consultant outreach clinics is not yet known and the primary care infrastructure may not be developed enough to support new services. Developments which have occurred have not been widespread and have not been unique to fundholders. Furthermore, it is not clear whether resources are being released from secondary care to fund new primary care services.

Research Gaps:

(5) The evidence does not show whether GPs trying to release hospital funds to develop primary care services, is a specific priority.

(6) Studies do not identify whether transferring financial resources from the secondary to the primary sector is possible and is occurring.

4.6.4 The Purchasing Function:

Evidence:

Chapter 2 proposed that GPs as individual purchasers have limited buyer power. The evidence presented here has shown that consortia/multifund purchasing is believed to have increased buyer power. Collaboration has also helped to pool resources (financial and human).

Studies have shown that purchasing decisions are based to a large extent on personal judgement and less so on formal information sources. GPs are operating within a socially embedded market where they value open dialogue with clinicians and seek partnerships. They do not develop sophisticated contracts for renewal the following year, but intend to continue with their traditional providers over the long term.

The market has been criticised for bearing heavy transactions costs. Costs may be negated to a degree by the move towards relational contracts but because the transactions costs framework is a comparative one and no fundholding pilots were conducted, research is unable to identify the real scale of these costs.

Research Gaps:

(7) Studies have not compared the relative strengths of individual versus consortia purchasers. It is not clear who has the greater influence over hospitals.

(8) The relationship between purchasers and providers has been described in terms of referral patterns, and has been characterised as based on trust, personal relationships and so forth. However, little is known about the detailed *content* of the relationships or the interaction process. For example: what do clinicians discuss which they did not previously talk about?; how do they communicate?; is the relationship characterised by conflict or harmony; how are quality issues tackled?

(9) Transactions costs have been of concern to management researchers and economists (see Chapter 2). It is not known, however, whether GPs and trusts are concerned about transactions costs or are actively seeking to reduce them.

4.6.5 The Scottish Health Service:

Evidence:

The uptake of fundholding was greater in England than in Scotland. Furthermore, in Lothian, Tayside and Grampian, the fundholding scheme was adopted with much greater enthusiasm than elsewhere in the country.

Research Gaps:

(10) Glasgow, although one of the largest health boards, is one about which little is known in terms of fundholding and purchasing. As an area characterised by a more reluctant uptake of fundholding, what are the attitudes of GPs in the area and do they differ from elsewhere in Scotland and Engand?

Of the research gaps identified above, all but number 2 are addressed in this thesis. This is because this study concentrates on the purchasing dimension of general practice rather than aspects of primary care provision.

4.7 Summary

The NHS reforms stimulated a broad research agenda, the pursuit of which has been hindered by the lack of formal review studies and has been made more complicated due to the influence of ongoing policy developments. Nevertheless, there is a growing body of evidence concerning GP fundholding and purchasing from which general conclusions can be drawn. It can be said that GPs have been motivated by social goals; have been largely insensitive to prices; have been preoccupied with issues concerning service quality; and have been reluctant to shift contracts, preferring instead to work collaboratively with (predominantly) local providers. They have also placed greater reliance on personal or local knowledge and judgement than formal information when making purchasing decisions.

There remain, however, a number of gaps in the research concerning GP purchasing. This chapter has identified 10 such gaps which are addressed in this study. They concern the extent to, and means by which GPs actively seek to improve hospital efficiency and service quality; the nature of the purchaser provider relationship (social and economic characteristics); and initiatives to stimulate resource transfer. Particular emphasis was also given to the need for more research in Scotland.

Having now reviewed the purpose and development of the reforms and identified the research gaps (Chapters 1-4), Chapter 5 proceeds with a discussion of the research aims for this study and the methodology that was adopted.

Chapter 5

Research Methodology

Introduction

Chapters 1-4 have provided detailed discussions about the historical context of the reforms; the theoretical arguments underpinning the market arrangements; the differing characteristics of market and network forms of organisation and their likely impact on the NHS; and the empirical evidence concerning GP purchasing behaviour. Having identified a number of research gaps in the preceding chapter, this chapter goes on to discuss the qualitative methodology that was adopted. Interview and observation techniques were employed in order to view the purchasing role and relationship from the perspective of the GPs. The mode of enquiry was therefore flexible, allowing emerging themes and dynamic processes to be accommodated.

Chapter 5 restates the aims and objectives of this study and justifies the ***research methodology*** adopted. It then goes on to discuss the ***interview*** and ***observation processes*** and ***sample characteristics***. Care is taken to clarify the geographical context of the research and the links between subjects who were interviewed and observed. The chapter also discusses the methods of ***analysis*** and ***concept derivation***. Reflections on the ***role of the researcher*** are made and the ***limitations of the research*** are also discussed. The chapter concludes by setting out the structure for the empirical chapters which follow.

5.1 Research Aim & Objectives

The subject of this thesis was very much driven by the issues stimulated after the introduction of the NHS internal market. As Chapters 1-4 have discussed at length, GPs were expected to be drivers of change and efficiency through their purchasing and commissioning activities yet, whilst some conclusions can be drawn about the extent to which these expectations were met, there is much that is still uncertain. Ten research gaps to which this study contributes were identified in the previous chapter. In order to contribute to these gaps, the following research aim was developed:

> ***to explore the role GPs are performing as purchasers and to identify which of the purchasing-/market-related issues are of particular concern to them.***

More specifically, the objectives were as follows:

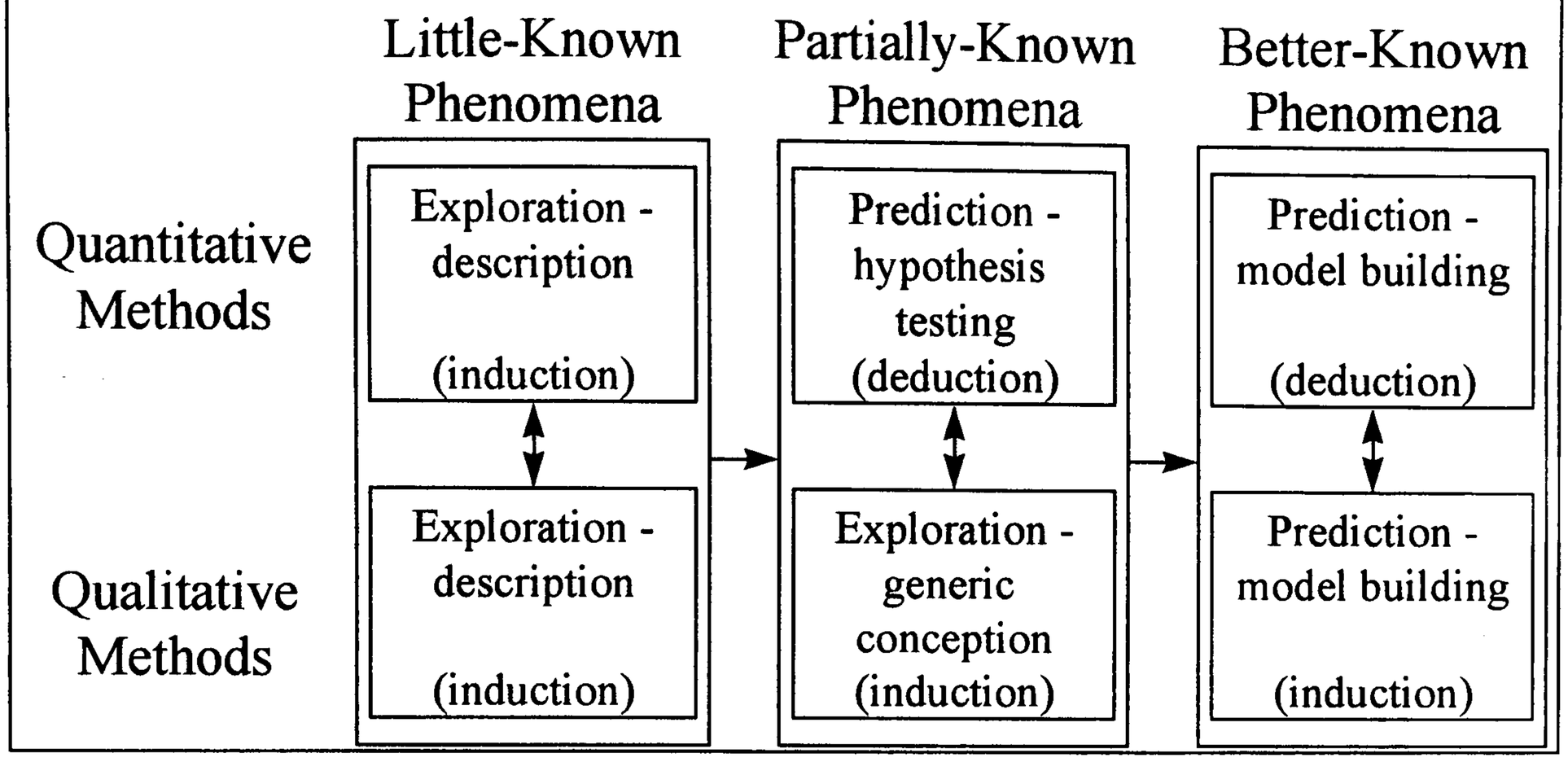
- to consider whether GPs are seeking to stimulate efficiency in secondary care;
- to find out whether GPs are seeking to initiate the transfer of resources from secondary to primary care;
- to understand the relationship between GPs (as purchasers) and hospital Trusts (as providers); and
- to identify implications for policy makers and managers within the NHS.

5.2 Research Methodology - A Qualitative Approach

When selecting a research methodology, it is important to suit the mode of enquiry to the research aim (Adams and Schvaneveldt 1985). Cassell and Symon (1994) offer a number of reasons why, when doing exploratory research in changing organisational environments, a qualitative method of enquiry is particularly suitable (see also Shaffir and Stebbins 1991). Firstly, it is less likely to impose restrictive a priori classifications on the collection of data, therefore "research is less driven by very specific hypotheses and categorical frameworks and more concerned with emergent themes and idiographic descriptions" (Cassell and Symon 1994:4). Qualitative methods also allow flexibility in the research process and thus the opportunity to pursue emerging insights. This flexibility extends to the methods employed such that the researcher can "change the nature of his or her intervention as the research develops in response to the changing nature of the context." (ibid. p4). This is particularly important because as Cassell and Symon note, "the fact that we are working in complex situations means we cannot define exactly what we are interested in or how to explore the issue at the outset", (ibid. p4) and "only qualitative methods are sensitive enough to allow the detailed analysis of change" (ibid. p5), which is crucial when organisational dynamics are of interest. Moreover, and importantly, qualitative methods are "concerned with understanding human behaviour from the actor's own frame of reference ..." (Bogdan and Taylor 1975) here, from the perspective of the GPs.

Figure 5.1 below shows the relationship between qualitative and quantitative methods as determined by the degree to which the phenomena are known.

Figure 5.1: The Relationship of Qualitative and Quantitative Methods
Source: Shaffir and Stebbins 1991



It indicates that both quantitative and qualitative data may be gathered during exploratory studies but that, "most exploratory studies … are predominantly qualitative, possibly augmented in a minor quantitative way by such descriptive statistics as indexes, percentages, and ennumerations." (ibid, p6). The better-known the phenomena, the more research tends to rely on prediction. This study lies to the left of the diagram as a little or partially-known phenomena.

Notwithstanding the importance of suiting the aim and mode of enquiry, there were a number of additional contextual and empirical factors which confirmed that a qualitative approach would be most suitable as they underpinned the need for face to face discussion or observation as a means of understanding purchaser-provider interaction.

5.2.1 General Practice Climate

Certain characteristics of the primary care environment at the time also suggested that a qualitative approach would be required. In particular, the policy environment was changing continually. The stipulated patient list size for fundholders was reduced giving greater scope for eligibility[1] and the scheme was expanded in two directions to

[1] The proposed criteria was 11,000 patients but when enacted in 1990 was reduced to 9,000. In 1993 the limit was reduced to 6,000 patients, and to 4,000 in 1995.

increase the range of services included (via total fundholding) and to reduce the scope of the budget (via PCP/ Community Fundholding). In addition, non-GPFHs were embraced within the purchasing framework via health board purchasing. At the same time, alternative purchasing and commissioning frameworks (from total purchasing pilots to consortia, locality purchasing, practice sensitive purchasing and health authority commissioning) were emerging across the UK in a mosaic of arrangements. The environment was, therefore, not only fluid but complex making the research a more difficult process (Robinson 1996). Cassell and Symon suggest that in an environment which is changing, only qualitative methods are "sensitive enough to allow the detailed analysis of change ... with quantitative methods we may be able to assess that a change has occurred over time but we cannot say how (what processes were involved) or why (in terms of circumstances and stakeholders)." (Cassell and Symon 1994:5) Although this is not a study of change per se, the characteristics of general practice are such that studies need to take account of and be sensitive to the changes which are occurring in primary care.

With such a diverse range of structures and a general ambiguity about definitions of and differences between purchasing and commissioning (see chapter 2 for discussion), the language and practice of purchasing/commissioning was complicated and it was clear that the language one might use within a questionnaire or interview about purchasing was also potentially complex. Theoretical concepts had been used within the medical literature but were often not explained. It was not clear therefore, to what extent they were accurately understood by medical practitioners. The term transactions costs, for example, was used but little explained and could easily have been taken to mean the administrative costs of the contract and invoicing system rather than the more comprehensive notion which includes search costs for information arising from uncertainty, switching costs incurred due to asset specificity etc. Where concepts such as 'fundholding' were well-defined it was not ambiguity which was a problem so much as the fact that the terms were emotive. For example, the word fundholding could provoke reactions ranging from apathy and indifference to enthusiasm or opposition.

Some final concerns which influenced the choice of methodological approach were that the agenda had moved on in primary care. In June 1996, the Scottish Office hosted a one-day conference in Dundee entitled "Primary Care, the Way Ahead". The meeting was attended by a range of people from the Scottish Office, HBs, social work, general practice, nursing and community services. The issues in which they were interested included service quality, involving and informing carers, integrating health and social care, working in primary care teams, strengthening primary care co-ordination, matching primary care resources to changes in patient demand, all dimensions of managing primary health and social care rather than purchasing or improving secondary care services or debating alternative models of fundholding. Indeed, the subject of fundholding was rarely raised during the discussions.

That the agenda was shifting to these issues raised concerns that the apparent irrelevance (particularly to non-fundholders) of a questionnaire about fundholding and purchasing might contribute to a low response rate. This concern was compounded by a general awareness that GPs felt they had too much administration, and by question marks over the future viability of the fundholding scheme. I decided to seek advice from primary care researchers at Aberdeen University. Their recommendation was that unless I had a prior relationship with practices in Glasgow, I ought to adopt an interview-based approach because their experience suggested that questionnaire return rates would be low.

It is clear from the literature review in Chapters 2-4 that there was a range of purchasing-related issues which could potentially have been of concern to GPs. Trying to identify those peculiar to any one GP and to explore them via some form of questionnaire was likely to prove problematic when coupled with the need to provide definitions of otherwise ambiguous terms and concepts in order that responses could be compared as like with like. Coupled with concerns about poor response rates, the arguments in favour of a qualitative approach were compelling.

5.3 Fieldwork

In line with the arguments presented above, a qualitative approach was adopted. The choice then became one of selecting a suitable method such as participant observation, interviewing or focus groups in order to yield data from the subjects' point of view (Bogdan and Taylor 1975:2). The choice of method was not only theoretical but also pragmatic. To undertake participant or non-participant observation, I needed access to inter-practice meetings or purchaser-provider meetings but I had not established the right contacts within general practice to begin with this strategy. Focus groups were also an unlikely option because of the need to bring a group of GPs together when they were already complaining about being over-worked and were seeking to reduce their commitments by, for example, working co-operatively in out-of hours services. On the advice of medical and academic colleagues[2], I decided to undertake a series of interviews with GPs and fund/practice managers gaining initial access through personal health service contacts (see below).

5.3.1 Interviews

Before detailing the nature of the interviews and observations, it is important to clarify some particular characteristics of Glasgow which are relevant to the sample choice. Of the health boards with fewer fundholders, Glasgow is a particularly interesting area to study because it accommodates 5 acute hospitals whose relative proximity means that patients can easily access alternative providers. As two of the hospitals are located on the south side of the city and the other three on the north, practices located in the city centre, west or east end are well placed to benefit from a number of alternative providers. There are also a number of private sector providers, so the potential for competition/contestability is high.

As Chapter 4 noted, GGHB is a Board which, in terms of fundholding uptake, ranked 9th out of the 15 Boards. The statistics in Appendix I show that in GGHB there were

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[2] Medical colleagues were public health clinicians and a GP with whom I had worked in previous years. Academic colleagues were Lorna McKee, Angus Laing and Gordon Marnoch from Aberdeen University.

53 live fundholding practices in 1996[3] and a further 8 shadow practices. By 1997 therefore, there were 61 live fundholding practices. These 61 practices represented 27.2% of all GGHB GPs and between them covered 30.9% of the population. Although at that time GGHB had a relatively low fundholding rate, it had the highest level of practices in the preparatory phase and the interest in PCP fundholding during 1996 was such that by 1997, more than 50% of practices were PCP budget holders[4].

Like other HBs and HAs, GGHB has created a locality framework for commissioning. The HB divided Glasgow into 3 sectors: south, north east and west. Each sector was then further divided into localities of which there were 19 and within which there are a number of LPAs to represent the GPs in their locality[5]. The LPAs' views were then given to the sector's Purchasing Facilitators who acted as the conduit between the HB and the locality on commissioning/purchasing issues. In 1998 an additional role of clinical commissioner was developed whereby one GP worked on a sessional basis as an advisor to the health board. GGHB's commissioning arrangements embraced both fundholders and non-fundholders although fundholders purchased certain services via their own direct provider negotiations.

5.3.2 Interview Sampling

A purposive interview sample was selected (Churchill 1991; Cassell and Symon 1994) to include each type of fundholder, (including practices who had been purchasing for some time and who had, therefore, had ample opportunity to build a relationship with their provider(s)) as well as non-fundholders. Some interviewees were selected specifically because they could "shed light on a particular aspect of the behaviour under investigation" (Cassell and Symon 1994) - this is sometimes known as the expert judgement technique (Churchill 1991; Cassell and Symon 1994). The LPAs, for example, were chosen because they could comment on their purchasing role within the

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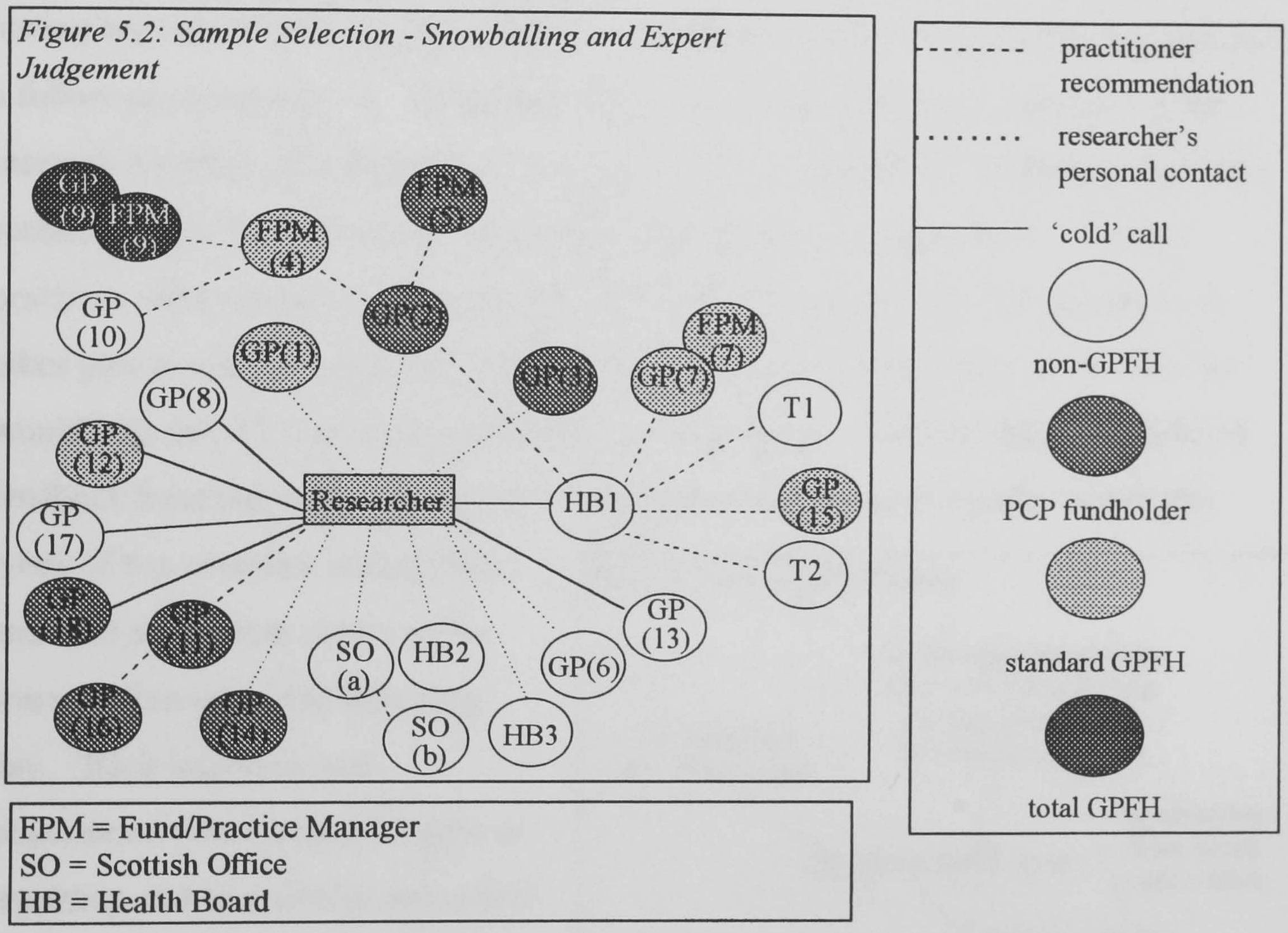
[3] The data for this thesis were collected in the GGHB area between the end of 1996 and the middle of 1998.

[4] By 1998 the figures had increased quite significantly to 78 PCP practices (including 6 in the shadow year); 38 standard fundholders (including the total purchasers) and 101 non-fundholders.

[5] This framework has changed under the new PCT and LHCC structure.

GGHB commissioning framework and could comment on how GPs in their locality behave as purchasers. Others were selected using the snowballing technique, (ie, the initial set of respondents were used as informants to identify others with the desired characteristics). The figure below identifies which of the interviewees were recommended (snowballing)[6], which were personal contacts and those who were 'cold' contacts (expert judgement). It is also clear from the diagram that interviewees HB1 and GP(2) were important gateways to subsequent interviews.

Figure 5.2: Sample Selection - Snowballing and Expert Judgement



FPM = Fund/Practice Manager
SO = Scottish Office
HB = Health Board

Eighteen practices contributed to this study via interviews and multiple observations and a further 13 were observed but not interviewed. Of those interviewed, 13 were fundholders, 11 of them from GGHB (17% of the fundholding population in Glasgow at the time)[7]. It is worth noting that this is the first published study in Scotland to have included PCP fundholders in its sample. In order to obtain a general picture of

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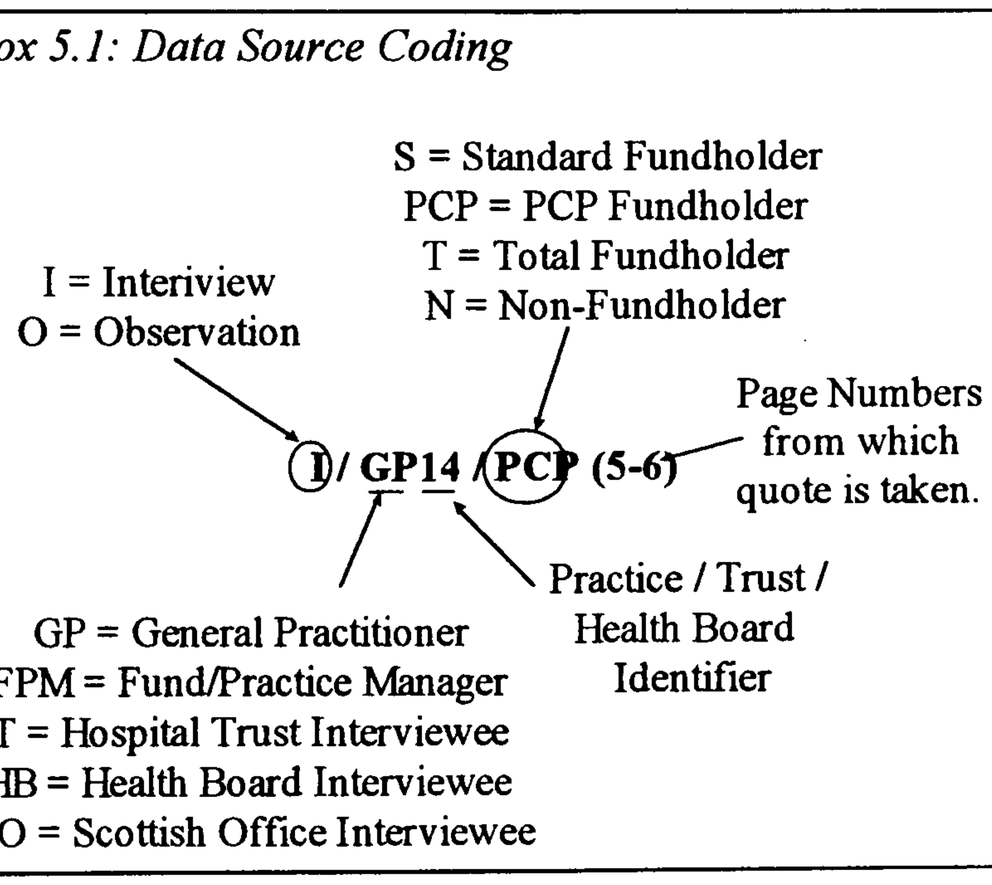
[6] It was sometimes through a combination of snowballing and expert judgement by which interviewees were selected. GP9, for example, was contacted through snowballing but had also been identified (expert judgement) as someone important to speak to because he was involved in the GPFHA, was a total fundholder and regularly spoke to the media.

[7] This includes PCP and shadow fundholders.

purchasing behaviour within Glasgow and across Scotland, interviewees included health board commissioners and members of the primary care division at the Scottish Office. Two Trust contract managers were also interviewed in order to gain an understanding of their view of GP purchasing behaviour. Two health board interviews (Forth Valley and Borders) were not used directly in this study but were used as background material.

Twenty six interviews[8] were conducted, all held at the employees' place of work and lasting between 45 minutes and 2 hours. Each interviewee was contacted by letter and a follow-up telephone call. Included with the letter was a one page summary of the research purpose and sample interview questions[9]. If the GP/Fund Manager had been recommended, the letter began by stating who had recommended them. Twenty practices were contacted of whom one declined to participate (the GP said he never takes part in academic studies) and one other said they were too busy at the time but would help out if I was having difficulties gaining access. Each practice was offered feedback from the study. Interviews were transcribed verbatim usually within one week of the interview taking place and field notes from observations were written up by the following day. Each interview and observation was labelled for ease of reporting and to maintain anonymity. The source coding is explained in Box 5.1.

Box 5.1: Data Source Coding



The breakdown of GP/Fund/Practice

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[8] The two Scottish Office interviewees were jointly interviewed.

[9] Colleagues at Aberdeen University had stressed the value of providing practices with a (nicely produced) summary sheet. The GPs they had worked with responded more positively when they could see that the researcher(s) had made an effort to clarify the purpose of the interview.

Manager interviewees can be seen in Table 5.1 which also identifies their length of time as fundholders and their roles (where applicable) within GGHB's commissioning structure.

Table 5.1: General Practice Interviewees, Their Purchasing Status and Locality Role

GP Identifier	Fundholding Status	Fundholding Date	Location NE/W/S	Wider Purchasing Role
GP6	Non-GPFH	-	W & NE	
GP8	Non-GPFH	-	NE	LPA and speaks publicly (eg, to the media) giving a non-fundholder perspective
GP10	Non-GPFH	-	W	LPA
GP13	Non-GPFH	-	S	
GP17	Non-GPFH	-	W	
GP3	PCP	1995	Forth Valley HB	Medical Director of a Community Trust
GP2	Prep. PCP	1996	W	
FPM5	PCP	1995	NE	
GP11	PCP	1995	S	Purchasing Facilitator, now Clinical Commissioner
GP14	PCP	1994	S	LPA
GP16	PCP	1998	S	Purchasing Facilitator
GP18	PCP	1996	NE	
FPM4 GP4	Standard	1993	W	GP is former Chairman of the GPFHA and is very involved at health board and local medical committee level.
GP1	Standard	1991	Lanarkshire HB	Also University Lecturer
FPM7 GP7	Standard	1991	S	
GP12	PCP Standard	1995 1997	NE	
GP15	Standard	1992	NE	
FPM9/ GP9	Standard Total	1992 1994	NE	Chairman of the GPFHA. Very outspoken supporter of fundholding.

In summary, there were 5 non-fundholders, 7 PCP fundholders, 5 standard fundholders and 1 total fundholder. With the exception of the total fundholder, each geographical sectors was represented in each category. An LPA for each sector was also included in the sample plus two purchasing facilitators for the south sector of whom one is now a clinical commissioner. In addition, the sample includes Glasgow's first fundholding practice, a total fundholder (of which there were only 3 in Scotland at the time), two very outspoken fundholding enthusiasts and an outspoken non-fundholder. Four of the fundholders had been involved in the scheme for more than 5 years and two of them had been fundholders since the scheme began in Scotland. Although the sample is not numerically representative, it represents the types of fundholding and non-fundholding purchasers and includes GPs at all levels of the health board's commissioning/ purchasing structure. It also represents the views of some of the most experienced fundholders in Glasgow who are particularly well placed to comment on the fundholding and purchasing scene.

5.3.3 Interview Design

The research design was neither highly inductive (loose) nor highly deductive (tight) but combined elements of both approaches as described by Miles and Huberman (1994): "Much qualitative research lies between the two extremes. Something is known conceptually about the phenomenon, but not enough to house a theory. The researcher has an idea of the parts of the phenomenon that are not well understood and knows where to look for these things - in which settings, among which actors." (p.17) This meant that there were aspects of both approaches within this study as described again by Miles and Huberman who write, "...we should not forget why we are out in the field in the first place: to describe and analyse a pattern of relationships. That task requires a set of analytic categories. Starting with them (deductively) or getting gradually to them (inductively) are both possible. In the life of a conceptualisation, we need both approaches ... to pull a mass of facts and findings into a wide-ranging, coherent set of generalisations." (p17)

Following the literature review, a number of market-related themes were identified and incorporated into an interview schedule (see Appendix II) to provide an interpretative

framework (Bogdan and Taylor 1975) for deductive analysis. The schedule included questions covering the following areas:

- efficiency of resource utilisation
- resource allocation / transfer
- transactions costs
- buyer power
- primary care-led decision making
- the necessity of the purchaser provider split

The interview schedule was designed to elicit data on these themes but within that, to allow related issues which were of significance, to be raised by interviewees and allow for inductive analysis and theory generation.

Although the first interview was guided in a semi-structured fashion based on the schedule, it became apparent that both the language used and the range of topics covered were not as suitable as intended. The data gathered were appropriate to the research purpose, but the interview was more restrictive than anticipated. Both the interviewer and interviewee felt constrained during discussions by the need to complete all the scheduled questions and there was, therefore, too little scope for new themes to emerge and be pursued. During reflections following the interview, it was thought that greater opportunity should be provided for GPs to raise issues they thought important and for the interviewee to guide the discussion more gently. In other words, the interviews became more thematic, "focused on particular themes ... neither strictly structured with standardised questions, nor entirely 'non-directive'." (Kvale 1983:31)

This more flexible approach meant that the schedule was reconstituted into a thematic guide of the territory through which the interviewee and interviewer travelled with greater freedom (see Appendix III). This accords with the position adopted by the researcher as what Kvale describes as a *traveller*. Kvale (1983) suggests that the researcher's approach to new knowledge will depend on whether s/he adopts the role of miner or traveller. The miner considers knowledge as a "given" which needs to be

sought by the miner as s/he digs deeper and deeper for the nuggets of treasure (knowledge) which are there to be found. The traveller, on the other hand, considers himself/herself as being on a journey which leads to a tale to be told when returning home. The traveller wanders through the landscape and enters into conversation with those s/he encounters. The traveller explores domains, roams freely around the territory talking to natives in order to learn about their world. S/he then interprets and re-tells these stories.

The change in approach did mean more pre-interview preparation because methodological choices had to be made *during* the interview (eg. when to close one topic and move onto the next, how to pursue a theme without loosing direction and when to pursue a new emerging issues). Each choice demanded a decision about the relative importance of that particular topic and the overall direction of the interview. Such choices are recognised characteristics of thematic/focused interviews (Kvale 1983). Kvale writes "The aim is to make decisions about method on a reflective level, based on knowledge of the topic of the study and of the methodological options available, and their likely consequences for the interview project as a whole[10]. The very openness and flexibility of the interview, with its many on-the-spot decisions - for example, whether to follow up new leads in an interview situation or to stick to the interview guide - put strong demands on advance preparation and interviewer competence. The absence of prescribed sets of rules creates an open-ended field of opportunity for the interviewer's skills, knowledge, and intuition. Interviewing is a craft that is closer to art than to standardised social science methods." (p84).

Adopting a more flexible approach transformed the interview encounter and suited the purpose of the research. By allowing interviewees freedom to raise their concerns at the outset, I could then explore in greater depth the nature of their concerns and could return later to raise issues from the thematic guide which had not already been tackled.

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[10] Methodological choices include decisions about how many interviews are needed, whether interviews should be taped, whether they should be transcribed, how interviews should be analysed and whether transcripts should be given to the interviewee or not.

5.3.4 Non-participant Observation

As a method of enquiry, participant observation is "exceptional" for studying processes, relationships among people and events, and the organisation of people and events (Jorgensen 1989). Jorgensen suggests that observation is particularly appropriate when there is little known about the phenomenon, when there are important differences between the views of insiders and outsiders and when the phenomenon is obscured from the view of outsiders. The method is one in which the researcher "depicts what goes on in [the subjects'] lives and what life is like for them, in such a way that one's audience is at least partially able to project themselves into the point of view of the people depicted." (Lofland 1971:4). As Bogdewic (1992) explains, one of the principal advantages of this methodology is its ability to identify the "sequence and connectedness of events that contribute to the meaning of a phenomenon" and that "Rather than attempting to piece an understanding together from various clues or repeated interviews, the context can be observed as it unfolds in everyday life."

Methodologists draw attention to the difficulties of access for the purposes of observation (Lofland 1971; Strauss 1987; Jorgensen 1989) and the need to develop a rapport with a gatekeeper. Earlier it was noted that observation as an initial method of enquiry was problematic because of these difficulties of access. The interview phase, however, presented an opportunity to develop the necessary rapport with interviewees to facilitate greater research access. Four of the interviewees (2 GPs and 2 Trust Contract Managers) functioned as gatekeepers to the observation episodes[11].

Ten observations were conducted. Nine of them took place between January 1997 and October 1997 whilst the tenth was almost one year later in August 1998. The meetings differed in kind. Seven of the meetings involved direct encounters between GPs and Trusts: five could be described as clinical or purchasing meetings and the other two contracting. Two meetings were HB commissioning meetings at which GPs were represented but Trusts were not. The first meeting was a half-day away day at

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[11] Whereas the two contract managers invited me to attend meetings which they were having with purchasers, I asked the GPs directly for permission to accompany them to meetings.

which the purchasing intentions of 10 practices were being discussed and co-ordinated. Meetings varied in length, the first meeting (O1) was the longest, lasting 4 hours, whereas O9 lasted just less than 1 hour. Standard fundholders were represented most frequently at the meetings, followed by PCP fundholders. (Table 5.2 below identifies the schedule of meetings observed (numbered O1-O10).)

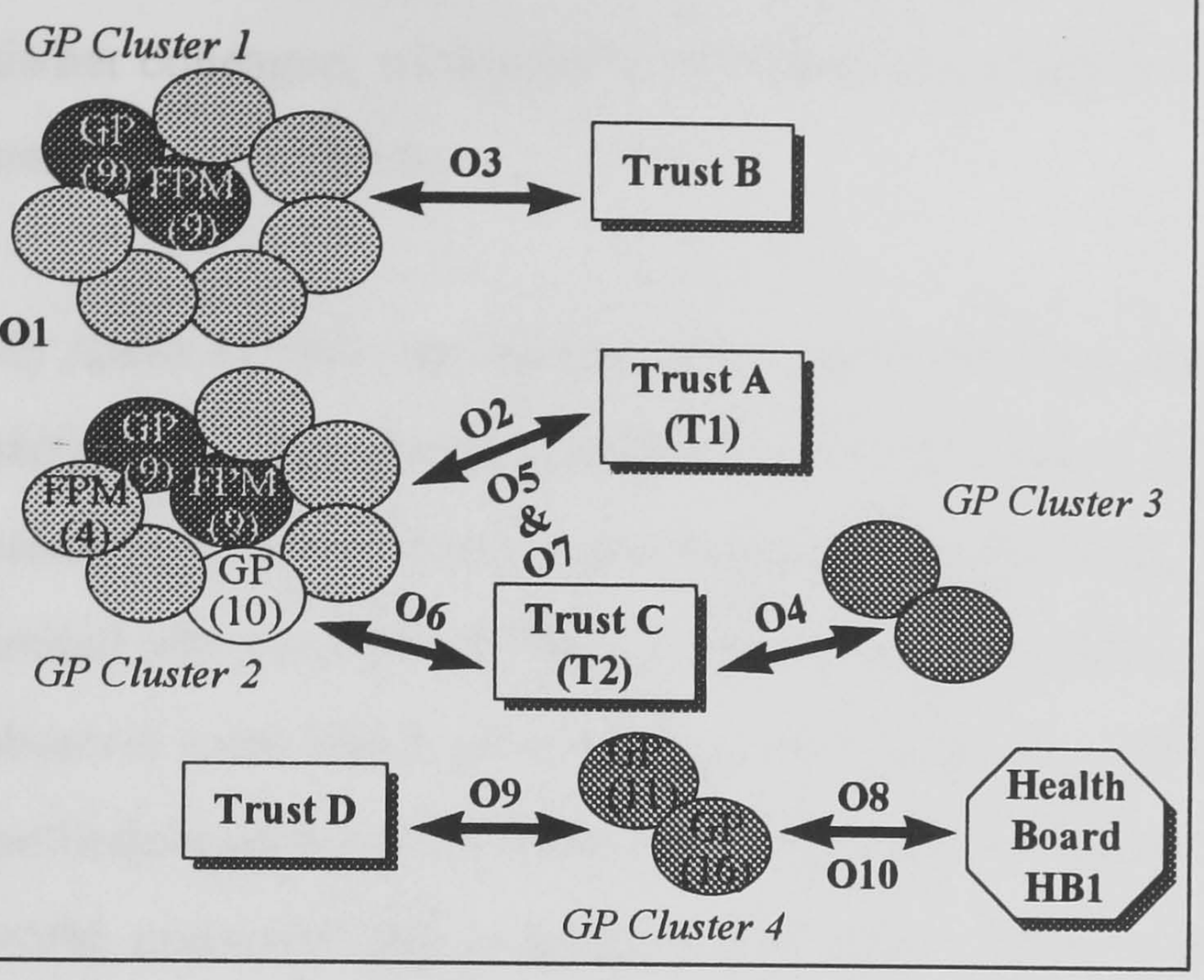
Table 5.2: Meetings Observed

Parties	**Date**	**Setting & Purpose**	**Attendants** (Total in brackets) **Code**
Collaborating GP fundholders	14th Jan. 1997	Half day 'away' in a nearby hotel for a group of GP practices who collaborate in their purchasing decisions.	6 fundholding GPs, 6 fund managers and an administrator from the fundholding association. **(13)** O1/ .../(..)
Acute Trust A and local GPs	14th Feb. 1997	One of a series of bi-monthly clinical meetings held at the Trust with GPFHs and the LPA	*Trust members*: Dir. Business Planning & Contracts, Medical Director, Clinical Director, Ophthalmologist, Financial manager, secretary *Primary care*: 4 GPs (incl. 1 non-GPFH LPA), 2 Fund managers **(12)** O2/.../(..)
Acute Trust B and fundholders	18th Feb. 1997	One of the quarterly meetings between GPFHs and the trust.	*Trust members*: Financial director, nursing manager, administrator, 6 consultants (incl.4 clinical directors), *Primary care*: 7 GPs and 3 fund/practice managers. **(19)** O3/ .../(..)
Community Trust and fundholders	17th Mar. 1997	Pre-contract meeting at a health centre with PCP fundholders.	*Trust members*: Locality manager, director of contracts, management trainee. *Primary Care*: 2 PCP fundholders, 1 practice manager, representative from the GP purchasing agency. **(7)** 04/.../(..)
Acute Trust A and local GPs	14th Mar. 1997	One of a series of bi-monthly clinical meetings held at the Trust with GPFHs and the LPA	*Trust members*: Director of Contracts, administrator. *Primary care*: 2 GPFHs, 1 practice manager. **(5)** 05/.../(..)
Community Trust and	23rd Apr. 1997	Pre-contract meeting at the trust with a group of collaborating	*Trust members*: Director of Contracts, management trainee, 3 locality managers,

fundholders		GPFHs	deputy director of finance, finance officer. *Primary care*: Administrator from fundholding association, 4 fund/practice managers, 2 GPs **(14)** 06/.../(..)
Acute Trust A and local GPs	11th Jul. 1997	One of a series of bi-monthly clinical meetings held at the Trust with GPFHs and the LPA	*Trust members*: Director of Contracts, Medical Director, Consultant, Business Manager, Administrator *Primary Care*: 3 fund/practice managers, 4 GPs (incl. 1 non-GPFH LPA) **(13)** O7/.../(..)
Health Board commissioning meeting	14th Oct. 1997	One of a series of fortnightly (now monthly) meetings about services in two sectors of the city.	*Health Board members*: Dep. Dir. Sector Commissioning, finance officer, contracts officer, public health clinician, senior health promotion officer, primary care development officer and information officer. *Primary Care*: Clinical commissioner (PCP fundholder) **(7)** O8/.../(..)
Acute Trust C and Clinical Commissioners	21st Oct. 1997	Meeting requested by the Trust to find out GP views on its services.	*Trust members*: 2 consultants *Primary care*: 2 clinical commissioners (PCP fundholders) **(4)** 09/.../(..)
Health Board commissioning meeting	25th Aug.1998	One of a series of monthly meetings about services in two sectors of the city.	*Health Board members*: Dep. Dir. Sector Commissioning, finance officer, contracts officer, senior health promotion officer, primary care development officer, secretary *Primary Care*: Clinical Commissioner (PCP fundholder) **(7)** O10/.../(..)

Figure 5.3 below summarises these observations indicating which of the interviewees were observed and illustrating that there were 4 clusters of practices meeting with providers one of which also met with the HB at commissioning meetings.

Figure 5.3: Observation Episodes



It was important to decide what to observe during the meetings. Jorgensen (1989) suggests that the possibilities include how people are arranged and the discernible relationships among them as well as the feelings that the observer gets during the meeting. Lofland's suggestions include acts, activities, and meanings (Lofland 1971). Although as a complete observer (rather than participant observer), note taking was easier because I took no part in discussions, it remained impossible to record all the acts, meanings, relationships and feelings. Field notes therefore, represented the subject matter for discussion, the main points made and by whom, the tone of the exchange and a small number of illustrative quotes. I was aware, however, that the content of the discussions was sometimes sensitive and I did not want to be seen to note down every significant comment immediately it was made lest the participants became guarded in their expression. I chose, therefore, to hesitate on occasion before writing down a particular exchange and to keep the quote in mind whilst watching the behaviours and interactions which followed. Sometimes I chose to note not what was said but the non-verbal communication. For example, during O2, one GP suggested a course of action to which the consultant made no verbal response but looked directly at the Trust's business manager, clearly angered by what was being said. His response to the GP was made without direct eye contact. The consultant offered a controlled, measured (and defensive) response whilst maintaining deliberate, angered eye contact with the manager[12]. On this occasion it was important that I could observe the encounter rather than take my eyes off the setting to write direct quotes. This type of

[12] His focus on the contracts manager was indicative of the consultant's reliance on the manager to perform the role of broker in the discussion.

choice was made regularly during the observation meetings. I did not keep a log of who entered the meeting, who left, the points at which any one individual spoke to his/her colleague, what papers were issued or referred to at any point during the meeting and so forth.

My status as observer did not permit me to interrupt and clarify the nature of what participants were meaning, neither did it enable me to develop a rapport with the participants (other than the gatekeepers). In this respect, my role as observer was limited when compared with the more prolonged, involved ethnographic participant-observer roles which can sometimes be conducted. Participant observer methodologists place considerable importance on immersing ones-self in the subject's world, understanding meanings and symbols, and developing an ongoing rapport with the subjects. However, the subjects in this case are clinicians who were discussing topics about which I had limited knowledge and experience and so whilst I could seek to understand the process, I was unable to contribute to the content. Furthermore, because I had to attend meetings which suited my timetable, I was unable to attend meetings continually with the same clusters to develop a longer-term rapport. That said, one member of clusters 1 and 2 on arriving at O6, said "ah, the ubiquitous researcher", laughed and asked how my research was going. Feeling a little guilty[13] I apologised for the intrusion but was reassured when the practice manager (supported by nods from 3 others) said that no such apology was required and that they did not mind my being there. I felt, therefore that I had been accepted and was unintrusive - an important dynamic of participant observation.

5.4 Data Gathering and Analysis: An Iterative and Interactive Process

One of the key characteristics of qualitative research is that data gathering and analysis should be concurrent activities (Coffey and Atkinson 1996) (See Figure 5.4 below.

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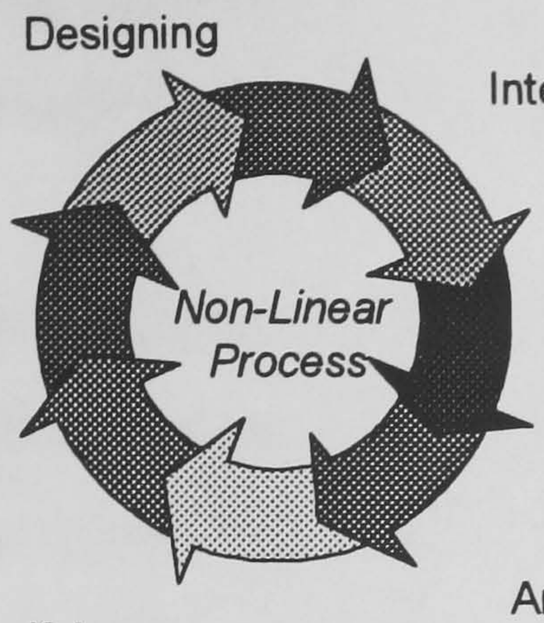
[13] My guilt stemmed from the fact that I had attended 4 previous purchaser-provider meetings at which this particular practice manager was present but had done so at the invitation of the Trust not of the GPs.

Figure 5.4: The Research Process



(Adapted from Kvale 1996)

Following accepted practice, analysis began after the first interview.[14] Initial analysis indicated that starting with a direct question about hospital efficiency (as was the case in the first couple of interviews) was problematic because it was too specific and not necessarily of interest to the GP. Consequently, a more general question was introduced at the start of the interview to set the scene and engage the GP's interest. Interviewees were asked "Why did you decide (or decide not) to become a fundholder?". If their response was along the lines that they were dissatisfied with hospital services then subsequent questions would pursue the line of hospital efficiency and service quality. If, however, the response was that they wanted a bit more influence in what happened to their patients, then questions followed the line of how they exercised that power, whether they were prepared to or had moved contracts and so forth. This allowed a more natural progression through the issues than the interview schedule had originally permitted, meant that both the interviewee and I were more relaxed and ensured that, in accordance with the research aim, the discussion was tailored to the issues of importance to the interviewee.

The iterative nature of the research process (as illustrated in Figure 5.4) is particularly well illustrated by the way in which inter-practice collaboration was explored. In the initial interview schedule, the question addressing inter-practice relationships was "do GPs compete with one another?". This was asked of a number of the interviewees. As the interviews progressed, various views about competition emerged and preliminary analysis showed that competition, whilst it was an element of inter-practice relationships, was less important an issue to practices than that of collaboration. Collaboration was, therefore, discussed in subsequent interviews. This same theme

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[14] It is important to note that this resulted in the change towards a more flexible, thematic interview schedule and process.

became increasingly important when in December 1997, the Government published its policy on Local Health Care Co-operatives. This is reflected in the interviews (GP15-GP18) which took place in late December 1997 and early in 1998.

The interaction between data collection and analysis was the same for the observation sessions. The initial step was to record the data as described above, noting the content of the discussions and the nature of the purchaser-provider interaction. When reviewing and analysing the first 7 observation episodes, for example, it became clear that the interaction being observed was characterised not only by a purchasing process, but by mutual learning, partnering and service design processes. These elements of what I later term a multiplex relationship (see Chapter 7), were verified during subsequent observations and reflections on interview transcripts. Ongoing analysis during the fieldwork phase thus supported analysis, interpretation and thematic development during subsequent interviews and observations.

5.5 Data Analysis

Data analysis began early in the data collection phase. It began with coding the transcripts and moved on into interpretation of the data. The analysis (described below) followed the 3 levels recommended by Coffey and Atkinson (Coffey and Atkinson 1996): (1) coded data are retrieved, recontexualised, parts are extracted and placed with other data to explore coded sets; (2) codes are explored and used as pathways through the data whilst looking for patterns, themes, contrasts etc; (3) coded data is then transformed into meaningful data. The last phase is done by recontextualising data or, as Dey (1993) (cited in Coffey and Atkinson) terms it 'connecting' data within a thorough description of context and social action.

Each interview was manually coded in terms of the interview themes. Maps were then drawn for each code and indicated interviewee responses (see Appendix IV)[15]. These maps provided an overall picture of the responses to any one issue and included cross-references to page numbers in transcripts. Maps were constructed for the following

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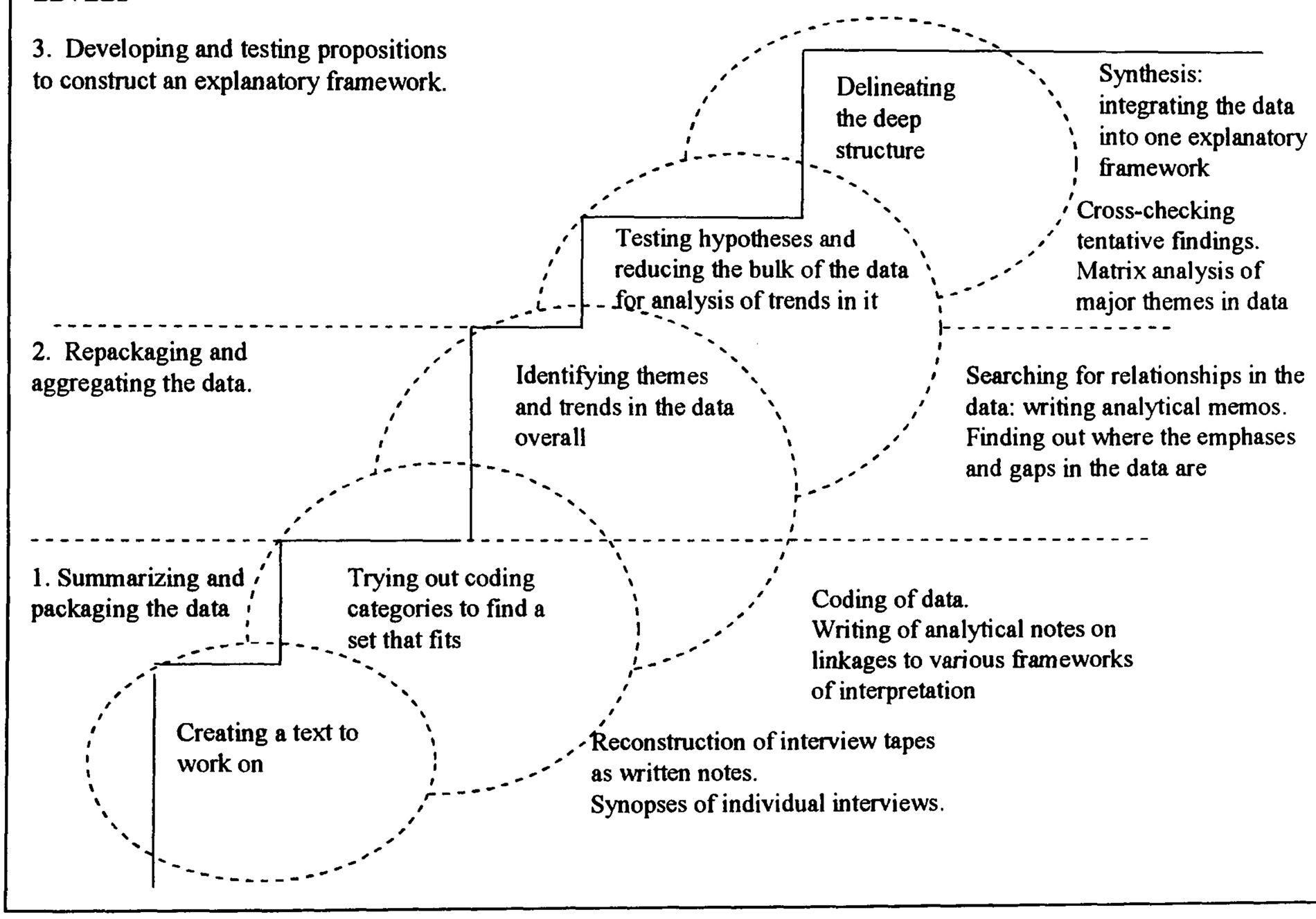
[15] Maps were not conceptual/cognitive of the type written about by Miles and Hubberman 1994

themes: competition/collaboration, commissioning, information, fundholding rationale, buyer power and contract switching, miscellaneous purchasing issues, hospital efficiency, equity, transactions costs, the necessity of the purchaser provider split, primary care-led and service quality. From the maps, it was possible to identify some patterns of response - the first level of analysis identified by Carney[16] (in Miles and Hubberman 1994) (see Figure 5.5 below).

Figure 5.5: The Ladder of Analytical Abstraction Carney, 1990



The second analytical approach was to read through the transcripts without looking for anything in particular but taking note of any surprising terms, looking at what was not said as well as what was said, noting commonalties and differences between respondents (level 2 in the above diagram). One of the most important findings (see Chapter 6) was discovered in this way. When reading through the interviews I noted the non-use by GPs of the term *power*. This was unexpected because there had been

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[16] Carney, T. F. (1990) *Collaborative inquiry methodology*; Windsor, Ontario, Canada: University of Windsor, Division for Instructional Development. Source: Miles and Huberman 1994.

much in the literature about GPs holding the purse strings, exercising power over providers and so forth. What interviewees did talk about, however, was *control*. Although my initial view was that perhaps it meant the same thing, (control over the provider), it became clear on further analysis that control meant something very different - professional autonomy. Furthermore, professional autonomy was ameliorated in a number of ways through the fundholding scheme (eg, control over staff appointments, control over service developments and prescribing, control over what happens to patients in hospital), none of which were synonymous with the original concept of power.

The third approach was what Kvale (1983) terms an ad hoc approach, one of a number of techniques he identifies (see Figure 5.6 for an illustration).

Figure 5.6: Kvale's Approaches to Analysing Qualitative Interviews

Approaches to Analysis of Meaning	Interview Text	Outcome of Analysis
Condensation		
Categorization		+ / - 1 - 2 - 3 - 4 - 5 - 6 - 7
Narrative		start → goal enemies > hero < helpers
Interpretation		
Ad hoc		+ / - 1 - 2 - 3 - 4 - 5 - 6 - 7 □ → □

The 'ad hoc' approach combines techniques of condensation, categorisation and narrative. It was a particularly creative part of the analysis during which I took themes and 'played around' with what they may have meant, what they linked to, whether they could be categorised or whether they were sub-categories of other themes and their relationships with other data. It was during this process that the main concepts presented in chapters 7 and 8 were developed. For example, thinking about the observations, I sought to describe the interaction process in various ways until the multiplex relationship was conceptualised. By trying to describe what was going on during the observations in a non-content way (ie, without describing the

subject matter of the conversation(s)), it became apparent that learning, service design, partnering and purchasing processes were occurring. Similarly, as I tried to understand and describe the inter-practice interaction, another learning process was identified. Both discoveries lead to a renewed analysis of the interview transcripts to find out whether there were data to support these observations. Maps were subsequently drawn (as in stage one of the analysis) to capture the themes of service design, learning and partnership.

A similar 'ad hoc' approach drawing heavily on attempts to categorise data was used to handle the data about information. The matrix presented in Chapter 8, was derived after a number of attempts to capture the form of the information and the way in which it was communicated.

Part way through the fieldwork, preliminary analysis was reported at a conference (Fischbacher and Francis 1997) and the paper was sent to half a dozen of the interviewees for feedback. Two GPs responded with comments which confirmed that, as they understood it, the analysis and discussion did indeed represent the purchaser-provider relationships with which they were themselves familiar. One HB and one Trust interviewee also responded to that effect. Later in the fieldwork phase and when further analysis had been undertaken, a second opportunity arose (this time a health care conference) to present and verify the findings. This paper was also found to concur with research elsewhere and a GP in the audience commented in depth on the findings after the session. The conference presentations were important opportunities to develop yet further my understanding of the market and to verify the findings in a wider research context. They contributed to the verifying and reporting processes identified in Figure 5.4. (The papers have since been published (Fischbacher and Francis 1998, 1999)).

Level 3 of the analysis process identified by Carney, involved taking the themes and concepts generated during levels 1 and 2 and interpreting them in light of the theoretical frameworks discussed in chapter 4. Chapters 9 and 10 represent the synthesis between the theoretical framework and the data analysis.

5.5.1 Data Gathering - When to Stop?

The difficulty with gathering qualitative data where there is no pre-determined sample size or number of observations, is that of deciding when to stop gathering data. There were several indicators though about when this should be.

As identified earlier, the interview sample included GPs who were involved not only in practice-budget holding but in health board commissioning activities, fundholding association and/or broader medico-political activities. During some of the interviews, two particular GPs were named as particularly active, experienced purchasers, those who had most frequently negotiated over prices. Their practices were both included in this study during interviews and observations. Two of the interviewees were often quoted in the National newspapers, one offering a fundholding view, the other a non-GPFH view. Because the sample included the more radical and the non-radical, enthusiasts and experienced purchasers, when it became clear that the interviews and observations were not yielding any new data, the decision to stop gathering data was taken.

The distinction between content and process was of particular relevance to this decision because whilst the topics being discussed would continue to develop in an interesting way (in terms of the range of issues tackled), the purchaser-provider purchasing process was not exhibiting any new characteristics or yielding new data. Similarly, interviewees towards the latter half of the fieldwork were raising similar issues to those previously interviewed. Furthermore, the same stories were raised during multiple interviews (eg, the issue of the endoscopy service at Trust A (I/FPM4 and I/T1) and the movement of an ophthalmology contract from the public to the private sector (I/FPM9, I/GP8, O1 and O3)). The repetition of the stories was in one sense a validation of their occurrence, but was in another sense indicative that these were probably the exemplars (perhaps the more extreme cases) which various purchasers and providers used to illustrate their points and that there were not many significantly different examples around. Furthermore, that they were the main examples used to demonstrate that contract switching did occur, one can infer that it

would be unlikely to find many other examples around the city because the most radical of Glasgow practices were included.

Before finally deciding to do no further data collection, I reviewed the empirical evidence which had emerged during the fieldwork phase. Studies such as Ellwood 1998, Lapsley et al 1997 and others (see for example, Farmer and Williams 1997; Whynes, Baines, and Tolley 1997; Whynes, Heron, and Avery 1997; Ennew et al. 1998; Farmer and Chesson 1998; Smith and Wilton 1998) were identifying similar behaviours (eg, non-price sensitive purchasing, reliance on informal information sources, little contract switching, loyalty to local providers, etc) which indicated that there were no obvious omissions from this study and that the sample was not uncharacteristic.

It was also the case that the purchasing issues had moved on. The launch in December 1998 of the Government's plans for locality based co-operatives meant that GPs would no longer be working independently but that fundholders and non-fundholders would come together, fundholding as such would be abolished, and new co-operative ways of working would be put in place[17].

Taken together, these factors lead to the decision to complete the fieldwork around Easter time during 1998. The meeting in August (O10) was attended some months after this though because it had been rescheduled from an earlier date in March.

5.6 The Researcher and the Researched

Before concluding this chapter by considering the limitations of the research and setting out the structure of the remainder of this thesis, some reflection on the role of the researcher is called for. One of the key characteristics of qualitative research is the interaction between the researcher and the subjects of the research (Kvale 1983; Adams and Schvaneveldt 1985; Cassell and Symon 1994). Adams and Schvaneveldt write that the "interview setting, skill, and training of the interviewer, openness and

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[17] The arrangements in Scotland differ from those in England where the locality purchasing is based on the total fundholding model. See chapter 1 for discussion.

frame of mind of the respondent, the subject under study, and a host of other mood-situational factors enter into the process of collecting data via the interview." (p213) These fieldwork dynamics must not only be recognised by the researcher but need, as much as possible to be managed and taken into account during analysis.

Given the broad range of theoretical issues and content questions included in the interview schedule and the measure of skill required in the craft of interviewing, it was no wonder that initial interviews seemed rather unsettling and intimidating. I can endorse Shaffir and Stebbin's (1991) comment that "For most researchers, the day-to-day demands of fieldwork are fraught regularly with feelings of uncertainty and anxiety." (p1-2) However, I sought to adopt an interview style which not only put interviewees at ease but during which I considered them as experts who had something interesting and important to say. By inviting them to identify the important issues, it secured their interest in the interview and allowed them their role as expert.

With participant observation, the interaction between the researcher and the subjects is of particular importance (Lofland 1971; Strauss 1987; Jorgensen 1989). Being accepted by subjects as a member of their group and participating in a way which allows both empathy and objectivity, immersion in the subject and withdrawal from the field can be difficult tensions to manage. As a complete observer, however, once I had secured a gatekeeper, I was not faced with many of the dilemmas observation can often present. However, as an observer and not a participant, there is an extent to which my understanding of the subjects, their language, culture, symbols and world view may be limited: "An accurate picture of daily life requires that the presence of an outsider-researcher be routinised. Time generally is an ally. The longer (or more frequently) you are in the setting, the more people are likely to come to perceive you as nonthreatening and otherwise take your existence for granted. Casual interactions when not forced also tend to put insiders more at ease, especially if you are able to engage them in casual conversation and provide routine assurances that you pose no threat to them." (Jorgensen 1989:58). I did not get to know many of the subjects individually, and most knew me only as a student from the University. My status appeared to pose no obvious threat to them and they did not appear inhibited in their behaviour in fact, as Bogdan and Taylor (1975) suggest, they may even have had some

sympathy with me as a student trying to complete her research. Nevertheless, it is the case that my immersion into the process which I observed and my rapport with the group members was restricted and thus my interpretations may be less complete than would ideally be the case.

My role as a 'traveller' became increasingly important during the observation episodes where I heard, recorded and interpreted stories and encounters between the 'natives' of the NHS world. These encounters proved fundamental in shaping my understanding of the purchasing process and the interpretations which are made in Chapters 6-8. Kvale comments that "the journey may not only lead to new knowledge; the traveller might change as well." (p4). This was certainly the case during the fieldwork and writing phase. On a personal level these changes occurred at an intellectual level, an interpersonal level and in terms of my view of the social world. Intellectually, ie in terms of my grasp of the theory, the fieldwork illuminated aspects of the theoretical framework and vice versa. This growth was further stimulated by the experiences of conference presentation and publication both of which encouraged increased rigour in analysis, writing and reporting the research. On an interpersonal level, interviews, observations, research seminars and conference presentations served as opportunities to become more articulate in clarifying my ideas, interpretations and findings to two types of audience: academic and practitioner. Finally, the fieldwork phase changed my view of the ways in which social interaction shapes decision making and learning and how organisational structures and the formal decision processes not only exist alongside but can be superseded by social processes. This change in outlook in turn informed my interpretation of the theory as I reflected on the research findings.

5.7 Research Limitations, Generalisability, Validity and Reliability

It cannot be assumed that the research findings from this study will necessarily be to be exhibited elsewhere in Scotland or further afield. This is because the purpose of qualitative research is to understand and give meaning to the phenomena under study not to ascertain the frequency with which it is occurring: "The label qualitative methods has no precise meaning in any of the social sciences. It is at best an umbrella term covering an array of interpretative techniques which seek to describe, decode,

translate and otherwise come to terms with the meaning, not frequency, of certain more or less naturally occurring phenomena in the social world." (Van Maanen 1979). Consequently, no attempt has been made to suggest that the findings are representative of the whole of Scotland. However, supporting evidence from other studies does allow for some findings to be considered indicative of the likely behaviour elsewhere in the country.

"The problem of validity in field research concerns the difficulty of gaining an accurate or true impression of the phenomenon under study." (Shaffir and Stebbins 1991:12) whereas the problem of reliability concerns the replicability of observations : "It rests on the question of whether another researcher with similar methodological training, understanding of the field setting, and rapport with the subjects can make similar observations". (Shaffir and Stebbins 1991:12) Hammersley, 1992:67[18] defines reliability as "refer[ing] to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions".

The concerns about validity and reliability centre around the effect of the observer/interviewer on those being observed/interviewed, the distorting effects of selective perception and interpretation by the observer and the limitations on the observer's ability to witness all relevant aspects of the phenomena in question. Jorgensen (1989), however, suggests that participant observation actually enhances the validity of the concepts used within the research because of the preoccupation with defining concepts in terms of the subjects' view point. Jorgensen's perspective is particularly important in this study where the potential incongruence between interpretations/meanings of terms such as purchasing/commissioning, transactions costs and efficiency (for example). Jorgensen goes on to suggest that participant observation is particularly concerned with the dependability and trustworthiness of findings which are dimensions of validity and which can be checked in a number of ways. That a participant observer does not rely on a single form of evidence, means

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[18] Hammersley, M *What's wrong with Ethnography: Methodological Explorations* Routledge: London cited in Silverman (Silverman 1993)

greater triangulation and access to otherwise 'unobservable' settings increases the validity of concepts, as their use in daily life can be tested.

It is important to bear in mind though, that "the character of field relations heavily influences the researcher's ability to collect accurate, truthful information .." Jorgensen 1989: 21. In this study, the role adopted was very much that of observer (not participant) and as noted earlier, prolonged exposure to the same cluster of GPs was not obtained. That I was not an active member of the group and did not have the opportunity to develop a rapport with members other than the gatekeepers, does suggest that interpretations could lack a degree of understanding of the NHS culture, language, symbols etc being observed. Shaffir and Stebbins (op cit.) however, suggest that one of the principal ways of countering these problems is "to play back one's observations to one's subjects ... by casting them in roles of local experts and helpful participants in the research project ..." (p. 16).

As earlier discussion has illustrated (and as chapters 6-8 show), there was a considerable degree of consistency with which the processes of learning, designing services, purchasing and partnering were observed during this research and with which the importance of professional autonomy, the desire for collaboration and a loyalty to providers was exhibited. Observations and interview material were mutually reinforcing[19] and were supported by feedback from academics and practitioners during and after the fieldwork period. Public presentation and refereed criticism of the data provided an opportunity for the data to be subject to debate and testing from external experts and practitioners and thus increased the validity of the data.

5.8 Presentation and Interpretation of the Empirical Findings

The data are presented in 3 chapters. Chapter 6 looks at what kind of actors GPs have become in the market place. GPs' views about why they became fundholders, their perceptions of bargaining power and the necessity of the purchaser provider split are

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[19] This form of reliability is termed 'synchronic reliability' by Kirk and Miller (1986) who are quoted in Silverman 1993. Kirk and Miller define synchronic reliability as "the similarity of observations within the same time-period". A standard way in which this form of reliability is assessed is through triangulation of methods such as the use of interviews as well as observation.

among the aspects discussed in the chapter. Chapter 7 moves on to discuss the relationship between purchasers and providers. The relationship explored was identified primarily during the observations and the chapter draws heavily on encounters between GPs and hospital clinicians. The third data chapter, Chapter 8, looks at inter-practice relationships and develops a typology of information used in purchasing decisions. The quotations used in each of the chapters are anonymised using the source coding explained earlier in this chapter.

5.9 Summary

In order to tailor the research methodology to the research aim, which was exploratory in nature, a qualitative approach was adopted. This approach utilised interview and observation techniques in order to understand the purchasing roles and relationships from the point of view of the subjects. The methodology was flexible, allowing emerging themes to be pursued and organisational complexities and changes to be accommodated. The analysis was both inductive and deductive drawing on an interpretative framework and also allowing themes to be generated from the empirical data.

The following chapters (6-8) go on to discuss the findings, conceptualising the data according to the research framework and emerging themes. Chapter 6 discusses GP perceptions of the fundholding scheme and of their purchasing role. Chapter 7 goes on to discuss the purchaser provider relationship in terms of its content and process, drawing heavily on the observation data. Chapter 8 then discusses the inter-practice relationships which support the purchasing process.

Chapter 6

GPs' Perspectives on Fundholding and Their Purchasing Role

Introduction

Chapter 6 is the first of three empirical chapters in which the study's findings are presented. The chapter discusses the fundholding scheme and purchasing role from the perspective of the GPs who were interviewed. It then goes on to present their views on resource utilisation/hospital efficiency, resource allocation and the market mechanism. Having done so, it turns to consider the extent to which these GP perceptions were mirrored by providers, HBs and the Scottish Office.

The data show that the most compelling reason for becoming a fundholder was that it offered GPs ***enhanced professional autonomy***. This strong ***social motive*** was accompanied by subsidiary ***economic motives*** such as the opportunity to gain additional financial resources for the practice. GP purchasing behaviour was characterised by a ***reluctance to switch contracts***, a general ***insensitivity to price***, a desire to focus on ***service quality*** and ***waiting lists***, and an express intention to ***collaborate with local providers***. GPs were united in believing that they had a legitimate role in influencing secondary care in their capacity as agents for their practice population and most believed that the ***purchaser provider split*** had served as a ***catalyst*** for making providers more responsive.

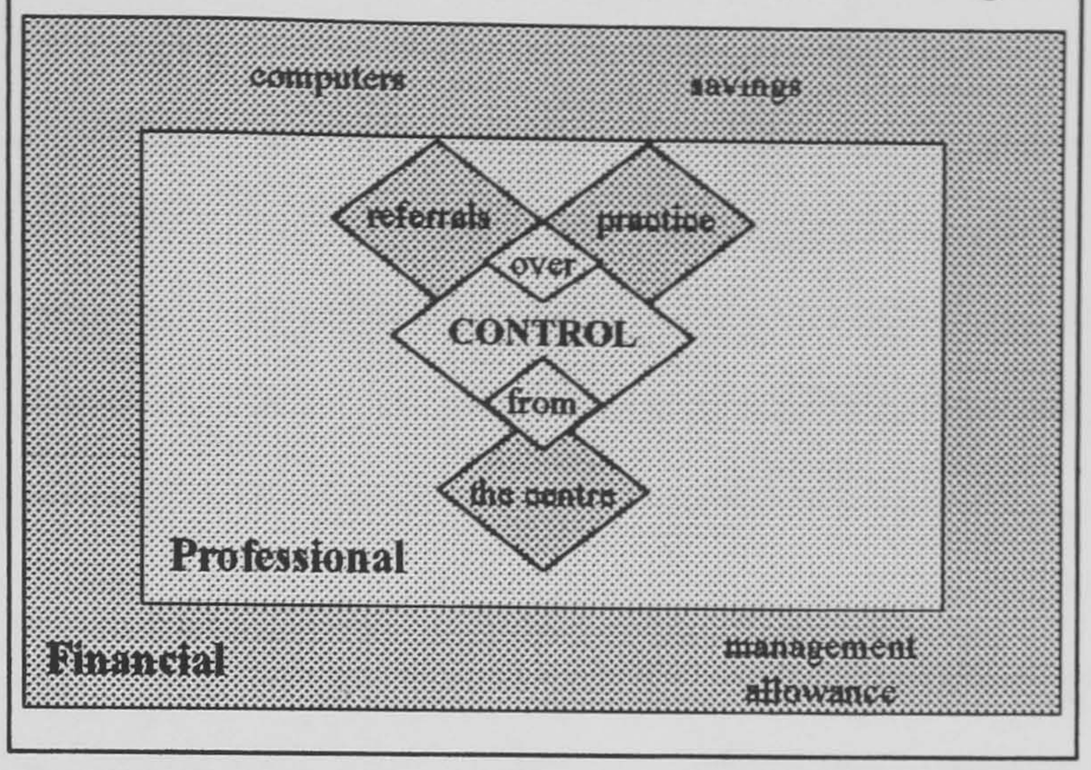
6.1 Fundholding - Incentives and Disincentives

GPs offered various reasons for becoming fundholders. The main reasons were: to develop services to patients (or more generally to develop the practice); to gain control over staff; to make savings; and to benefit from upgraded computers and a management allowance. Less frequently mentioned were the ability to change referral patterns and to compete with other GPs. Only two interviewees said that a main reason was to stimulate better service from the provider. Following the analysis, these reasons have been categorised according to two types of reward: *professional rewards* and *financial rewards* (see Figure 6.1).

6.1.1 Professional Rewards

Professional rewards derived from two domains of general practice activity: (1) practice organisation and (2) making hospital referrals and influencing secondary care services. The two aspects are demonstrated in the following quote from one GPFH:-

Figure 6.1: Motivational Factors in Fundholding



> ...4 or 5 years ago, we used to wait 50 weeks for a psychology appointment and 20 weeks for a physiotherapy appointment ... we weren't getting clinical services that we wanted and we thought 'well if we had the budget that perhaps we might be able to influence it'... also ... GPs wanted to develop a better building for their practice and wanted to be able to make some savings which they could put into a better building and better facility ... and put some money into extra staff for some of the things we were doing in primary care ... We wanted to be able to have ownership over the services patients were getting and there's nothing worse than having an anxiety patient and knowing it's a year before you could get an appointment with a psychologist. It wasn't very satisfying for the GP... I/GP9/T(1)

This interviewee, however, was one of only two who addressed the matter of improving secondary care performance. Only one interviewee (a fund manager) said that they had hoped to make ...innovative referrals...I/FPM4/S(1) and to perhaps move their contracts. In the main, interviewees wanted to improve the way in which their practice was organised and in particular, to be more in control of co-ordinating and recruiting staff.

> ... just to have a little bit more control over how the practice was running and what we could do for our patients. That kind of sums it up ... I/GP12/PCP(1)
> GP7/S(1)

> ...From a professional point of view it's being in control of your own working environment. It's just more stressful for everybody when they're working, not being in control and that was the case where I was. GPs now feel that they are more in control if they have an input into decision making... I/GP1/S(4)

> ...I think one of the significant things perhaps is a bit more control over your staff, your attached staff. I think the difference between staff you employ and staff you don't employ is gargantuan ... With attached staff you don't have the same 'control' ... [in addition] ... I knew there was incentives, there are financial incentives as well, computers, locum expenses. Also, having a little more control over your practice budget from a drug point of view. I've found it very stimulating. I've had the Medical Prescribing Advisor out and the pharmacist who worked with him. I found it quite challenging to get the drug bill down ... I/GP16/PCP(1-2)

The last quote is interesting because the ability to reduce prescribing costs yielded a financial reward in the form of savings, and presented a professional challenge. Rising to the challenge lead to a change in professional practice - ...it has asked many pharmacological questions whereas before you would just prescribe something. There's an overall look at it to say 'why are you prescribing that instead of that?'... I/GP16/PCP(2).

Fundholding also represented freedom from 'control' by the Health Board. Some practices were frustrated because if they lost a practice nurse, securing a replacement took a great deal of time if processed through the health board. Holding the budget enabled them to recruit more quickly and also enabled greater GP influence over nursing workloads and priorities.

> ...We went into fundholding 4 years ago because we felt that was a way to improve services for patients plus to be quite frank we were sick fed up with the Health Board being so interfering in everything we did ... other major reasons were all the standard ones - gaining a little bit more control ... I/FPM4/S(1)

PCP fundholders were influenced by additional factors. Three PCP practices felt they had been heavily influenced by the Health Board who "sold" the scheme as a means of making savings and gaining control over staff. Four chose PCP fundholding after rejecting standard fundholding on ethical grounds, and another because they were neither adequately organised managerially nor inclined to engage in standard fundholding. PCP fundholding offered the opportunity to manage a prescribing budget, make some savings, and have 'control' over practice staff, without becoming embroiled in purchasing acute services.

Although only a minority spoke about influence over secondary care being a specific

reward from fundholding, it became clear later in the interviews that most of the practices had sought to reduce waiting times and some (see Chapter 7), sought to increase their control over what happened to their patients in the hospital setting by, for example, developing protocols to increase patient management in primary care. Interestingly, the fuller picture of how control was exercised with respect to hospital referrals and patient management, only really emerged clearly during the observation sessions (see Chapters 7 and 8). It was not something about which GPs and fund/practice managers were very specific during interviews.

6.1.2 Financial Rewards

Financial rewards came in the form of upgraded computers, practice savings and the management allowance. Many interviewees were open about the importance of additional funding. One PCP fundholder felt ...it was an offer too good to refuse ... a win win situation... I/GP3/PCP(1) He could benefit from a management allowance and savings but if no savings were made, he was no worse off.

Another said,

> ...I suppose to be truthful, monetary. You can make savings on various aspects of it, you obviously get the management allowance to use to improve the practice to get things that you maybe wouldn't otherwise have had the funds to have... I/FPM5/PCP(1)

Six of the interviewees said that financial incentives were a main decision criteria. Two (one non-GPFH and one standard GPFH) were particularly clear about the importance of increased funding:-

> ...we're struggling financially to manage the system the way it is, ... In fact talking to people in other practices that have gone fundholding, they say the reason they went fundholding was because they felt forced into it because of the money ... the attraction of PCP, one is that we'll get updated computers and the management allowance which would probably allow us to function. So that's one of the big attractions, putting aside the fact that it would be quite nice to have a bit more control over your district nurses... I/GP10/N(6)[1]

[1]This practice was considering becoming a PCP fundholding practice but at the time of the interview was non-fundholding.

> ...We went into fundholding because there was this promise of extra money for running the practice, that's the major thing. Ehm, we knew that we would be able to buy new computer systems with any potential savings that we made ...I mean, we're businessmen, we saw it as a way of getting more income into the practice and just took it that way... I/GP15/S(1)

In one respect, taking control of the drug budget was an expression of the sense of professionalism incurred by improving primary care practice. On the other hand it was a concrete means of bringing in additional income to the practice. None of the interviewees said that making savings was the primary reason for becoming a fundholder, where savings from prescribing were mentioned, it was generally 2nd, 3rd or 4th in the list of reasons provided[2]. However, it was clear in recent years money had become a dominant topic of conversation in general practice.

> ...I think there's a greater awareness ... doctors never talked about money. Now they talk about money all the time. Money's number one. 'Till 5 years ago we never discussed money... I/GP16/PCP(3)

> ...in one week I had two meetings. One was with the LPA people where we sat down and got really into detail about something clinical and I thought it was a really good meeting, we'd achieved a lot and we'd moved forward. About 2 days later I had a meeting with a group of GP fundholders and we spent probably 1.5 hours of a 2 hour meeting having a huge discussion about finance and how we put our prices together ... the difference was incredible ... there will **always** be a discussion about money at a GP fundholding meeting... I/T1(3-4)...

6.1.3 Non-Fundholders: Immune to Rewards?

None of the non-fundholders gave any indication that they were unattracted to fundholding rewards. What had prevented them from becoming fundholders was mainly the efficiency or equity of the scheme. The disadvantages of the scheme were perceived to outweigh the benefits of professional and financial rewards[3].

> ...I think that the input and the voice but no actual financial management is the way I

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[2]It is important to bear in mind that GPs were not asked to rank the fundholding rewards but the sequence in which they recounted the decision factors may be indicative of priorities.

[3]This also applied to PCP fundholders who chose not to opt for standard fundholding.

would like to see things develop ... there's also the skills and I think financial management is a skill that few GPs have and although I think that it's good that we are cost conscious, to devolve decision making too far down just increases bureaucracy... I/GP13/N(1-2)

... not just the £30,000 management allowance but ... the amount of personnel the Trusts have to employ to deal with all the GPs and different contracts, we felt if it was logically going to be that every practice was going to be a fundholder .. the amount of money that was being spent on administration was going to be too great... I/GP11/PCP(1)

... if I want to be totally selfish, it would make life easier for me because I could buy in all the services and make it happen. I would get money thrown at me, the grants just now are extremely generous. But how efficient is that really?... Budget holding is superficially attractive because you see an immediate effect, but that's only because this is a new concept and there's a small number involved. I think there's an element of short-termism. There will not be more money at the end of the day ... we need to take a long term view. If you do that, budget holding is not the true answer ... I/GP6/N(3-4)

Far from being untouched by issues economic, non-fundholders took a philosophical stance against fundholding often on economic grounds based on concerns about two-tier services their unwillingness to need to take financial criteria into account when deciding on patient care.

6.1.4 A Two Tier Service?

Views on a two-tier service were mixed. Some interviewees felt that the system was unethical and proliferated a two-tier service. One fundholder had deliberately avoided negotiating shorter waiting lists because he did not want to incite two-tier treatment. Others though felt that it was not as black and white as that, and that there already was a two- or even multi-tier service.

...We already have a multi-tier service. It depends on where you live, who your GP is, which consultant you see. That's reality. Single tier is, I'm afraid, just political talk... I/FPM4/S(10)

...I actually get quite irritated with the 2-tier label that's attached ... There are inequalities which do come from fundholding ... but in the main the 2-tier thing as it is flagged up is totally inappropriate. There's always been a multi-tier service. For

> instance, we employed a dietician, prior to fundholding. We could get a patient seen by a dietician within 2 weeks. The practice next door had to refer them down to the hospital which at that point had a 31 week waiting list. That's a 2-tier system and nothing whatsoever to do with fundholding... I/GP7/S(6-7)

Most fundholders had sought to reduce waiting times, and they generally felt that waiting time reduction had benefited their patients and patients of non-fundholding practices too.

6.2 GPs as Leaders in the NHS

There was a general consensus that GPs ought to have a direct influence upon decisions about secondary care provision because they are gatekeepers to secondary care and agents for their patients. Most interviewees felt that if a primary care-led service was to become reality then they needed to be able to influence hospital services. The degree of influence was a point over which GPs differed. Some felt that GPs should have direct decision making power whereas others simply wanted a voice, some representation at the decision making table.

> ...I would like it to be more direct decision making power. I don't think it should be exclusively the province of GPs, but there's an inevitable swing too far towards GPs because for too long the hospitals abused the power that they had, to provide the services that they wanted to provide rather than what was needed and it may take some time to get the balance of what is more appropriate... I/GP1/S(10)

> ...I suppose primary care led means you're looking to primary care to give a lead and be the innovators and to even lead the decision making process... I/GP6/N(1)

> ...I think GPs as a group are much closer to their patients as a whole and have a much better idea of what patient needs are and I think people who work inside hospital all the time get a totally distorted view of what the health service should be doing. But up until now it's just that the power has been within the hospital sector. I think that radically needs to shift around but it needs to shift around in partnership ...hospital consultants are starting to do an interesting type of meeting where they get local GPs along and discuss the services they re offering and they discuss the latest research and how that relates to what they should be offering ...That's the way I d like to see things moving... I/GP12/PCP(9)

Not surprisingly some were more keen than others to be personally involved in decision making meetings but they were all of the view that as advocates for their patients they had a valuable input to make.

6.3 Resource Utilisation / Organisational Efficiency

Previous chapters have continually stressed that one of the main intentions of fundholding was that GPs would stimulate provider efficiency. Policy makers assumed that GPFHs would be concerned about hospital efficiency and would seek to improve waiting times and service quality by moving their contracts and that they would respond to price signals.

6.3.1 Hospital Efficiency

When asked about hospital efficiency, there was a general agreement that inefficient practice was a problem:

> ...I think there are concerns and that's come from [some local] practices. They held a meeting last week and they're having a follow-up meeting this week because there are concerns generally over the service the Acute Trust is giving... I/FPM7/S(3)

> ...I think it's always a problem. I think that they're grossly inefficiently ...there are a lot of things they could be doing to make the show a lot better, a lot easier but they're not interested in that. They want to keep their own empires... I/GP15/S(1)

> ...Yeh, certainly there are now delays in getting people seen at the ENT clinics, dermatology clinics, orthopaedic clinics where waiting times seem to be rising. Anything that's introduced like the endoscopy, open access endoscopy, the waiting list for that is now rising - it used to be 2-3 weeks, now it's up to 10 weeks... I/GP18/N(1)

Some who acknowledged the problems were more hesitant though about 'accusing' providers of being inefficient. They were sympathetic to the financial pressures on Trusts and accepted waiting lists were a means of controlling demand.

> ... I think ' Hospital X' has probably been a bit inefficient because it has been cash starved and you do get into that situation. I think a little bit of extra resource would

probably bring a lot of savings .. [it] got into a situation of fighting fires all the time rather than fire prevention ... it is a more inefficient provider but that's due to cost and being addressed to an extent. I'm a great believer in systems... Inefficient systems create inefficient bureaucracy and a lot could be improved there ... I/GP11/PCP(15)

...Of course ...[efficiency] ... concerns me because the system is structured to provide built in long waiting lists as a cost control measure. It's as straight forward as that ... You re going to need some control system cause there isn't enough money to provide everything for everybody, but that's the way it's been structured as being the choke point and to drive people to look for alternative means to channel or to organise secondary care ... I/GP6/N(3)

Interviewees dealt between them with 6 Glasgow Trusts plus others outside the health board area, so it is likely that their perceptions of efficiency differed because of differing experiences of hospital services. Two PCP fundholders, for example, said categorically that hospital efficiency ...was not an issue at all ... I/GP2/PCP(2) and had no desire to give any examples of what they might consider to be inefficient or wasteful practice. They remained entirely happy with service provision. It is interesting though, that even the fundholders who spoke most strongly against provider efficiency had only moved perhaps one or two smaller contracts. The strength of their feeling had not translated into direct economic action.

Another possibility for the differing views is that there may have been some confusion over what was meant by efficiency. In one interview, for example, a fundholder said he was not concerned about the efficiency of his main provider but later in the interview explained that they had ... moved slightly away from Hospital X and a bit more to Hospitals Y and Z,...I/GP7/S(2) because of lengthy waiting lists and quality issues. It seems he considered waiting lists and service quality to be clear cut quality issues and not matters of organisational efficiency.

6.3.2 Price

The role of price did not come up in conversation at all except if mentioned specifically as an interview question. GPs spoke of having rather less waiting time information or clinical guidelines than they would like (see Chapter 8) but they did not complain about

a lack of price/cost information. Prices did not seem to be high on the agenda, (a point confirmed by Trust representatives) but to suggest that GPs were indifferent to prices would, however, be misleading.

> ...Their contracts are first and foremost about volume of activity, numbers of patients treated. Price, they're very concerned about price and very concerned about quality issues. To be fair to them I think that they are more concerned about quality than they are about price. In terms of quality it's usually access to services, so short waiting times, good clinical communications ... I/T1(1)

Earlier quotes suggested that financial considerations have become increasingly important to practices. This concern translated into efforts to reduce the cost of services and to re-engineer services more effectively (see Chapter 7) but price was not a dominant factor in selecting the provider. GPs' were more concerned about functional quality (care management).

6.3.3 Service Quality

Almost all the interviewees had tried to influence service quality and found their discussions with hospital clinicians particularly fruitful in this regard (see Chapter 7). The main quality issues were the speed and quality of discharge letters and the timeliness of death notifications. Waiting lists were also mentioned but to a lesser degree.

Most practices had benefited from improved communications particularly in terms of the timeliness and quality of discharge letters. Letters had previously contained very little information and more often than not, had arrived late.

> ... In one week, we had 28 people coming ... looking for results that weren't in. Seventeen of those were in one surgery. That's nearly one whole surgery wasted in this practice by people coming for a letter that the hospital said would be back and wasn't ... I//GP7/S(11-12)

> ...we have seen, across Glasgow, hospitals communicating better, actually telling us on occasion that our patients have died in hospital which is quite a useful thing to know. I'm being ... sarcastic ... but that was the type of thing that we didn't get told in the past. Communication was sometimes bad - you could wait a couple of months on occasion to be told

> that your patient had been taken into hospital for an operation and of course there are all sorts of ramifications for the GP if they don't have that information. So we feel that's all improving and that fundholding and what we've done in it has given it all a nudge in the right direction ...I/FPM4/(10)

Improvements to waiting times were unclear. One practice was convinced that it had negotiated improved waiting times, but others offered no such definite assertions. Interviewees spoke vaguely about things changing and improving but even in the observation sessions, waiting times were not major topics of discussion. They were mentioned, but almost as if simply to remind the provider that GPs were waiting. GPs did not appeared to be having any direct impact on waiting times as one non-GPFH confirmed,

> ...With the number of procedures now being done in general practice in terms of minor surgery and so forth, where are all these surgeons not doing things because it's all being done in primary care? There's still the same number or more, doing the same things, apparently still as busy, with just as long waiting lists. But that should have changed and it hasn't happened... I/GP6/N(13)

At the time this fieldwork was conducted, the GPFH Association was co-ordinating efforts to improve quality. The Association had agreed quality standards for inclusion in fundholder contracts (most of which were block contracts) so that practices across an area would be able to set and benefit from similar quality standards. Coupled with this was a move by fundholders to include penalty clauses in their contracts although as Chapter 7 shows, they were reluctant to impose penalties and tried hard to get Trusts to invoice them on time, thereby avoiding penalties. Chapter 7 goes on to provide more detailed discussion about the range of quality issues tackled by GPs.

6.3.4 X-efficiency

As well as tackling service quality, there was some evidence that purchasing and commissioning activities had improved hospital X-efficiency. For example, one LPA said that through their negotiations they had managed to change the way in which new patients were allocated to a hospital consultant. The former arrangement had been that all patient referrals were allocated sequentially to consultants 1-8 irrespective of

the length of individual lists. For example, one urgent referral might be made and allocated to consultant number 1 whose waiting list was only two weeks. The next urgent referral would then be allocated to consultant number 2 despite his/her list being10 weeks. GPs highlighted the matter and the Trust ... looked into it and discovered that's what was happening and they've now equalised the waiting times so that if someone's got a shorter waiting time they get all the urgent ones 'till they're up to the same waiting times as the others ... I/GP8/N(3)

Elsewhere, practices had negotiated improved nursing management at the community trust:

> ... We've managed, not through PCP, but through my role at the health board along with others, to have the mental health trust delayer its management structure and allow GPs to have much more influence over what the nurses are doing ... I/GP11/PCP(7)

The scale of such x-efficiency improvements was not ascertainable from this study, but the Trust interviewees indicated that they had, on a few occasions, had to reorganise service management.

6.4 Switching Provider

Most standard fundholding practices had moved contracts but only one or two per practice. Moves included switches to the private sector for ophthalmology and investigative procedures (eg endoscopy, CT scans) plus switches to other NHS providers for urology, dermatology, chiropody and physiotherapy. On each occasion, contracts switches were considered temporary and used merely to alter the status quo. Those who had moved (or threatened to move) contracts found that providers were responsive.

> ...In our own case it was urology services that were absolutely abysmal so we were having to refer patients to Stirling to put pressure on local hospitals. That has resulted in another urologist being appointed... I/GP1/S(2)

Responses were not always swift though and were sometimes unsatisfactory. One fund manager provided a lengthy explanation as to how, and why, his practice had

moved its contract for upper gastro-intestinal endoscopy and the response this had elicited from the provider. The practice had become increasingly frustrated with the fact that patients with a possible ulcer, for example, had to wait 3 months for an outpatient appointment. Then, when the consultant recommended an upper GI endoscopy, the patient needed to wait a further 3 months before the procedure could be undertaken. The practice became fed up with what they said was ...a decade, making suggestions to the Health Board and to hospitals which they said they couldn't take up... I/PFM4/S(2).

After becoming fundholders, the practice put forward another proposal for direct access endoscopy but the provider again refused. The practice threatened to remove the contract which, including in-patient and out-patient attendances, would cost the provider £50,000. As there was still no response, the practice ...very reluctantly... took their business to a nearby private provider in a move which saved £35,000. The following year they returned to re-negotiate with the NHS provider. The Trust said that it lacked sufficient resources so the practice invested £23,000 in an endoscope which consultants requested for the direct access service. Despite pledges from the provider, the GP practice (whose contract remained with the private sector provider in the interim) heard nothing for 8 months after which they contacted one of the business managers, warning that they would never again agree to contribute their money to a hospital service. The following day one of the hospital consultants visited the practice. The direct access service was subsequently set up but, it took a further 14 months and GPs had no input into the design. As a result, access was ...much, much more restricted .. than we had anticipated ... so the practice's contract remained with the private sector provider.

What was interesting about this particular case was that the interviewee went on to say that they remain unhappy with the direct access service and were still reluctantly dealing with the private sector, but they were ... willing, if the NHS can match a private hospital in speed and money, every single time we'll go to the NHS. Our ethos is stick with the NHS, support the local hospital, but if we think they're being unreasonable look elsewhere and use that as a stick to beat the local hospital to try and change their attitude... I/FPM4/S(4) The practice were continuing to meet regularly with the hospital's managerial and clinical staff hoping to work in partnership despite the frustrations.

A similar earnestness to work with the provider existed even where communications had broken down entirely. Another practice experienced difficulties ..getting past the management... We can't get them to talk to us. They won't come to meetings, they won't give us any data. They elucidate tons of problems but they won't share with us what the problems are. They say they're terribly underfunded. Give us the evidence and we'll fight your case, they never give us any evidence ... I/GP7/S(4,2-3) Later in the interview he went on to say ...I would like to be listened to by the consultants and I would like to have a much closer relationship with the consultants. Consultants know sod all about general practice, and I know I know sod all about their work. I need their knowledge and they need our knowledge and at the moment the hospital structures have kept us apart ... we're being kept apart by the management ... I/GP7/S(14)

Practices generally exhibited considerable loyalty to their local provider and a few stated this loyalty quite clearly:-

> ...Interviewer: Do you see yourself as having a role in supporting [hospital x] because it is your local provider?
> GP: Of course, yes. Absolutely... I/GP15/S(5)

> ...hospital X has been a local provider for a long time ... in fact one practice came into fundholding because they wanted to help hospital X, we didn't want it to go down the tubes or anything like that... I/FPM9/T(5-6)

It was not always clear though whether they felt some traditional loyalty to that particular provider and the staff working within it, or whether it was local provision which they valued regardless of the provider's identity.

> ...We're all reluctant [to move a contract] because if you remove a dermatology service, you're reducing the service locally for your patients, so things have to be pretty bad before you'd go to those lengths with it... I/GP1/S(3)

> ...Interviewer: Do you see it as important to support your local provider because of issues over access?
> GP: If you can. But it's not essential. The cataract operations .. our patients would travel 30 miles if they knew they were going to get it, and they do ... they go by taxi and are very happy to do so...I/GP9/T(10)

Although the above quote indicates that patients were willing to travel, the contract for cataracts was the only one this practice had switched to the private sector. They had invested considerable energies in stimulating changes in ophthalmology for some time before moving the contract and as Chapter 7 will show, were continuing to do so with a view to switching back.

6.4.1 Buyer Power

Although there was only a small amount of contract switching, interviewees were asked whether they thought fundholders had sufficient buyer power to influence the activities of their providers. In the main interviewees felt they had some influence but that it was limited.

> ... I have had hospital finance people turn around and say to us 'your £100,000 that you're saying you're going to take away from us ... we get around £160 mill, you're in the margins you don't really matter'... I/FPM4/S(15)

> ...I think they probably felt we're too small. That's the impression we get from any meetings we've been to ... I get the impression that we're just small fish really... I/PFM5/PCP(6)

Nevertheless, there was only one interviewee who had encountered an entirely intransigent provider.

> ...they were quite enthusiastic and quite positive until we started to try and change anything and then they were extremely negative and obstructive. Trying to get to the clinicians has proved very difficult. I think [they] see us as irrelevant annoyances that can be ignored and so far we certainly can be ignored... I/GP7/S(2)

When GPs collaborated with one another (through fundholding or commissioning) their perceptions changed. LPAs felt that although they had been ...tinkering around the edges... I/GP8/N(2) trusts had been fairly responsive. Fundholders thought their influence increased substantially through group efforts and they were also able to avoid fragmenting services across the locality.

> ... Banding together will give us more power. It will also force individual practices to take a more strategic overview, a more long term overview whereas new fundholders tend to be very focused on themselves... I/FPM4/S(15)

> ...we meet probably once a month with the local Trust. I think that's probably more useful because they're keen to hear from GPs, what their concerns are, what problems they're having and we've managed to change one or two things about the way they do things in the local Trust ...of course we're talking to the managers, not to the clinicians... I/GP8/N(2)

6.4.2 Pressures for Change

It was generally accepted, even by those who had less positive purchasing experiences, that 'things' were changing. The attitudes of clinicians were ameliorating towards GPs, services were improving and communications were better than before. The degree though to which GP buyer power alone was sufficient to stimulate providers was unclear. There was a belief among interviewees that no amount of pressure from purchasing or commissioning GPs could singularly make any difference. They thought that it was the combined influence of purchasing, commissioning and extra-market pressures (eg a cash crisis, Scottish Office or Health Board pressure) which stimulated hospitals to be responsive.

> ... I think you're finding a big change particularly in Glasgow medicine, particularly because of all these pressures which have come ... The trusts are now saying 'we can't go on with this'. I think it's a combination of pressures, all these things coming together: commissioning, fundholding, attitude of the health board, financial pressures, all these things, realisation of the consultants that they can't go on this way, the ostrich mentality ... I/GP16/PCP(6)

In the urology case cited earlier, the problem was particularly widespread. The fundholders placed pressure on the Trust to improve urology services, but recognised that the specialty was experiencing difficulties on a national scale and that it was not fundholding alone which could bring about the solution.

> ...urology's too boring a specialty that they can't get young doctors to do it. Presumably they have taken steps to improve the pay and conditions ... to the extent that surgeons and trainees now consider it to be a reasonable option. After about 5 years of constant pressure it's resulted in somebody to do it... I/GP1/S(2)

In addition to national and local pressures it was suggested that uncertainty about future service configurations was also a pressure for change:-

...there have been improvements ... obviously hospitals are competing to provide a service, it's obviously going to improve the situation but I think now it's not so much that, it's competing to survive and I get the impression that because of the changes that are taking place, the hospitals are not going to be closed because of fundholding, they're going to be closed because services are going to be concentrated in certain areas ... I/GP17/N(2)

Uncertainty is likely to have played a particularly strong role in this study because the Scottish Office Acute Services Review (reported in June (?) 1998) was underway during the data gathering phase of this research and there was speculation about which Trusts would survive. One more consistent influence for change was, as in the past, the interests of particular clinicians which determined the degree of responsiveness.

> ...There's a few initiatives that have come up, a few waiting list initiatives that have been either suggested by ourselves [LPAs] .. or have been supported when the hospital suggested them ... There's new services coming on line all the time ... but I wouldn't like to claim credit for them. The Trust sees a business opportunity and decides to develop it ... Probably there will be an interested clinician, it's still happening that there'll be somebody in the hospital who has an interest in a particular specialty and puts forward a case and manages to get funding from somewhere, whether it's a drug company or the Scottish Office ... and goes ahead and develops an excellent service... I/GP8/N(4)
>
> ...the management structure and the consultants working in the units ... I/GP14/PCP(3)

Clearly there have been changes and efficiencies occurring within secondary care provision. On the basis of this evidence and the studies reviewed in Chapter 4, however, it remains unclear just how much of a catalyst fundholding has really been (see Chapter 7 for further discussion).

6.5 Resource Allocation

Previous chapters have stressed the importance of transferring resources into primary care. GPs can influence resource transfer in two ways. Firstly, they can do more in primary care and therefore reduce the volume and value of secondary care contracts. Secondly, they can make savings through prescribing which free up resources to develop primary care services. Ultimately, however, the substantial transfers of

resources can only come from the closure of hospital wards.

6.5.1 Redistributing Existing Resources

Most GPs in this study had made savings through more efficient prescribing but only one spoke about making savings from changing their provider or from increasing primary care activity and thus reducing the value of secondary care contracts. Where prescribing savings were reinvested in primary care developments, this was mainly to *supplement* rather than substitute hospital services and represented a redistribution of existing primary care resources.

Savings were used in various ways in particular to increase nursing provision, examples of which are shown below:-

Practice-Based Nursing Services

- Breast feeding facilitator
- Increased district nursing
- CPN sessions
- Health visitor and district nurse clinics (eg: diabetes and asthma clinics, in-house mental health programme)

Other Practice-Based Services included:

- Psychology sessions
- Minor Surgery
- Chiropractice

These new services, however, were not easy to develop. Two GPFHs explained the difficulty of getting health board approval for service developments.

> ... it's enormously complex and difficult to get anything out of savings. It has to be approved by the Health Board and the mechanisms for getting it approved are Byzantine .. if people get approval then they can often make quite imaginative use of it... I/GP1/S(4)

> ...It's very difficult in Glasgow to actually improve the services to your patients. Spend

it on some capital project, on something which is nice and safe and that the accountants can look at and say fine, that's easy. Spend it on something that's slightly risk taking, developing a new service which is actually patient centred is actually bloody difficult in Glasgow. We could spend it much more easily on repainting this health centre than we could on employing an acupuncturist. We have to jump through hoops as soon as you have a new innovative idea. If it's something safe you can get a quote on, three quotes to compare, no bother! ... I/GP7/S(5-6)

To suggest that savings were used only in practice refurbishments or developing primary care services is only part of the picture. In fact some savings were used specifically to boost secondary care service provision such as the endoscopy example. The same practice put a further £5,000 towards kick starting a laboratory specimen pick up service which doubled the number of collections. Now the provider collects specimens from practices (or a central pharmacy) and delivers practice mail twice daily to all practices in the area. Another practice had contributed to a CT scanner.

6.5.2 Changing the Location of Activity

Little mention was made of consultant outreach clinics. One fund manager said ...We have not brought in consultants from outside ... the hospitals were very, very resistant to it, very resistant indeed. I can understand it because it means taking away a consultant from a clinic that would be based there ... we also felt a lot of our out-patient clinics would require specialist equipment which we wouldn't have on the premises ... I/FPM4/S(8)

Some outreach clinics had, however, been set up. A paediatric consultant had been invited to provide health centre-based clinics in one sector of the city because parents had been opting not to take their children to the hospital, and fundholders hoped that an outreach clinic would reduce non-attendances. Elsewhere in the city, one provider offered to provide paramedic outreach clinics where there was sufficient demand. In another location practices had combined to purchase additional psychology sessions. On the whole though there was not much evidence of GPs actively seeking to increase the number of outreach clinics.

6.5.3 *Shifting Resources from Secondary to Primary Care*

Two fundholders commented that they had initially focused on changing hospital services but after 4 or 5 years were thinking more about developing primary care services and transferring resources into primary care.

> ...I don't think there's an awful lot more services that we want out of acute providers. I think this is much more about developing primary care and therefore what we're not looking to do is to spend much more money on the provider, we're looking to actually spend less so that we can develop primary care and the services that we provide here. I think the provider and ourselves have accepted that and therefore our negotiation with them is very much aimed at **trying to release some resource that can come into primary care** rather than us giving them extra finance for services they've already got... I/GP9/T(2) (emphasis added)

Transferring real sums of money from hospital to community provision is, however, a complex task. GPs were aware that for resources to be released, wards needed to close and trust services rationalised.

> ...because of financial pressure on us all we're going to be able to look at is how we could maybe do it much cheaper than a hospital could ... it will mean an actual transfer of services into primary care with a view to reducing the cost and therefore achieving efficiency and developing the services ... but I do think the hospitals will need to merge in some way so that the reduction in cost will produce more services out in the community ... I/GP9/T(2-3)

One group of collaborating practices had, however, found a way of releasing some resources even where wards were not being closed. They had agreed a form of discount with the Trust where 4% of the value of their contracts would be released into primary care:

> ...We contract with a block contract with a discount of 4% and the Trust and ourselves agree that that's for primary care development and that allows the GPs to provide more follow-up of patients, more diabetic services, psychology and other things. So we ring fenced the amount we spend with our local provider ... I/GP9/T(3)

There were also indications that some practices were attempting prophylactically to reduce hospital admissions. The total fundholding practice had employed nurses with specialist skills in asthma, cardiology and respiratory nursing so that they could provide

more intensive care to their patients and prevent emergency admissions. Another practice was hoping to reduce admissions for the elderly.

> ..."If you save £5,000 - £10,000 on your drug bill you can spend it in other ways. I'd like to get a physiotherapist here and maybe a chiropodist ... The other thing is there's a lot of old people in this area - 25% of my practice are over 65 ... One of the main reasons they go into hospital is 'cause they fall and can't get up but I'm sure you can prevent that with health visitors going in prophylactically, physiotherapists going in to build up their leg muscles, get them aware of the carpets and things. Basically their leg muscles aren't strong enough. **I felt that if we did a project like that it would prevent hospital admissions...** I//GP16/PCP(2) (emphasis added)

These findings suggest that shifts of resources and activity from secondary care to primary care have been occurring, but not on a large scale. Practices have developed primary care services largely through their prescribing savings and only minimally through savings on contracts. Reinvesting practice savings, however, only redistributes existing primary care resources and does not release secondary care resources. However, given the difficulties inherent in closing wards, it may be that practices can only gradually build up their primary care services in order to reduce the need for hospital referral. Given that they have only their prescribing savings with which to do this, and given that the potential for long term prescribing savings is limited (see Chapter 4), this could be a slow process with limited long term scope.

6.6 The Market Mechanism

Although the focus of this thesis is on GPs' purchasing role, particularly (although not exclusively) through fundholding, interviewees were invited to think beyond their immediate purchasing/commissioning experiences and to consider whether the purchaser provider split had been necessary and/or beneficial and to comment on the transactions costs of the system.

6.6.1 The Purchaser Provider Split - A Necessary Divide?

Of those asked about the necessity of the purchaser provider split, around half felt that it had been necessary. The other half were uncertain and only one interviewee said that it ought never to have been necessary and could have been prevented had there been open lines of communication with hospital clinicians. Separating the purchasing

and providing functions was supported largely because of the improved communications which had occurred as a consequence. Most interviewees thought that the attitudes of managers and clinicians had improved and that hospital resources were being managed more appropriately.

> ...I can see a lot of good things have come out of the purchaser provider split. The management in Hospital X is much more in touch with what's going on than it was before, as far as I can tell .. say you come to me and you've got some medical problem and I want an urgent appointment for you, I can get on the phone just now, phone up the hospital, and they have a computerised system and if they have a cancellation for this afternoon, you can get that appointment. That never happened before, that used to be the sort of service we'd get from 'Private Hospital' and I have managed to get patients seen on the same day several times .. just because they are now managing their resources much better. So I think there's been some improvements in that respect. I think it was crazy to have some wee guy sitting in Bath Street running 6 hospitals in Glasgow... I/GP8/N(3-4)

Those who were uncertain about the split, were primarily concerned with the costs which it had generated.

> ...I don't know! I haven't seen enough other different models to suggest what might work better. The main thing I don't like about it is the bureaucracy it's created. I see that continuing to be a problem whether we have fundholding as it's presently constituted or whether we move on to other types of purchasing. There still may be a lot of clerical work involved, chasing patients and deciding who's paying for what procedure... I/GP12/PCP(6)

> ...I don't know if you can answer that quite honestly. I think it did produce benefits. I think there were very substantial administrative costs all the way up, not just at practice level ... I/GP17/N(4)

Only one interviewee, a fundholder, offered the view that really the market philosophy was incompatible with health care and so it was impossible to conclude whether the split had been necessary or not.

6.6.2 Transactions Costs

Most interviewees accepted the transactions costs (either resignedly or after some justification) or were indifferent about the matter. Two primary care interviewees and the two Trust interviewees, however, thought them unjustifiable[4]. The basis for accepting transactions costs seemed to be because the NHS system was thought hugely costly anyway and transactions costs were only one element of a costly service. Other justifications were that the costs were at least being monitored, might be lower than under alternative structures and were coming from a source which did not impinge on clinical resources.

> ...There's costs in everything and it's good that they're being monitored. Aside from contracting there are substantial costs that people forget about. For example .. the cost of discussing the case between a GP and practice nurse, the cost of looking out the records ... I/GP3/PCP(3)

> ... I think the amount of money we waste on the transactions costs, it would be more than wasted on the unfocused activity if there wasn't fundholding. Both is a waste... IGP7/S(4,8)

Opposition to transactions costs was identified earlier as being the reason why two of the PCP practices had decided not to become standard fundholders. It was the trusts, however, who were most strongly opposed to the need for contracting, invoicing and monitoring. They bore the brunt of the cumulative effect of many fundholding contracts. Furthermore, Trusts frequently wrote the GP contracts; practices just checked and signed them.

6.7 GPs as Purchasers, the Overall Picture

The main emphasis in this chapter has been on the views which GPs held of the purchasing scheme and of their purchasing role. The findings are developed in the following chapter where data from the observation sessions is presented. Nevertheless, some initial comments can be made on what has been presented so far.

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[4]It was noted earlier in the chapter that these two PCP practices chose not to opt for standard fundholding because of the transactions costs element.

This section looks at the picture which has emerged in Chapter 6, and goes on to consider the extent to which the findings were supported during interviews with trust, health board and Scottish Office representatives.

6.8 The View from General Practice

On some issues GPs presented a relatively consensual view (eg, motives for fundholding) whereas on others they offered a range of opinions (eg, transactions costs and buyer power). However, a general picture has emerged. GPs did respond to the financial rewards offered by the fundholding scheme but they did not then behave in response to incentives to lower cost through their purchasing activities. Some savings were made when contracts were moved, but the driver to move the contract was not financial so savings were fringe benefits. GPs were concerned about quality although the improvements and changes were sometimes intangible, pertaining to changed attitudes. Fundholding and non-fundholding GPs were, however, quite clear about the legitimacy of their role in influencing secondary care provision and felt entitled to contribute to the shape of services in their capacity as agents for their patients.

6.9 The View of General Practice

In order to validate these findings, the following section presents views obtained from interviews with representatives from two trusts (one acute and one community), the health board, and the Scottish Office Primary Care Directorate. Each interviewee was asked to talk about how they considered GPs had responded to the market and had been behaving as purchasers.

6.9.1 Hospital Efficiency

There was no doubt that the trust interviewees felt under pressure from GPFHs and commissioning GPs. The acute trust, for example, had been pressed by GPs to improve access to services and this had resulted in more direct/open/rapid access services.

> ... [practice x] ... the year before they bought us some new endoscopy equipment out of their savings. This current year they've funded part of a transport service to collect specimens from their practices, to deliver all their letters from the Trust so rather than posting them they go on

> this van twice a day ... they invested [savings] specifically so they could get better access to that service ... I/T1/(8)

This would suggest that there have been improved efficiencies if one regards waiting times as a measure of efficiency rather than quality. Neither of the trust interviewees, however, offered examples of any other ways in which efficiency had been stimulated. One health board interviewee thought that health boards were stimulating efficiency but practices were stimulating effectiveness.

> ...the Board ... has been the main driver of efficiency into the system ...and fundholders have been the main influencers of effectiveness... Probably ... 'cause they're at the sharper edge of improved effectiveness ... I think that the contracting at the moment that we do as a Board is a pretty big blunt tool. It's about getting money back into the system as efficiently as possible. I think with fundholding it's about getting it back as effectively as possible in terms of the front end quality of the service that you get. I think on both counts as a Board and as Fundholders, there will be a move in the next 5 or 10 years to improve the effectiveness clinically of the services that we provide ... I/I/HB1a(5, 15-16)

By effectiveness, the interviewee meant both clinical effectiveness and the effectiveness of the service. GPs have been more preoccupied with the effectiveness of the care process which includes how the patient was treated on arriving at hospital, whether staff were courteous etc; in other words, the care management process (functional quality). Once again though the delineation between efficiency and quality is blurred. Interviewees perhaps see efficiency as an aspect of quality.

6.9.2 Quality

GPs, concerned initially with care management, were moving on to address clinical care. This was thought to be for two main reasons: firstly, GPs are fairly operationally oriented and want control over what happens to their patients; secondly, as they become more involved in discussions with providers, it is natural that discussions develop to include clinical aspects.

The community trust were particularly aware of the GPs' focus on operational aspects. The interviewee explained that discussions with GPs occurred at three levels:

...there's probably ... 3 levels of issues. First of all you'll get issues which are around what I would call day to day routine kind of issues where they bring up things like poor communications ... It's more about the process ... The second level would be .. some specifics about things they want to buy ... it's a question of then trying to match what it is they want to buy with what it is that we can provide. Now some of them, and that ... brings us then to the third level ... want to buy and want to change ... I can see here's a GP who's thinking quite strategically, who's sitting and saying 'I'm not happy about my nursing mix' for example ... but they'll also bring up other types of issues which you say to yourself 'why are they bringing those up?', more kind of operational things ... nursing tends to dominate ... they could see that nursing was something that they wanted more direct control over ...of the 59 practices that we have agreements with just now, I would say .. there's only about 19 of them (that leaves a balance of 40) who genuinely want to sit down and talk strategically with you... I/T2(1)

First and foremost, GPs want control over what is provided in the community by the nursing staff employed by the Trust and secondly, they are interested in clinical issues like skills mix. This may, however, be because there are two agendas: the short-term care management agenda and the longer-term clinical care agenda and only now are GPs moving to the latter.

...many of them [GPs] wanted to move on from what the early days of fundholding were about which was the process of it, and they wanted to move on to the more clinical concept of it ... I/SOa/(7)

6.9.3 X-efficiency

The emphasis on nursing management at the community trust resulted in x-efficiency gains. GPs were unhappy with the management of their attached staff (district and health visiting) but, through the purchasing facilitators and fundholders, they instigated the restructuring of nursing management within the community trust.

...We met with a very influential group of GPs, these are the opinion makers ... who are actually paid by the Board to be advisers, they're called purchasing facilitators and there's 5 of them ... [they felt the way] that community nursing is managed and organised leaves a lot to be desired. They accused us of things like introducing tiers of management which weren't required, introducing bureaucracy that wasn't required etc. So we've now made a fairly fundamental shift and we've reduced some of the bureaucracy ... We've stripped out levels of management and as of the 1st April there'll be no nurse managers left in Greater Glasgow.

We took the whole lot out... I/T2(4)

The acute trust indicated that there had been improvements to services (see Chapter 7), but did not give any examples of managerial changes of the nature described above.

6.9.4 Switching Provider

Trusts and the health board were aware that GPs were reluctant to move their contracts and were very loyal to staff delivering services.

> ...They're very supportive and very loyal ... I think the greatest loyalty is to the staff actually, the staff in the front line. It's not a loyalty to [manager] or to the Chief Executive ...I/T2(9)

> ...there is a great deal of loyalty between a GP and their Trust. So if they can get that relationship better by holding the purse strings and getting the leverage to get better effectiveness of the quality of the service then that's what they've been doing ... I/HB1a(4)

They also concurred that when contracts had been moved it was not because of price but because of quality and waiting times.

> ...they tell me, and I've no evidence really that it's not true, that [switching] it's on the basis of quality. I don't think they shift their patients around the city looking for the cheapest price. I honestly don't think they do that. ... I/T1(4)

It was also thought GPs didn't switch contracts because they appreciated that by offering accident and emergency and intensive care, NHS trusts necessarily incur higher overheads (and therefore higher prices) than the private sector. GPs understood that if they removed their contracts, they might jeopardise the livelihood of the provider.

> ...they get all their other stuff here and they know that if we go to the wall over certain services, if they took their elective work somewhere else then clearly we couldn't offer the rest of the services that they need and then we're stuck. I think .. they understand some of the economics of it... I/T1(6)

6.9.5 Buyer Power

Although GPs questioned the degree of power they had, the perception at the other side of the negotiating table was that GPs were rather more influential than they realised. This was not simply because of the money they might remove, but because of their influence on the Health Board:

> ...say that it costs £140mil to run this Trust every year ... fundholders represent probably £3 mill of that. So, it isn't huge amounts, but ... GPs will then influence health boards and they could influence health boards to stop purchasing with you if they're not happy. Now, we've had an incidence of this ... I/T1(5)

The incidence to which the interviewee referred was one where the health board removed its contract because of complaints from fundholders and an entire service was lost to the Trust. It had been offering an outreach clinic in a hospital some miles away. The clinic was run by two older consultants who were nearing retirement and who were reluctant to travel the distance so often arrived 'out of sorts'. There were complaints from the patients and because of mishandling[5] by the trust, the contract was removed by the fundholders and by the health board to whom the fundholders complained. It cost the Trust £7m in total. Although this is not an example of direct buyer power, this scenario indicates just how much influence GPs can actually have.

Trusts felt that commissioning GPs had an influential voice too, despite the fact that they have no direct contractual control.

> ... [LPAs] have a big influence ... If we say 'oh we'd love to do this for you but we can't because we haven't got funding for such and such a development', they have a voice on the health board which says 'we think this is really important, we back the Trust getting that development', so they're hopefully on our side, sometimes... I/T1(3)

The trusts were ...obviously keen to make sure they don't have a hole in their finances so they will improve in the way they deal with people ... I/HB1a(4). Although they recognised GPs were loyal, they claimed not to see the potential threat of removing contracts as an empty

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[5]The interviewee explained that the Trust ought to have dealt ...much more vigorously with the consultants ... but that's not been traditionally the way that the health service has worked although it is changing ...

one.

> ...We've got quite a big practice ... they only want to guarantee something like 50% of their work here. Now they nearly always put the rest here anyway but it's just to give them the flexibility ... but it just makes us that little bit more at risk because you can only guarantee 50% of that income coming in and the rest might or might not ...I/T1 (6-7)

> ...they can sit down and say 'we've got this money, if we don't give the money to you we can give it to somebody else'. Until they actually do it, ... unless they've actually genuinely got a viable alternative to us, we could consider it to be an empty threat. Now we would consider it to be an empty threat at our peril. I've always argued ... it's not an empty threat, it'll only be a matter of time before someone else decides to set up. In Glasgow for instance, you could say what's to stop the other acute trusts in Glasgow from saying 'wait a minute', if you've met [south side GP] he'll have told you about some of the discussions they've had in the South with the [provider] ... they went to the [provider] and said 'instead of us getting our community nursing service from the community trust, could you supply it?'. They said 'yeh, no problem ... ' ... At the end of the day they decided that we were still the better bet but .. there's nothing to stop that from happening... I/T2(7-8)

The recent popularity of PCP fundholding contributed to even greater pressure on the community trust because from 1st April 1998, fundholders represented around £12mil of the trust's income. A few years before there were only a handful of fundholders who were ...small beer ... but the increase means that ...the small beer now is starting to rise and rise and rise ... I/T2(6).

6.9.6 Pressures for Change

Trusts were clearly aware of direct pressure from fundholders, the fundholders' influence on health board purchasing and the LPAs and purchasing facilitators. There was also a further dynamic involved. Trusts were keen to keep GP business because there was a feeling that the money given to GPs was really the trusts' in the first place and they cannot afford to lose it.

> ...In truth, that money's come from us in the first place anyway because traditionally they got their activity here before they went fundholding. When they go fundholding the health board looks at all the services they bought here, takes that money away from us and gives it to them. So, we actually can loose out doubly really so we have a great deal of pressure on us to make

sure that they do continue to buy from us ... I/T1(4)

6.9.7 Resource Allocation: Money and Activity

It would seem that the main emphasis of activity has been on making better use of existing resources. For example, one trust trained GPs to do joint and soft tissue injections in the practice (see Chapter 7) thereby avoiding an outpatient referral. Direct access services offered a more efficient means of delivering services using existing resources some of which also required one-off injections of funding up-front. Increasing activity within primary care was evidenced by both fundholders and non-fundholders.

There has been rather less focus on leveraging more substantive reallocations of money and activity from secondary to primary care. One interviewee suggested that this was in part because GPs had more immediate concerns, but that it was also because a service like the NHS takes a long time to change and shifting resources on a large scale means shutting down hospital wards to release the money. One only need read the newspapers to know how quickly local and national opposition to hospital closures can arise.

> ...I think most of them have been concerned in the short term with improving upon the quality of the service in terms of access, in terms of availability of the services ... I don't think that many of them have been concerned about getting the best deal value-for-money-wise necessarily ... It's only now 5 years since the reforms came in and yet people are expecting there to be massive, massive changes ... time goes quickly and changing the health service ... moves slowly. One of the great difficulties is that historically money has been locked into acute. To get that money out, you don't by saying I'm not going to refer Moira anymore for her chronic knee problem, I'm going to treat her in the practice. You don't get the Trust freeing up the cost that you are going to incur - the bit of consultant time, the bit of nurse time, the bit of in-patient or day case time ... You actually need to close up wards, hospitals to free up money and bring it back into primary care ... I/BH1a(2, 14)

The resource allocation issue is further complicated by the fact that doing more in primary care may not be less expensive,

> ...that kind of [resource allocation] decision is a local decision between the practices and

increasingly the local health board saying 'where is the trade-off between having a locally accessible service and a centralised service which may be more efficient in pure cash terms, but in terms of accessibility and in social terms it might be worth paying the extra. But if it's worth paying the extra, it's the opportunity cost question, what are we giving up in order to do that? But that is I guess what local decision making is all about, it's about the trade-offs. I think one of the things we don't know very much about in the NHS, and we ought to know more about, is something about these trade-offs in different services. Where does the balance lie? I don't think there's one answer 'cause that might depend where you are in Scotland... I/SOa(13)

6.9.8 Market Mechanism

Health board, Scottish Office and Trust interviewees were positive about the division between purchasing and providing services but less happy with the administration and contractual aspects of the market. A Scottish Office interviewee felt that the market model was not really appropriate to health care:

> ...I think in fact you could argue that you can't have a real market (a) in a public service (I think you could argue that), but (b) in a public service which fundamentally has a cash limit. There seems to be some contradiction around markets and cash limits. We have some kind of ... quasi market arrangement ... However, within some parts of Scotland, the reality is that there is ... not very much competition ... people had to find different ways of dealing with that issue, so you get into things like contestability rather than just straight competition, and using comparators to say 'the performance in that hospital, which is very similar to your own, looks like this, and yours looks like that, why?' .. So it's not competing one with another. It's using a benchmarking process... I/SOa(7)

The trusts seemed to feel they were subject to competitive pressure so might disagree in part with the views presented above. They were particularly aware of the administrative burden and the transactions costs which the market incurs. Invoices needed to be issued in three schedules (in-patient, day case and out-patient) each listing the patients from the practice, dates of admission, discharge and the nature of the procedure. A separate schedule was then issued listing the costs. (Trusts are not allowed to list finance and patient related data together). Assimilating the patient information required for invoicing procedures and processing invoices is a very time consuming exercise which, in one trust, involves 2 full time staff. Nevertheless, Trusts felt that the purchaser provider split had been beneficial and that they were better able

to concentrate on provision.

> ...My own view is that the whole thing has been helpful in the extreme. Not the money side of it - certainly with GP fundholding, that whole cycle of invoices and all the rest of it is such a waste of time but, yes I think they should feel that they've got control over spending and commissioning and what gets done 'cause if they're not close to the public and the patients' needs then nobody is, and they have to be given their place ... IT1/(10)

> ...Well, I think it's helped to focus on what's important there's no doubt about it. What it does is that once someone tells you you are a provider of services then you focus on that ... but having said that, whether we needed all this bureaucracy that goes with it I'm not at all sure ... I think the important difference has been about those who commission services and those who deliver services... I/T2/(18)

The Scottish Office interviewees agreed that the split was something which ought not to be changed.

> ...I think there's still a concern from a number of people at the use of the terminology of markets if anything. I think if you get beyond the terminology and talk to people about a different set of relationships where you do have people who are concerned with commissioning or purchasing on behalf of a local population to meet those local needs and you can work in partnership with other people to supply those needs, I think if you phrase it that way, and look at it that way, then I think there'd be a lot more people saying that actually makes a lot of sense, and indeed there seems to be no particular desire to change that fundamental relationship... I/SOa(15)

6.10 Discussion & Conclusion

The results presented in this chapter are generally consistent with the behaviours and perspectives discussed in Chapter 4. In this study, however, one particularly powerful motive for becoming a fundholder stood out above all others, that of enhancing professional autonomy. Calnan and Williams (1995) and Lapsley et al (1997) identified control as being important to GPs, but did not convey it as being as significant as it was found to be here. As other studies have reported (see for example Lapsley, Llewellyn, and Grant 1997; Ennew et al. 1998) this social goal was accompanied by the pursuit of economic goals ones such as the ability to make savings. This is consistent with the theory proposed by Granovetter (1985) (see Chapter 3) that

actors pursue social goals such as status in addition to economic ones.

That GPs were more concerned with the quality of the service in terms of accessibility, care management and clinical care than with efficiency was also similar to other studies (see for example Mahon, Wilkin, and Whitehouse 1994; Laing and Cotton 1996). As far as reallocating resources is concerned, progress has been made in redistributing existing resources and shifting some activity from secondary to primary care. Some outreach clinics had been set up and practices were providing an increased range of services as Corney (1994) also found. However, releasing major amounts of money previously locked into acute services has proved more problematic and long-term and it is unclear how cost-effective some services are when provided in the community.

Switching from one provider to another rarely occurred. Where it did occur, switching was because of quality and accessibility not increased costs, a factor which was also noted in the studies reviewed in Chapter 4 (see for example Ellwood 1998; Ennew et al. 1998). GPs proved to be loyal to their providers seeking an ongoing partnership even when GPs had found the provider unresponsive. Evidence concerning the importance of financial criteria within GP decision making though does appear slightly contradictory. Clearly the management allowance and the ability to make savings were valued and both GPs and trusts acknowledged that discussions often revolved around finance, yet GPs appear unresponsive to price signals. This ambiguity continues to an extent throughout the next two chapters although greater insight is gained into where and when the subject of money is raised.

In this study, fundholders thought they had very little buyer power as individuals and that it was greatly enhanced when they collaborated. However, the trusts seemed to think that fundholding and non-fundholding practices could not be ignored, however empty their threats of switching might seem. It is probable though that Trusts' responsiveness was the result of additional pressures from the Scottish Office and health boards to improve performance, meet targets etc. (These non-market influences were found to complicate interpretations of findings in other studies (Petchey 1993; Le Grand 1994).)

It emerged very clearly that GPs do want a direct influence over secondary care services. Almost all of the interviewees were confident that the purchaser provider split had been beneficial although much of its accompanying administration had been difficult and costly to handle. GPs generally believed that they had a legitimate role in, and valuable contribution to make towards, influencing secondary care services although they differed in the extent to which they wished to become directly involved. The purchaser provider split, whilst not universally favoured, was recognised to have been a catalyst which has made providers more responsive and which has opened up opportunities for GPs to influence hospital services.

6.11 Summary

This chapter has discussed the views of fundholding and purchasing held by GPs. They were found to have been strongly motivated by the opportunity to enhance their professional autonomy (a social motive) but were also responsive to economic incentives. Their purchasing behaviour was characterised by a reluctance to switch provider or bargain over price. Rather, they focused on working collaboratively with providers in order to influence service quality and to transfer some resources from secondary to primary care. The purchaser provider split was considered beneficial as a catalyst for making hospital services more responsive but GPs believed that additional pressures from the HB and Scottish Office had contributed to this responsiveness.

Chapter 7 continues to discuss these themes in the context of the purchasing relationship. It discusses the relationship in terms of the content of purchasing discussions and conceptualises the relationship process in which GPs and Trusts are engaged.

Chapter 7

The Purchaser Provider Relationship

Introduction

Building on the GP perspective of the purchasing process, Chapter 7 considers the nature of the purchasing relationships in which GPs and Trusts in Glasgow were engaged. Earlier chapters have described the purchasing relationship as being relational but none have studied its *content* in detail. Chapter 7 discusses both the relationship content and process, and considers its impact upon service efficiency, resource allocation and service quality.

Drawing extensively on the ***observation data***, the chapter ***conceptualises the purchaser provider relationship*** as being ***multiplex*** and ***socially embedded***. GPs and Trusts are engaged in 4 key processes: ***learning, partnering, purchasing*** and ***service design***. Direct discussions between primary and secondary care clinicians have resulted in a number of ***innovations***, and ***efficiency improvements***, and have provided opportunities for GPs to enhance their ***professional autonomy*** through directly influencing the treatment of their patients in the secondary care setting.

7.1 Purchaser Provider Interactions

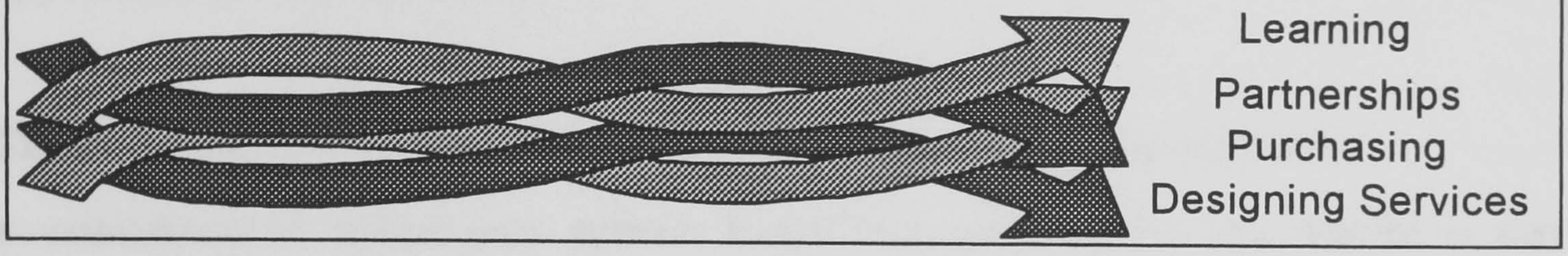
Previous chapters have characterised purchaser provider relationships as being socially embedded within a relational contracting framework. Studies reviewed in Chapters 2 and 4 have described patterns of GP activities and explained purchaser provider interactions from either studying contracts or interviewing transacting parties but have not provided detail on the content of the relationship. This chapter examines data obtained from non-participant observation of meetings between mainly fundholders and Trusts (supplemented by interview material) in order to provide a greater understanding of the relationship process and content.

7.2 A Multiplex Purchasing Relationship

Five of the meetings observed were entitled clinical meetings. They were not concerned with contracting but with broader purchasing issues such as shaping services, expressing purchasing interest and intent. Contracting meetings O4 and O6 dealt specifically with the details of the contract, clarifying prices and so on.

Discussions between the practices and the trusts indicated that a multiplex function was being performed. The purchaser provider relationship was a co-operative one comprising four elements: learning, designing services, partnerships and purchasing (see Figure 7.1)

Figure 7.1: Multiplex Purchasing Relationship



It was virtually impossible to isolate purchasing from activities of service design, learning and partnership processes as they were occurring simultaneously. The relationship was dynamic, influenced continually by a number of underlying tensions some of which were specific to a particular Trust or GP, some of which were peculiar to the HB and thus contextual to the purchaser provider interaction being observed.

Accounts from two of the meetings (O2 and O3 presented below) demonstrate the nature of the multiplex relationship. They are presented as two separate cases and occurred in two acute Trusts within the city. Both meetings were attended by management/ contracting staff, senior clinicians and a group of GPs who were purchasing services collaboratively. In case 2, a non-fundholding LPA was also present.

7.2.1 Case 1: Acute Trust A and Local Fundholders (O2)

Every 6 weeks or so this group of practices met with the contracts manager, medical director and other invited members[1] of the Trust (see Table 5.2 for attendants). The main focus of discussion during the meeting was on an initiative proposed by one of the fundholders to alter patient referral letters. He had proposed that a pro-forma letter be used in which there were two options for the GP to tick. The first would indicate that the GP wished the consultant to see the patient only once and to inform

[1]Particular clinical directors, consultants, members of the finance department etc, are invited to meetings where an item relates specifically to their area.

the GP of his/her recommendations concerning future outpatient appointments/ treatment. This would allow the GP to decide whether or not to proceed with the consultant's recommended course of action. The second box indicated that the GP was happy for the consultant to proceed directly with any necessary treatment and follow-up. The letter had been circulated to the clinical directors in the hospital by the Professor of General Medicine (PGM) who reported that there was a degree of opposition to the proposal.

The PGM and Medical Director (MD) presented the grounds for objection:

- consultants no longer keep patients longer than necessary for ego reasons as may have been the case in previous years.
- assessments might be made, opinions given and then the patient sent elsewhere (somewhere cheaper) for the treatment.
- consultants felt that they wouldn't be able to do an urgent procedure if the GP had ticked the 'single appointment and return' category. This presented risks to the patient.
- the PGM was in favour in some cases of a 'one stop shop' approach. He was not willing to concede that it was desirable in every circumstance or specialty.
- the MD indicated his concern that there were legal and ethical issues associated with all of this. Consultants might feel that they no longer had the freedom to treat patients according to their knowledge and expertise. This is something they need time to consider.
- the MD also said that consultants are already under a lot of pressure to reduce repeat referrals, to meet waiting time targets (ie to eliminate attendances which don't add value).
- attention was drawn by the PGM to the resource implications. Where there are similar types of service changes in the hospital they are being done with extra funding (from the health board, the Chief Scientist Office or Management Executive etc). Where would money come from for this type of reconfiguration - albeit that it may only require extra clerical time?

The clinicians' dislike of the proposal was clear. They resented the implications that

unnecessary out-patient sessions were being recommended and were resistant to any infringement of their clinical autonomy. Whilst they remained calm, the atmosphere was tense and they appeared rather annoyed.

To counter what he clearly viewed as a miscomprehension of his intentions in suggesting the letter, the GP was quick to point out that the letter had certainly not been designed to enable GPs to obtain a professional opinion and then refer elsewhere. He stressed that it was designed to inform the consultant about the GP's preference because some GPs want to ...regain control...O2/GP/(2) of their patient and deal with the condition within the practice if possible. He considered that rather than increasing the demand on Trust resources it should actually relieve some pressure.

The GPs and hospital consultants both repeated their respective positions each time seeking to clarify their motives. The discussion which ensued, whilst tense, was neither acrimonious nor aggressive. The PGM however, was obviously frustrated. He often shook his head as the GP spoke, screwed up his eyes and sighed appearing tired of yet more paper work. The GP seemed taken aback by this response and by the fact that his intentions could be interpreted as opportunistic.

During the discussion, a fund manager quipped ...it's a lot cheaper at the [private hospital]...O2/FPM/(3). This comment provoked a more angered response from the PGM who began to clarify that the private sector did not incur the level of overhead that NHS hospitals did because private hospitals do not provide intensive care facilities. Should they require intensive care, patients are sent to an NHS Trust so in effect the NHS was subsidising the private sector.

As a compromise, the GPs requested a short pilot of the letter, but were cautioned by the Director of Business Planning that savings might not be as significant as the practices anticipated. The Trust conceded that the PGM would discuss with the lead consultant in gastroenterology, some way of improving services. Practices in turn agreed to select 2 or 3 examples of 'unnecessary' outpatient sessions so the Trust agreed to respond to any perceived problems. The matter of categorisation though remained unresolved so the hospital consultants agreed to give it further thought.

7.2.2 Case 2: Acute Trust B and Local Fundholders (O3)

The setting was similar to Case 1. The fundholders were attending the hospital to discuss clinical matters which had a bearing on their purchasing intentions. Six consultants from different directorates had been invited to talk with the GPs about the changes in their area of work and the services they provided. (See Table 5.2 for attendants).

- Ear, Nose and Throat (ENT) Services:

The consultant asked why so few children were referred to this service. GPs explained there was a common assumption that they should refer to Yorkhill Hospital for Sick Children. Furthermore, GPs were concerned that referrals to Trust B would then be referred on further to Yorkhill so they would incur additional costs. Other concerns though related to the patient experience - eg, the non-availability of mother and baby facilities for parents at Trust B and the longer waiting times.

During the discussion it became clear that the GPs were willing to refer to Trust B (their local provider) but that they also wanted more control over the referral process. GPs identified 3 phases in dealing with a patient who had ENT problems:- (a) an initial visit to the GP (or assessment by a health visitor/speech therapist from Yorkhill at the health centre/practice); (b) an outpatient appointment for further investigation; (c) surgical procedure if necessary. GPs were interested whether a protocol could be established so that they could undertake stages (a) and (b), referring only those who needed surgery to the hospital.

The response by the consultant to this suggestion was one of scepticism and a remark implying good luck to you. He clearly thought the GPs were underestimating what was involved but the GPs were persistent and after some discussion the consultant agreed to send them the criteria which he would use to determine whether or not a patient needed surgery.

- Radiology:

The issue here was of direct access to the CT scanner. The consultant agreed in principal to providing the service but needed to approach his colleagues about it. The GPs indicated that although their contract was with another provider, they would be prepared to move but needed to know what the price would be. The Trust, however, wanted to know the expected volume of activity before they could calculate costs. There was considerable debate on this point. The GPs wanted a rough figure but the Trust were disclosing nothing and continually restated their difficulty in costing the service: there were issues about entry levels (the lowest volume to ensure a cost-effective service), recruitment (they couldn't recruit someone until they were sure there would be enough work. Ultimately, to break the deadlock, one GP said ...if I sent you 1 per week could you quote me?...O3/GP/(6) At this, the Trust agreed to calculate the figures.

- Ophthalmology:

This service had been under discussion during a number of previous meetings and for quite some time. This was evidenced by the fact that the clinical director began by saying how relieved he was to see that finally ophthalmology was no longer a major issue and he listed the many changes and improvements that had been introduced into the service. However his tone then altered. His frustration with the requests being made of his department became apparent. He stated categorically that under no circumstances would he work within standards set by non-ophthalmologists. He was particularly opposed to agreeing with timescales imposed by GPs about when a second cataract could be operated on. Only recommendations from the College and his own clinical judgement would determine the stage at which a patient was to be operated on, and not something written into a GP contract. Furthermore he pointed out that a bilateral contract was not the same as two unilateral cataracts for the price of one, or of one-and-a-half.

7.3 The Learning Function

The learning aspect of the relationship involved knowledge sharing and mutual education. In Case 1, two conflicting perspectives came together - the view of the GP and of the hospital consultant. They each sought to explain their position and the way in which they hoped to operate. The referral letter allowed GPs to express their preference about patient management. It also reflected their desire to manage more of the patient's care, to ...regain control ...02/GP/(2) after the outpatient appointment. Furthermore there was a resource implication - fewer outpatient visits meant less expensive treatment.

To the hospital consultant, however, it represented the entrance of the GP into the hospital medicine domain and the erosion of their professional autonomy. It also restricted their ability to exercise professional judgement about how many visits patients should make and how they should be treated. They did acknowledge though that historically much has been done in the name of medicine which is really the furtherance of consultants' research interests or careers. Their second point revealed their mistrust of the nature of fundholders who they regarded as financially driven opportunists who were there to cherry pick and to exploit the system for their own ends. Whilst this may seem an extreme view, the PGM towards the end of the meeting, in an outburst of frustration, said that he was fed up of the ...cherry picking... O/2/Cons/(8) which was going on where GPs were taking ...all the good or easy bits and leaving the hospitals with the rubbish or expensive bits...O/2/Cons/(8) This was not taken up by anyone present at the meeting, but this brief declaration revealed a deep-seated resentment of what he believed to be behind the changes proposed by his primary care colleagues.

As the two parties spoke about their respective worlds of health care GPs explained their primary care-based philosophy, their processes, preferred management style, and implicitly what they felt they had the knowledge and skills to do themselves. The consultants meantime presented their philosophy, the ethical implications of the letter, their knowledge base and the extent to which they wished to retain control over their own working practices.

The discussion was free-flowing and engaging for both parties, but the underlying tension became apparent when one of the fund managers made an off-the-cuff remark about prices being lower from the private sector provider. This sparked a much broader discussion where the MD unequivocally defended the Trust's position. In his view prices were higher because in fact they are subsidising the private sector. Private sector hospitals use accident and emergency facilities provided by NHS hospitals which allows them to reduce their costs. It was simply a fact of life that if the GPs wanted accident and emergency and intensive care services then prices would be higher.

Ongoing discussions about the GP referral letter illustrated further opportunities for learning. The topic was raised again during two subsequent meetings (O5 (14/03/97) and O7 (11/07/97)). Although during the first discussion (O2) all parties had agreed to conduct a preliminary review of cases, the promised action by the PGM had not ensued. In March, a fund manager proposed an alternative solution but this too made little progress. The subject arose again in July with a consultant rheumatologist (CR) who had been brought in to speak about this matter. The CR conceded that within rheumatology there were return appointments for new patients which might be construed as unnecessary, however, there were sound reasons for this and so once again in presenting his reasons, there was an opportunity for learning. The CR explained that:

- he had a policy of always seeing a new patient himself. Patients are sometimes seen by a senior house officer (SHO) on the first visit, so the CR requests a return visit so he can make his own assessment. Changing this policy would be detrimental to hospital training.
- there is sufficient motivation to discharge patients because of the constant flow of new patients who can be better served if the doctors' time is not preoccupied with unnecessary repeat visits.
- it is unclear how GPs would assess whether a consultant's recommendation for returning a patient 6 months later for review was a good decision or not? As far as routine follow-up is concerned, the issue of specialist review versus GP review

often comes down to GP preference and there is little comparative research to indicate which is more clinically effective.

- repeat attendance is sometimes due to clinical trials. It is important to be able to do research on patients undergoing standard medication and therapy to advance knowledge about accepted practice and drug usage.

His final remark immediately prompted a response from one GP who questioned who would be paying for these repeat attendances - it seemed fundholders were indirectly contributing to the research grants by having to pay for hospital attendances. The Trust personnel reacted with unanimous incredulity and exasperation which was further fuelled by the GPs insistence that returns for research purposes could ...all too easily become a habit... O7/GP/(2).

Another clear example of mutual education and knowledge transfer occurred during a meeting between Acute Trust C and two clinical commissioners. The Trust had called the meeting because they wanted to know the GPs' views about the future direction for services. The GPs welcomed the invitation to comment on services but stressed that what they really needed was evidence of real change. GPs (especially LPAs) were becoming increasingly ...dejected ... O9/GP/(2) because they were putting in lots of work but the hospital seemed ...intransigent... O9/GP/(2). They discussed how services could be better organised to suit the needs of general practitioners, for example, they could have more problem oriented clinics (eg, chest pain clinics) and GPs explained why this would be appropriate[2]. They also explained that follow-up letters often do not arrive at the practice either on time or at all. Patients make an appointment with the GP but it is wasted because the hospital letter is late in arriving and so the GP does not know what the consultant has recommended.

As they discussed new clinics, revised processes etc, one of the GPs said ...a lot of it is education ... O9/GP/(4). He felt that the hospital had a role to educate GPs because techniques and medical knowledge are changing all the time and GPs need to be continually updated. One of the consultants took this further, acknowledging that

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[2]See later quote under innovations in clinical care.

there are also changes in primary care to which some hospital clinicians are oblivious - ...there is a shift out there that people in here don't understand ... O9/Cons/(4). At the end of the meeting the GPs asked whether the meeting had been useful to which the consultant replied, ... Oh yes. It's a new way of looking at things, breaking down the barriers between primary and secondary care. ... O9/Cons/(5).

After the meeting I commented to the consultant on the apparent importance of mutual education/learning. She agreed, commenting that whilst GPs had of course worked in hospitals, hospital clinicians had never worked in general practice and had no idea about what was involved. This was further confirmed during an interview with a PCP fundholder who pointed out that in primary care, medical practice and the doctor patient interaction is very different. It is something to which hospital consultants should be exposed:

> ...I think all doctors should spend a year, at least maybe six months, as a GP because it's one of the hardest jobs of all ... you're dealing with everything ... every patient's demand. I am a property consultant, I'm an employer and I've got a partner. Consultants don't have any and they don't have the constant demand of patients ... One of the chaps in my year, he's a vascular surgeon, vascular surgery is one of the most dramatic things in medicine - traumatic. He's had the hairiest moments of his life when he did locums in general practice. ... What do I do here with this screaming wain? Does it have meningitis? Huge responsibility ... I/GP16/PCP(4-5)

7.4 Designing Services

From the interviews and observed meetings it emerged that a number of existing services had been redesigned and others newly designed as the purchasers and providers engaged in clinical discussions ie, where GPs and hospital clinicians were in direct communication. Design was generally stimulated from discussions about service quality, both the care management process (functional quality) and clinical care (technical quality). Sometimes ideas were stimulated by GPs, other times by the Trusts.

> ... Sometimes the GPs come along with bright ideas and say can we do this or not? , .. our guys will say no way, you can't do that . But very often good ideas come out of these joint meetings that we have ... What tends to happen is that the GPs pick a subject. I then make

sure that we get the clinical specialists from the hospital involved in the meetings and we sit around, they put their point of view and we discuss how we can best provide that service for them. There are lots of examples of good practice that have come out of these meetings ... I/T1/(2-3)

7.4.1 Innovations in Care Management

During the meetings between trusts and GPs, a number of innovations in care management were stimulated. For example, during the meeting with Acute Trust C (O9), the GPs tackled the usual subject of discharge letters[3] and then went on to discuss the discharge process and follow-up appointments. They complained that letters often do not appear at the practice. Patients wait for an appointment date but nothing arrives so practice staff need to phone and ...badger the consultants' secretaries ... O9/GP/2. One GP suggested that an appointment date be arranged at the time of discharge rather than a separate process having to kick in later. One of the consultants explained that in fact 4 forms are completed for discharge and retained in the hospital. She assured the GPs that a committee was looking at the discharge process and its associated paperwork with a view to creating a template for a single discharge form. The form would be longer than any of its previous incarnations, but would have headings which would stimulate junior doctors to think through and write about the relevant issues. The form would ultimately contain much more qualitative information and would be copied to the GP. Enthusiastically one of the GPs suggested that ...re-engineering is the key... O9/GP/(2). The consultant heartily concurred that ...if the system works well it will run efficiently...O9/Cons/(2).

Other innovations were witnessed at Trust C and in other settings. At Acute Trust C (O9) GPs also questioned how **referrals** were prioritised, suggesting that too often all referrals were being treated as routine and not being stratified. A system alteration was again proposed (by the GPs); different types of referral letters for different clinics could be set up. For example, GPs could state on the letter the types of tests they had carried out. Clinicians at the hospital would then have a better idea of how to prioritise the case. **Asthma services** were being streamlined at Acute Trust B (O3).

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[3]This issue was raised at most of the meetings because letters were said to be late and often of poor quality.

The Trust had written a protocol on the casualty card which would be followed on admission. The card would later be sent to the GP so that they would be fully informed of the patient's condition and the treatment provided.

Concern for, and influence over, the design of processes extended to the redesign of organisation structures within the Trust. In one case, pressure from GPs meant that supervisory and management structures had to be altered. Chapter 6 showed how purchasing facilitators had complained about the management of community nurses. Their influence was such that the Trust fundamentally restructured its nursing management for the whole city.

Not all the changes were so radical. Sometimes all that was required was a more incremental enhancement of care management. For example at Trust A (O2), the consultant ophthalmologist pointed out that whilst GPs were complaining about the discharge letters and seeking more control over **referral letters**, they were neglecting to provide patient information on referral. She had taken a small sample of referrals from a 3 week period and noted that 60%[4] had contained no information at all about patient medication and general medical health. All that was required was for the medical director to write to GPs reminding them of the need to provide comprehensive patient information on referral.

7.4.2 Innovations in Clinical Care

As well as modifying the care process, clinicians also worked on designs which combined more efficient processes with changes in clinical practice. For example, at Acute Trust B (O3) a new approach to **ultrasound** was proposed by one of the hospital consultants. The clinical director for radiology issued copies of a short publication describing a recent study which suggested that it was efficient to provide open access ultrasound to GPs. Moreover, open access enabled GPs to manage patients within the primary care setting (ie, they need not relinquish control). The publication read as follows:

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[4] Forty percent of the 60% were from fundholders.

Increasing demands on diagnostic ultrasound make it important to ensure **the most efficient use of services**. Recently, [Acute Trust B] allowed direct referral for pelvic ultrasound to some of the local GP practices and this retrospective study aimed to determine the potential of this facility to improve patient management, and which individuals were most likely to benefit. Patients referred de novo by GP for pelvic ultrasound scan over a 24 month period were studied ... Of the 104 cases studied, 32 (31%) of the scans were positive, matching published figures for referral for general ultrasound from hospital outpatient departments. Of the patients with negative scans, 47 (65%) were managed in the community, and 25 (35%) were referred to hospital outpatient clinic. Of those with an abnormal scan, only 8 (25%) were managed in the community and 22 (68.75%) were referred to clinic.

The highest proportion of positive scans (645) came from the group presenting with a palpable mass, but, as the majority of such patients will require further investigation, the value of an ultrasound scan prior to referral is not clear. ... We demonstrated that in all other categories, if the ultrasound scan result was negative, most cases required no further input from hospital services, and that **provision of this service can reliably help GPs to decide on the future management of such patients**. (Reid, S. R; F.M. Bryden and I. A. MacLeod. Department of Radiology. Source unknown)(emphasis added)

On hearing this account, GPs were interested in whether radiologists could do the diagnosis. This would avoid any need for a consultant appointment and would further reduce the cost of the service. The consultant confirmed that this was the case. However, GPs then asked ...how can we have confidence in the diagnosis?...O3/GP/(5). Although they were assured that radiology training was intensive and that service quality could be guaranteed, they had to decide whether they wanted a consultant opinion. This mitigated against the GPs' initial enthusiasm and they decided that they needed time to think about the relative risk of perhaps receiving a mis-diagnosis.

The development of **ENT protocols** (Case 2) also addressed clinical care. Their proposals entailed the removal from secondary care of some routine testing and diagnosis which meant an increased clinical role for GPs in dealing with ENT cases and a reduced need for patients to attend hospital. Trust A (O2) had launched an initiative where hospital consultants were training GPs to do **joint and soft tissue injections** in the practice. They had successfully piloted the project and were planning to provide further GP training elsewhere in the city. There were suggestions that this might be extended to include training in the **management of acute knee conditions and chronic back pain**. The same Trust had also launched a new **chlamydia screening**

service. This service differed from most in that it was available on request. GPs had voiced concern about the possibility of women contracting chlamydia but the medical director and the infectious diseases consultant thought that because it is only women with multiple partners who were at risk, there was no need for large-scale, routine screening. Instead, they offered that GPs could send a urine sample and request screening when required. Direct access for **minor operative procedures** had also been set up so practices who do not have their own facilities for minor day case operations (eg, removal of ganglions etc) can refer their patients directly to a day case operating list bypassing all out patients and other procedures.

It is clear that fundholders and non-fundholding LPAs were directly involved in service design by virtue of ongoing clinical discussions with the Trust. It was also said to be the case though that similar discussions took place through the commissioning process between trusts and LPAs. I did not observe any such meetings at the Trust, but during a Health Board commissioning meeting (O7), the clinical commissioner[5] indicated that he had been involved in a number of service design matters: prioritising **gastroenterology** patients at an acute trust and improving the efficiency of the care process; exploring the scope for **community radiology**; and issuing guidelines to GPs about how best to use the **pain clinic**. Because of increases in **laboratory spending**, GPs were drawing up guidelines and revising the lab handbook so as to educate GPs about the availability and appropriateness of various tests in the hope that services will be used more efficiently and effectively. Prior to the meeting I had interviewed this clinical commissioner and asked about whether he thought he was involved firstly when as an LPA then latterly as a clinical commissioner in designing services. His response was definite and demonstrated that he was concerned with both design and resource utilisation.

> ...Interviewer: Given your commissioning role, do you see yourself as designing services?
>
> GP: Oh yes. We are looking at templates for the haematology service.
>
> Interviewer: Like flow charts of what will happen?
>
> GP: Yes, and the kind of service specification for what we'd expect to happen. We're working with

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[5]Clinical commissioners are GPs who attend the health boards as representatives for the LPAs (see Chapter 5).

the consultants to do that.

Interviewer: The technical function of the service or the niceties of how you treat the patient etc?

GP: Not a lot of that (niceties!). Here's an example ... The Trusts give us their wish list every year and indicated £16 mill of wish lists this January ... Now the Health Board doesn't actually have any money to give away at all, but some of the services they were asking for, they'd put in say £50,000. Rapid access chest pain clinic, we were given a budget and asked by a Trust for £50,000 to fund this[6]. Now I look at it this way. Someone comes here with chest pain, how are they dealt with at the moment? Well it depends, if they're an emergency they end up in coronary care, if you think it's angina you treat them, maybe refer them to a cardiologist, or if they're a halfway house they maybe end up being sent up to casualty to be seen by the receiving physician who decides whether it's cardiac or oesophageal and they get discharged. If you run a chest-pain clinic once per week for more urgent types of chest pain you then have a set up where they go and see a consultant cardiologist and they get all the investigations done and are reassured or admitted or whatever. Now, the benefit to the patient is that they're seeing a cardiologist, not an A&E officer or junior hospital doctor. So what do you need? To employ more consultant cardiologists? Well perhaps that's why you need more money, but if you're employing more consultant cardiologists you need less junior staff. There aren't enough patients. It's being dealt with in a different way so why do you need £50,000. The immediate knee-jerk response for the Trust is 'oh well we'll just keep everything we've got already but add in a few new ECG machines, we'll produce a new department, a department of chest-pain, or something. They need to get out of this and give a proper costing. If you're going to employ an extra cardiologist and loose half a junior member of staff then OK, I'll buy it for £25k if that's what it is, but you're seeing the same patients with the same conditions in the same hospitals, so you need zilch unless you can prove to me otherwise. They're always wanting more money for reconfigurations of services and I certainly wouldn't give them it... I/GP11/PCP(17-18)

Not all of the new services had arisen directly from discussions with GPs. There were cases where the Trusts had recognised a need to improve a service or had recruited a new consultant who was keen to launch a new service. Trust A had launched a chest pain clinic because ...a new consultant came who'd done the same thing in Edinburgh when he worked there and wanted to do it here and we were able to set it up and offered it. They [GPs] all think it's wonderful and want more different things ... I/T1/(11). The same trust had also launched a new urology service, again because of consultant interest: ...that was because one of the consultants realised that there were a lot of nurse practitioners down in England ... he went off to a conference and he came back saying 'they're using ... nurse practitioners ... So he thought this would be really good and we happened to get an

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[6]He is speaking as a clinical commissioner so 'we' refers to his role at the health board.

excellent appointee into the job who's really done a lot of work ... It was really from him seeing the light and then us saying to the GPs that 'this is a better way of doing things, what do you think? ... I/T1/(11).

7.4.3 Barriers to Innovation

Whilst designs could be stimulated by consultant interest, they could also be prevented by a lack of consultant interest. At Acute Trust B (O3), GPs wanted to develop **neurology services**. Neurology complaints are generally dealt with in a hospital well known for its neurological services, but it is not so readily accessible for patients living in the area around Trust B. However, the consultant physician explained that nobody was interested in neurology. The only scope was for patients to attend general medicine clinics where ...they do a lot of 'soft neurology' ... O3/Cons/(3). The alternative was to set up direct access to CT scanners, an option which the GPs eagerly pursued. Trust A had attempted to set up an open access endoscopy service but, ...One of our consultants is not convinced that this is the right way to go, so he really has not blocked it but he's not been very helpful and every time you try to do something he says 'oh, we don't have the nurse' or 'oh, I'll have to change the doctors hours', so it took months to get that going ... He thought it would open the floodgates, that suddenly all these patients would creep out of the woodwork and need this service ... I'm clear that it won't. It's the same group of patients, it's just that they come directly rather than via an outpatient clinic ...I/TI/(12).

It is clear that purchaser/provider discussions stimulated a number of innovations. Those noted above were only examples of what was said to be a number of innovations.

> ...there's lots of innovative things like that but the whole emphasis is to keep patients as far as possible with the practice... then, of course we get into the more hi-tech stuff that clearly only we can do and it's more then about outcomes of care and to some extent shared care. There's lots of discussion around at the moment about how cancer services should be managed at the moment ... I/T1(2)

7.5 The Partnership Process

Forming a partnership was important for service design. It was also valued as a goal in itself as was clear from the findings presented in Chapter 6. Practices actively sought a partnership with their providers so that services could be integrated, patients could have access to local facilities and so primary care clinicians could benefit from dialogue with specialists and visa versa.

It was clear that not only did purchasers make demands of the providers, but providers made demands upon GPs. The very presence of the consultant ophthalmologist at one meeting had been because, as she put it ...I flew off the handle at my business manager one day...O2/Cons/(4). This was because she had been receiving patient referral letters with little or no medical information. She said she resented that when hospitals fail to provide information they are not paid, but when GPs don't provide information hospitals need to just accept the status quo. The consultant went on to point out in a slightly jocular fashion that she had observed in the proposed pro-forma letter (see Case 1 earlier) that there was little space for patient information. In response, both a GP and a fund manager suggested that GPFHs should be penalised for providing insufficient information and that this should be formalised in their contracts.

At Trust B (O2) a similar situation occurred concerning death notifications. For more than a year the GPs had been registering their dissatisfaction with the delay in death notifications. At times they would not know for weeks that a patient had died in hospital and this led to unpleasant repercussions. One GP, for example, was not notified that one of his patients had died in hospital. Consequently when the GP later met one of the patient's relatives he made no comment on their unfortunate circumstances. This was clearly damaging to the doctor patient relationship and ought never to have occurred. The problem it seemed lay with the Trust. Protocols had been set in place to govern death notifications but they were not always followed. However, what was also raised was that when patients die in the community, GPs often fail to inform the Trust. This was, therefore, an area where information flow was undoubtedly a shared responsibility. The two parties undertook to improve their efforts in notifying one another respectively.

Another aspect of the partnership was the recognition that GPs were rightfully becoming involved in hospital services. At Trust B, the Consultant in Respiratory Medicine said that he was ...acutely aware of the need for interaction with GPs ...O3/Con/(3) and that he wanted to be sure their services were flexible, community based and ...sensitive to GPs... O3/Con/(3). He invited GPs to 'phone if they wanted to discuss the service. At Trust C (O9), consultants stressed their view that GPs needed to be brought in on

discussions about the future of hospital services. In response one GP said ...it isn't about sides, we're all in the one boat ... O9/GP/(4). He said that there should be more joint meetings between hospital doctors and GPs where they could state their respective agendas and then work towards a shared agenda so there could be a continuum of care. At this same meeting, it was noted that waiting lists for the pain clinic had increased. Interestingly to alleviate the problem one of the GPs (a clinical commissioner) wrote to GPs suggesting they took on more responsibility for pain management so that the burden on the hospital might be reduced. He did so knowing such a move would increase the burden on primary care.

There was also a sense that when working in partnership, practices and trusts could take a much broader, locality-wide focus. During a meeting at Trust A (O5), GPs enquired whether the Trust had seen an increase in the number of referrals to open access endoscopy and respectively, a decrease in referrals coming through out-patients. This proved not to be the case although there had not been a large increase in open access referrals. As they explored the difficulties in collecting the right activity data, the discussion snowballed. GPs were interested in data about referral levels and activity levels for the current and previous years. This interest extended to comparing referral rates across specialties, including emergency referrals, and then grew into a discussion about cross-boundary referrals and whether referral patterns were changing across specialties and sub-specialties. The enquiry was partly to ascertain whether the GEMS[7] service had stemmed the number of casualty admissions. It was not entirely clear during the discussion what the direct benefit would be from working out these figures (they were not easily available), however, one benefit emerged later when the subject of prices was raised. At Trust C, GPs also expressed concerns about the impact of activities on a locality or sector wide basis. They too were discussing referral patterns and the need for co-ordinated action between GPs. They couldn't just decide to do anti-coagulation in one practice and not on a sector-wide basis - ...GPs can't cherry pick, and they have to do it in the whole sector for it to be cost effective ... O9/GP/(4). In other words, they were seeking to avoid fragmenting services across primary care and across

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[7]Glasgow Emergency Medical Service: ie, the overnight emergency general practice service which is co-ordinated city-wide.

the primary/secondary interface.

The partnership aspect also enabled practices and trusts to extend their work beyond clinical services. At Trust B (03), GPs became involved in a complex discussion about shifting care for the elderly from hospital to the community. The clinical director for medicine for the elderly explained that GPFHs would need to put their savings into the hospital in order to reshape services because the Trust did not have sufficient financial resources. GPs explained that they were already investing money by increasing prescriptions for Aspirin and other medication so their drug bills had already increased. The clinical director, however, said there had been an increase in emergency admissions and that the hospital could not cope, far less reduce hospital services, unless GPs stopped the referrals. The trust gave fuller explanations about the need for bridging finance and pressures for wage increases but it was obvious that neither party had sufficient funds at the time to invest in medicine for the elderly. Although in some respects they reached an impasse, neither party questioned the fact that they had a shared responsibility to make the shift from hospital to community actually happen.

Financial pressures proved to be unifying forces. Two city-wide pressures had been brought to bear at the time this research was conducted: reduced funding for Glasgow as a whole and the redistribution of community nursing resources. GGHB had received a significantly reduced budget allocation for the year 1997/98. This meant that Trusts and GPFHs would receive smaller budgets. At the same time, however, prices had increased. At Trust A, one GP expressed his concerns about funding for GPFHs and for the Trust. He considered that Glasgow as a whole had been badly served by the SHARE formula because it made inadequate allowances for deprivation. He said ...I want to see GPFHs equitably treated but not overly so...O5/GP/(6). When the contracts manager for the trust spoke of the difficulties the trust was experiencing because of their funding the GP was quick to say ...exactly, that is why we need to work together to make savings by, for example, reducing the level of outpatient referrals...O5/GP/(4). One cannot know from this statement what all of the motives might be. Clearly there was an opportunity for the GP to further justify his intentions behind the revamped referral letter, there would undoubtedly be a financial or economising motive too, but nevertheless, there

was an identification that the two parties had to work together in partnership to make the best of an uncomfortable and worrying situation. At two meetings (O4 and O5) fundholders reminded the Trusts that invoices were arriving late, GPFHs didn't want to apply penalty clauses but the later the invoices arrived, the more difficult it was to pay the trust in time. During the meeting with the community trust (O4) a representative from the fundholding association persisted in his attempts to convince the trust to issue invoices on time because they did not want the Trust to lose out.

7.6 Purchasing Services

The very fact that GPs needed to agree a contract, means that purchasing is one element of the purchaser provider relationship. Even where purchasing was not explicitly discussed (eg. provider 'A' did not offer service 'X' to purchaser 'B' for price 'P'), there was an underlying assumption that if service developments progressed agreeably, it would be unlikely that contracts would be removed. Incidences of purchasing were less clear in the clinical meeting, than the functions of learning, designing services and partnering to which most of the time was devoted except during two of the meetings (O4 and O6) which were contract meetings, where more attention was given to pricing structures and volumes of activity.

There were times when negotiation and bargaining not to mention some strategic manoeuvring were quite overt. The most overt solicitation of GP business occurred at Trust B where the Clinical Director of ENT services openly asked why it was that GPs did not refer children for surgery (O3). This lead to a discussion about the availability of comparable family facilities and comparative waiting times all with a view to encouraging GPs to change their referral patterns.

During this same meeting parties were discussing setting up direct access for CT scans (O3). The GPs indicated that if this service were available they would move their contract from another acute trust to Trust B. Not wishing to commit themselves to an under-priced service however, the Trust asked what volume of activity the GPs would provide; finance could not be calculated nor could they contemplate appointing staff when there was no commitment in terms of volume of referrals from the GPs. The

GPs did not want to quote figures so asked for a rough cost-per-case. Again the Trust refused. The point of increment, they said, was critical to their calculations and they couldn't suggest a price. Again the GPs returned, what would the entry level be? How many referrals before they could begin to think of setting up direct access? The Trust were unable to answer that without some financial assessment. The GPs persisted in a quest for ball park figures. The Trust reiterated that there were marginal costs and they needed to know that there would be enough activity. They reached stalemate until one GP said ...if I sent you 1 per week could you quote me?...O3/GP/(3). The Trust conceded and agreed to produce the figures.

This example was the clearest and most obvious bargaining situation observed. Both parties were frustrated by the dialogue although the GP who lead the negotiations seemed to be enjoying his role. It was unclear whether the Trust's agreement to cost one case per week was out of exasperation or whether this was a workable volume of activity.

The contracting meetings served as the forum for discussing prices (O4 and O6). The subject of the two contracting meetings was community care services, not acute services. Practices met with the provider, Trust C, to finalise prices and volumes of activity. However, three factors made this a difficult task to accomplish. Firstly, the trust was not able to confirm its prices. Contracts run from 1st April to 31st March, yet by the middle of March (O4) prices were not available. (This was also the case at Acute Trust A.) By 23rd April (O6) when prices had been issued there was a considerable difference between old prices based on historical activity and the new prices based upon the same activity levels. Part of the difference was due to a confusion between GGHB and the Trust. GGHB had requested pricing information from the Trust in a specific format (costs split between core and non-core). However, the Trust alleged that when interpreting those costs and allocating practice funds, an anomaly had occurred. One fund manager explained that she had been unable to reconcile the prices for 1996/97 with those for 1997/98 for her practice and could make little sense of the figures.

The second difficulty facing the purchasers was that they had not received confirmation from the health board of their fundholding budget. They were aware that funding was restricted and prices had increased but they had no final figures. This produced a remarkable situation whereby purchasers were discussing 'in principal' decisions because, until they knew the correct prices, they could not guarantee to purchase the same levels of activity they had previously bought. The Trust, therefore, was continuing to provide services without any guarantee that they would be purchased in full.

The third complication was that the Trust had just introduced an equity model to reallocate existing community nursing (district and health visitors) throughout the city. The practices represented at O6 were net losers whilst those at O4 were net gainers. The reallocation was to be phased over a 3-year period during which time the Trust were proposing that practices be billed on the basis of pre-equity service, then after they had decided what to do with their shortfall or increase, they would receive a credit note or additional invoice for the balance.[8]

Most of the discussion revolved around the costing principles rather than specifics (probably because information was unclear and prices and funds were unconfirmed). However, a situation arose in which some friction was apparent between a fund manager and GP (not of the same practice). This illustrated the need for GP input into contracting. The FPM expressed an objection to paying management costs for 2 sessions out of every 10 psychology sessions. Unknown to the FPM, the costs were clinical management costs not administrative management costs, ie, for every 10 sessions, a psychologist needs 2 for supervision. The FPM disputed the need for these costs during a debate with the Trust's Director of Contracts. He explained that if the practice refused to pay these costs then they would need to purchase the services of a more highly qualified psychologist who required less supervision time and that would ultimately cost more. The FPM was reluctant to accept this explanation until a GP

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[8]The issue is conflated because practices may decide to pay extra and keep existing staff rather than lose out. This has a knock on effect on the reallocation of those resources. Gainers, however, may decide that whilst they stand to gain in district nursing, they would like to use the resources to pay instead for additional health visiting. This makes managing the reallocation of nursing staff very complex.

quite forcefully said that was just the way it worked and they would need to accept it.

Another clash between financial detail and clinical procedure arose later in O6. Practices questioned how they might accurately calculate costs for referral to mental health centres (MHCs) which house multidisciplinary teams. Although a GP may refer his/her patient to a psychiatrist, the MHC team may reallocate the patient to a community psychiatric nurse. There was no way that fundholders could tell from their monitoring statement which MHC member carried out the activity. This had direct cost implications for practices because nursing staff are cheaper than psychiatrists. The Trust undertook to try and produce more sensitive information.

7.6.1 Marketing

In Chapter 6 Trusts were identified as being keen to secure future contracts with their customers. Even although switching rarely occurs, it would be unreasonable to assume that Trusts did not view encounters with fundholding practices as an opportunity to market their services. It was clear from the interview material presented that GPFHs could influence health board purchasing if they were dissatisfied with a service.

A number of incidences occurred when Trusts took the opportunity to market their services. They did so subtly and often it was the clinicians who 'told the good news'. At Trust B, for example, the Clinical Director for ophthalmology talked about how his directorate had responded to pressure from the GPFHs and had set up a new ophthalmology suite. A physician explained that there had been a number of changes in the general medicine wards (eg, more cubicles and fewer mixed wards) and outlined the potential benefits of the changes. Clinicians also explained the improved asthma services and possible new radiology services.

During the course of O2, the endoscopy service came up for discussion. One of the GPs present had previously removed his endoscopy contract. The Trust took the opportunity to report the satisfaction ratings from GPs since the service had been improved. They cited figures on waiting times and affirmed the importance of this particular service development to the Trust. The contracts manager commented to

the GP concerned that although he no longer purchased this service there had been good reports.

This form of marketing was not met with disinterest. At O2 GPs enquired about the referral rates, referrals to related investigative procedures and so on. Whilst neither party engaged in a discussion about the pricing of the service or the quality of delivery as such, the Trust was aware of the GP's reluctance to remove the contract and that he would be keen, in principle, to return his business to the NHS.

7.7 Learning, Partnerships, Designing Services and Purchasing: Integrated Activities

The four elements of the GP-provider relationship are not mutually exclusive. For example, resolving contract issues at the community trust very clearly demonstrated the integration of purchasing, partnerships and learning. The Trust looked to the GPFHs to lobby the GPFH Association for support in the proposed billing system. They knew that to make the reallocation work, they needed to work with the practices. The practices present agreed to explain the situation to members of the association in an attempt to ...defuse...O6/FPM/(3) the difficulties. The Trust pledged to ... go along with the association if there's unanimity, whichever way you want to go... O6/Mgt/(4). The amount of discussion about how the equity model would be applied, plus the discussions over pricing and activity levels illustrated the learning process as each party sought to clarify their situation and the difficulties they faced.

The potential purchase of ENT services from Trust B developed into a matter of redesigning services. Service redesign and purchasing were also central to discussions about direct access CT scanning, radiology and endoscopy services. Almost every discussion involved clarification by both parties as to how service redesign would impact on their practices, so learning was integral to redesign. Furthermore, redesign clearly depended upon a partnership between general practice and secondary care to ensure that processes suited both parties.

The cases cited show a direct link between learning and the design of services. As

clinicians talked together they identified ways in which secondary care processes could be modified to better suit GPs and patients. As was clear in the earlier examples, discussions were sometimes frustrating, sometimes enlightening and sometimes crossed clinical boundaries. The opportunity though to actually discuss services was valued by the GPs and the trusts as was shown in the previous chapter. Open lines of communication between clinicians were thought to have been one of the most significant benefits of the purchaser provider split.

Service design was also based upon a partnership between primary and secondary care in which GPs often agreed to fund elements of the new service as described below.

> ...traditionally we've only really talked to health boards about all our service developments for the coming year. What I'm going to do shortly is to circulate a list to all the GPs of what we've been looking for in terms of service developments. If they re not aware of them they can't support them. For example, for fairly small sums of money they've sometimes got enough savings in their practice for the previous year to be able to fund that for you and they will do that. Like Dr X's practice, .. the year before they bought us some new endoscopy equipment out of their savings. This current year they've funded part of a transport service to collect specimens from their practices, to deliver all their letters from the Trust so rather than posting them they go on this van twice a day. I think there are better understandings and if they don't know what we need, or if there is a really good idea about service developments but the board can't fund them they might want to... I/T1(7-8)

7.8 Discussion

7.8.1 Hospital Efficiency / Resource Utilisation

The interview data in Chapter 6 did not provide a clear picture of the importance to GPs of reducing costs and improving efficiency. The data examined in Chapter 7, however, show that economising was central to the process of service redesign. Case 1 outlined the proposed referral letter which would increase GP control over their patient. However, were the proposal to be accepted, there would be an impact on hospital resource utilisation. Wasteful or unnecessary referrals (if they exist) could be reduced. This would reduce the flow of money from the practice to the hospital and thus release resources into primary care[9]. The possibility of direct access radiology

[9]The Director of Contracts suggested, however, that the savings potential was limited.

had similar implications. By making direct referrals, GPs avoid out-patient appointments and thus can reduce the cost of their contract. Furthermore, if it proved feasible for a radiologist to offer the diagnosis, this would avoid all consultant contact reducing the total cost of the contract even further. Direct access for minor operative procedures offers similar economic benefits to GPFHs.

It was not just the standard fundholders who were keen to reduce costs. The two PCP fundholders in O9 were also keen to reduce waste. They were aware that the practices were wasting appointment time because patients were appearing to discuss discharge letters which had not yet arrived and were thus using up appointment times unnecessarily. Their enthusiasm for problem oriented clinics also had an efficiency/cost implication. A GP quoted earlier explained that sometimes GPs do not know which consultant to refer to when a patient presents with chest pain (it could be angina, heart failure etc). By referring to a problem-oriented clinic they guarantee that the patient will be seen by a consultant who can address all types of chest pain. This therefore reduces the number of unnecessary referrals and ensures that more can be done on one single hospital visit which reduces administrative costs. At one commissioning meeting (O8), a PCP fundholder said that he wanted to ensure that gastroenterology cases were stratified so that the process could be ...as efficient as possible ... O8/GP/(4).

Interestingly, as far as radiology services at Trust B were concerned (O3), it was the consultant who identified direct access as being efficient, and he had clearly done previous research to verify its efficiency.

The role of price became more apparent in this chapter. There was some indication that GPs had tried to negotiate deals over ophthalmology procedures (a bilateral cataract being two unilateral cataracts for the price of one, or one and a half). One practice had also sought to reduce the management costs associated with community psychology services. Fundholders were perceived by some consultants as being overly-concerned with finance but whilst discussions about service costs did occur, they remain a relatively small part of the overall dialogue.

7.8.2 X-efficiency

The findings illustrate an important aspect of stimulating efficiency. To the GPs, identified in Case 1, repeat out-patient attendances seemed inefficient and costly. However, there were a number of reasons why this apparent inefficiency was occurring, none of which were directly due to a waste of resources. Furthermore, it would seem from the response made by the consultant rheumatologist that the problem was not one of x-inefficiency either. This would imply that when purchasers are making assessments about efficiency, ignorance of some of the underlying factors would lead to an entirely wrong conclusion and perhaps the detrimental removal of a contract. Contract removal in this case could have jeopardised the viability of clinical trials and medical training.

The findings presented in this chapter did not yield any greater insight, nor did they identify any further incidences of improved x-efficiency than have already been discussed in Chapter 6.

7.8.3 Quality

GPs' concern for quality is clear from the findings. For example, their reluctance to refer children to Acute Trust B was because they doubted the quality of the patient experience. It is interesting to note how discussion about quality resulted in suggestions for improving efficiency at a process level. At Trust C (O9), when GPs and consultants began by talking about the quality of discharge letters and the discharge process, their suggestions for re-engineering the process enabled them to improve both the quality and efficiency of discharge. Similarly, at Trust A (O2) one could imagine that improving the quality of information in referral letters would improve the efficiency with which diagnosis could be made and appropriate treatment offered. It is not possible to tell from these data whether proposed quality improvements would be costly to implement or not, but it could be suggested they will mean less time is wasted trying to work out diagnosis etc and thus overall costs are reduced in the longer-term.

The relative importance of quality and financial gain were illuminated in this study. GPs were regarded by some as being cherry pickers who were preoccupied with money. Casual remarks like ...it's a lot cheaper at the [private provider] ... O2/FPM/(3) reinforced any stereotypes. One senior consultant commented at the end of a meeting that meetings with fundholders were worse than meetings with the health board or Scottish Office. They were purely ...accountancy driven... (O7/Cons/(5) and for that reason, most unpleasant. However, at trust B (O3), concerns about the quality of an ultrasound diagnosis given by a radiologist constrained any pursuit of financial gain from a lower cost service. This suggests that GPFHs are eager to encourage innovations which result in lower costs, but maintaining quality has a higher priority.

7.8.4 Resource Allocation

The observations provided evidence of moves which would result in a transfer of resources from secondary to primary care. Efforts to implement ENT (O3) protocols, for example, showed a desire for such a transfer. GPs could reduce the value of their contracts because they were doing more in primary care and thus retain some of the original contract funding within the practice. If protocols were implemented city-wide then there would be a marginal release of resources into primary care. Direct access radiology (Trust B (O3)) would also release some resource into primary care because patients need not attend (costly) outpatient clinics.

There was evidence of another, albeit marginal, shift in activity at Trust A (O2) in the form of joint and soft tissue injections being conducted within primary care. That there is scope for this to develop to the management of acute knee and chronic back pain conditions, common complaints, indicates the potential for release of further funds.

Outreach clinics met with a mixed response. At Trust A, there are oncology outreach clinics. Consultants travel considerable distances to provide this service which the Trust does feel is valuable, but not all outreach is viewed in this way. For example, a large health centre requested outreach orthopaedic clinics but the consultants said that they did not have the time to attend and that they were limited in what they could do because health centres did not have adequate facilities. Other outreach services

though, (eg paramedic clinics (O2) and community radiology (O8)) were under discussion and had not yet been ruled out. As was made clear in Chapter 4, the 'jury is still out' on the cost-effectiveness and appropriateness of outreach clinics.

The clearest debate about major resource transfer occurred at Trust B (O3) and related to care of the elderly. The difficulties in releasing large amounts of resource from hospital wards became clear. GPs felt that they were doing all they could by increasing prescriptions of aspirin (a direct cost to their fund), but hospitals also needed practices to reduce emergency admissions as well as contribute money up front if wards were to close and money to be transferred to the community. There was no question as to the appropriateness of community-based provision, but the means for releasing the necessary funds proved highly problematic.

The evidence suggests that some resource transfer is occurring but that it is on a relatively small scale. Mobilising the transfer of larger amounts of secondary care money which is locked in acute beds, is a much more difficult nettle to grasp and requires substantial initial investments which practices are unable to support. It is, however, on the GPs' agenda.

7.9 Conclusion

Consistent with the literature reviewed in Chapters 2-4, market relationships between purchasers and providers were found to be socially embedded within a relational market (Bennett and Ferlie 1996; Laing and Cotton 1996). Studying the *content* of the relationship has indicated that GPs and their providers are actively engaged in discussions about service characteristics, quality and developments. These activities are embedded within a relationship which comprises the 4 key processes of learning, service design, partnering and purchasing. Importantly, service efficiency and resource transfer are being addressed within the relationship process and are done so not through competition and cost cutting, but through collaboration, partnering and an emphasis on quality.

It may be that the desire for ongoing collaboration is in part because the boundaries

between primary and secondary care are in some respects blurred. From the point of view of the GP, what is the primary care service? Is it simply to consult with the patient and to instigate a referral? Or, it is to instigate a referral and bring it to a satisfactory conclusion? If one takes the view that it is the latter, then primary and secondary care services from the GP's point of view were seen as a whole, or integrated package. It is then difficult to differentiate who is responsible for what as was pointed out by one interviewee:

> ...I think because GPs, many of them wanted to move on from what the early days of fundholding were around, which was more about the process of it, and they wanted to move on to the more clinical content of it. As soon as you do that you form a different relationship because it's not just then about competition, it's actually about saying 'we have a common problem to tackle here', maybe a particular service, 'how do we get the orthopaedic service working more effectively between primary and secondary care?... I/SO/(7)

This would explain why GPs were so keen to work closely with providers and to do so even where they had experienced difficulties and intransigence in the past.

The findings indicate that the role of finance is rather more important than was suggested in chapters 4 and 6. Economising was central to discussions about service redesign. GPs were clearly seeking to reduce wasteful activities and this went hand in hand with increasing their control over their patients. Chapters 4 and 6 indicated that financial issues were constrained by a desire for quality and this was confirmed in this chapter. Quality remains a superordinate criterion but it is important to note that discussions which initially tackled quality often resulted in improved efficiencies. This may suggest that concerns about price inflation conveyed in chapter 4 (see for example Ellwood (1995, 1996)) may not necessarily be a direct consequence of an emphasis on quality, particularly as there would appear to be no consistent meaning to the terms quality and efficiency (see chapters 4 and 6).

It was also clear that in order to provide a seamless transition from primary to secondary and then back to primary care, GPs and trusts needed to spend time clarifying their priorities, explaining their motives, and updating one another on their respective communities of practice. Current government policy and medical opinion

support the endorsement of integrated or seamless care and these findings demonstrate that integrating two different worlds requires a considerable investment in organisational and individual learning. However, resource transfer remains troublesome because of a lack of cost-effectiveness information, the difficulty of releasing money from wards and restricted GP facilities for outreach clinics. Nevertheless, it is clear that there is a desire on the part of the GPs to ensure that resources are released and there is no evidence of their efforts being deliberately opposed by hospital clinicians.

The design of new services and the stimulation of innovations relies on a partnership and learning. Both the Trusts and the GPs were responsible for stimulating innovations. This would appear to have been a symbiotic process in which the input of both parties was required in order to provide an integrated solution to the problems they faced. However, although designs were stimulated by purchaser / provider meetings they were not solely driven by them. The historical picture of an interested clinician still continues. Furthermore, trusts were in discussion with health boards and LPAs who were simultaneously putting pressure on providers to introduce changes.

7.10 Summary

Analysis of the observation data has lead this study to conceptualise the GP-Trust purchasing relationship as being socially embedded and multiplex in nature. The four key processes of learning, service design, partnering and purchasing have contributed to the further enhancement of GPs' professional autonomy, to service innovations, efficiency improvements and to resource transfer. It is important to note that improved efficiencies and resource transfer were realised by way of service design activities rather than being pursued as stated objectives.

From this chapter it is evident that GPs have been working together when meeting with service providers. Not only has this given them enhanced buyer power (see Chapter 6) but it has also enabled them to share information and to secure locality-wide service developments. The following chapter turns now to examine the inter-practice dimension of the purchasing network, indicating the contribution that primary

care networks make to efficiency improvements and resource allocation as well as to service design and purchasing.

Chapter 8

Inter-Practice Relationships and Purchasing Information

Introduction

This chapter discusses the inter-practice dimension of the purchasing network. It examines the ways in which GPs were found to collaborate with, and compete against, one another and discusses the types of information used in their purchasing decisions. The chapter draws attention to the constraints upon, and outcomes of, the collaborative process and discusses characteristics of the group context.

The chapter shows that fundholding did not necessarily encourage practices to ***compete for patients***. Instead, practices may have been ***stimulated to communicate*** and ***co-operate*** with other practices and to identify common interests more so than in the past. Much more important to practices than competition, was ***collaboration***. The meetings where practices collaborated seemed to offer the type of mutual, micro-level support that might be likened to some form of ***Purchasing Development Network***. Practices were engaging in collaborations which facilitated ***information exchange***, ***learning*** and ***nurturing***. The chapter also offers a ***typology*** of formal and informal information indicating the most appropriated ***modes for information exchange***.

The discussion proceeds in two sections. The first section looks at inter-practice competition and collaboration and the second turns to discuss the nature of formal and informal purchasing information exchange.

8.1 Competition

In *"Working for Patients"* the Government spelled out as a key principle that fundholding was to encourage competition between GPs:

> "...to help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to obtain a defined range of services direct from hospitals. Again in the interests of a better service to the patient, GPs will be encouraged to *compete* for patients by offering better services. And it will be easier for patients to choose (and change) their own GP as they

wish." (Department of Health, 1989:5) (Emphasis added.)

The data in this study suggest that the relationship between practices is complex, neither entirely collaborative nor entirely competitive. Views about the extent to which competition existed between practices varied across the spectrum from the perception that there is no competition at all, to one that believes there is relatively intense competition. The three interviewees who said they felt that practices did compete, offered explanations as to how competition was manifested and the basis on which it existed:

> ...Yes, but it's difficult to know exactly how it's operating. I think it's there under the surface and I think it has to be happening in Glasgow because patient numbers are dropping in Glasgow. If you look at inner city Glasgow patient numbers are dropping rapidly and GP numbers are staying relatively constant so I think there's underlying fears there and anxieties there. In other areas, perhaps in the outer areas of the Health Board area where population numbers are actually rising due to new housing and so on, then I think there's competition there 'cause as new patients come along they don't know where to go. I don't think it's really overt competition... I/GP12/PCP(11)

> ...Interviewer: Do you seek to differentiate yourself from other GPs? Is there competition amongst practices?
> GP: Very locally yes. The competition is not for patients, it's for the value added stuff, drug trials, research, health visitors, district nurses, but I have very good relationships with the other local practices ... Patients are extremely loyal, they don't move. There's a GP who's been struck off here, he's still practising and patients still go along, they're very loyal... I/GP7/S(12)

Only one of them felt that practices competed intensely for patients:

> [competition] ...Oh yes. Quite intensely.
> Interviewer: For patients? I didn't think that patients changed their GP all that often.
> GP: They didn't use to but it is increasing with the general move to consumerism, patient empowerment, citizens' charters and everything. Again in some areas it will be more so than others ..There was a practice in Lanarkshire where there was a health centre and the two practices split .. and the competition lead to one changing their hours - it was a commuter area so they started opening at 8.30am so the other practice started opening at 8am and the

other one went to 7.30am. Then one practice started getting the whole place decorated, so the other one started putting fruit bowls out. Then the next practice started putting out daily newspapers... I/GP1/S(12)

Other interviewees were less certain, suggesting that there was no competition at all. One interviewee even said that they would be reluctant to accept patients from another practice unless there was a very good reason for the patient to leave.

... We certainly don't have a big flow of patients from practices. Patients are fairly loyal, they tend to join a practice and if they're happy with it they stick to the practice. I think it's to do with the personalities of the GPs rather than services that they get. ... I think also most GPs have a great deal of integrity. If patients come and ask to join our list and they're at a local practice we try and strongly discourage that 'cause we don't like the idea of patients leaving a local practice unless there's a major problem with their relationships with their own doctor. We tend to say that unless they've moved into the area we're not terribly happy with them joining. I should think fundholders would be very much the same... I/GP10/N(8)

Indeed, this practice had a particularly close, non-competitive, working relationship with another practice with whom it shared its practice premises:

...Interviewer: There's two practices here, is the other practice thinking about PCPI too?
GP: Well, we do work together as much as we possibly can so it would be, yes, between the two practices. We'd be joining together. We have the equivalent of 2 full timers, 1 full time and 2 part time ... The other practice has 3 full timers. So it's the equivalent, I suppose, of a 5 doctor practice and we jointly share the staffing costs and the running costs... I/GP10/N(13)

It is not possible to come to a conclusion from these data about the degree to which practices compete, although the views offered indicate that there is some form of underlying competitive tension at play:

...Interviewer: You do seem though to be keen to work together despite this competition?
GP: It's an interesting area 'cause we do realise this when we go and sit down with people and talk about service delivery and then at the end of the day we realise that if Dr Smith next door gets all the new patients then our practice will either not survive or will have to change its character... I/GP12/PCP(11)

The lack of evidence about the degree and nature of competition in general practice both generally (see chapter 4) and specifically from this research would suggest that the political objective to increase competition between practices has not had a significant impact. What is evident however, both from the evidence reviewed in Chapter 4 and the data presented here, is that regardless of the degree of competition, practices are collaborating in a particular way which enhances their role as purchasers and enables them to develop skills and acquire knowledge pertinent to their purchasing role.

8.2 Collaboration

This research provided an opportunity to observe an afternoon of inter-practice collaboration during a practice away day for practices in one part of Glasgow who collaborate quite closely on an ongoing basis (O1). The group of 10 practices meet voluntarily on a quarterly basis to discuss purchasing issues. The particular meeting observed in January 1997, was held 2 months before the annual NHS contracting period and was the one at which the practices discussed their purchasing intentions.

8.2.1 Group Organisation

The group is led by one particularly zealous fundholding GP whose leadership role extends beyond his chairmanship of the group to that of educator. Most of the members purchase the majority of their services from one particular provider, Acute Trust B. However, three or four of the practices experience either a 50%/50% split between acute trusts B and A or a preponderance towards the latter.

All of the practices involved were standard fundholders although the length of their experience as budget holders varied. The group's leader was one of the first in Glasgow to participate in the fundholding scheme whereas others had been fundholders for only a year or two. Three of the practices in the group had a particularly close relationship for two reasons. Firstly they are located very close to one another within the same suburb of Glasgow - two of them are situated virtually opposite one another - and secondly, the three are involved in a total purchasing pilot scheme and so have

developed a more fundamental, formal link than the others in the group have. As total fundholding covers a greater range of services than the standard fundholding scheme, it was agreed by the group that only standard fundholding issues would be discussed in this large-group setting with total fundholding matters being settled by the three practices in an alternative meeting.

Participants were not interviewed about the consortium' structure and organisation, so comments as to the range of organisational issues they have dealt with as a group cannot be made. However, two organisational aspects which arose during the meeting indicate something of the group's structure and the types of issue likely to arise in a group setting:

- At the time (January 1997), the group received a 4% discount from Trust B, which was shared between the practices[1]. The discounts were calculated as shown in Box 8.1.

Box 8.1: Discount Calculation for Group Purchasing

Discount Value:

4% on the total contract value*

Practice Calculation on Sliding Scale:

where a practice's contract represents 22% of the total contract value, they receive 22% of the 4% discount.

.
.
.

3% of services purchased → 3% of the 4%

* ie. The value of the combined contract when adding together the 10 individual components. There is no upper or lower limit to contract value.

The Trust, however, had indicated that because some of the practices purchased from it less than 50% of their services, it was reluctant to award them a discount. It was considering including in the discount scheme only those practices whose purchases with the Trust exceeded 60% of the practice's total purchases. Furthermore, the Trust was proposing that the discount be applied to a ***limited*** value contract. The Trust's stance was explained to the group by the chair who indicated that under the new discount conditions, if the group admits any new members then current members

[1] Very often the group re-invest the discount in the Trust in order to support the development of a new service or the purchase of new equipment.

would have to accept a reduction of the fixed discount rate[2].

- At the end of the meeting, the group were invited to consider the possibility of setting up a total purchasing locality in which all GPs (including those non-fundholders in the area) could become involved. This illustrated some further structural issues such as the optimal group size for collaboration and the possibility of some practices not carrying their own weight within the group but piggy-backing on others.

8.2.2 Group Context

This particular meeting (O1) was attended by 6 fundholding GPs, 6 fund managers and an administrator from the GPFHA. It began informally with a buffet lunch during which conversations varied from discussions about funds and general practice to friendly chats. After half an hour the meeting began with a review of the minutes from the previous meeting in October 1996. Particular items from the minutes were updated and short discussions ensued. The group then moved on to what was the main focus of their afternoon, their purchasing intentions for 1997/98.

The Chairman made the fullest contribution throughout the day. GPs from the other two practices in the total fundholding group also made a contribution but most of the other GPs were relatively quiet throughout. The fund manager from the Chairman's practice was the most vocal of the fundholding support staff. The 'dominance'[3] of this particular practice was a reflection of their length of experience as fundholders, their roles within and knowledge of the GP Fundholding Association, and their knowledge of Trust B. However, as one view expressed informally during a coffee break illustrated, such 'dominance' led to a concerted emphasis on one particular provider (Trust B) which some members felt excluded them from certain discussions. Practices purchasing 50% or less from Trust B said informally that they did not feel they could contribute fully to the discussions and thought it would be better in the future for them to split from the group and either form another group or join with a more appropriate

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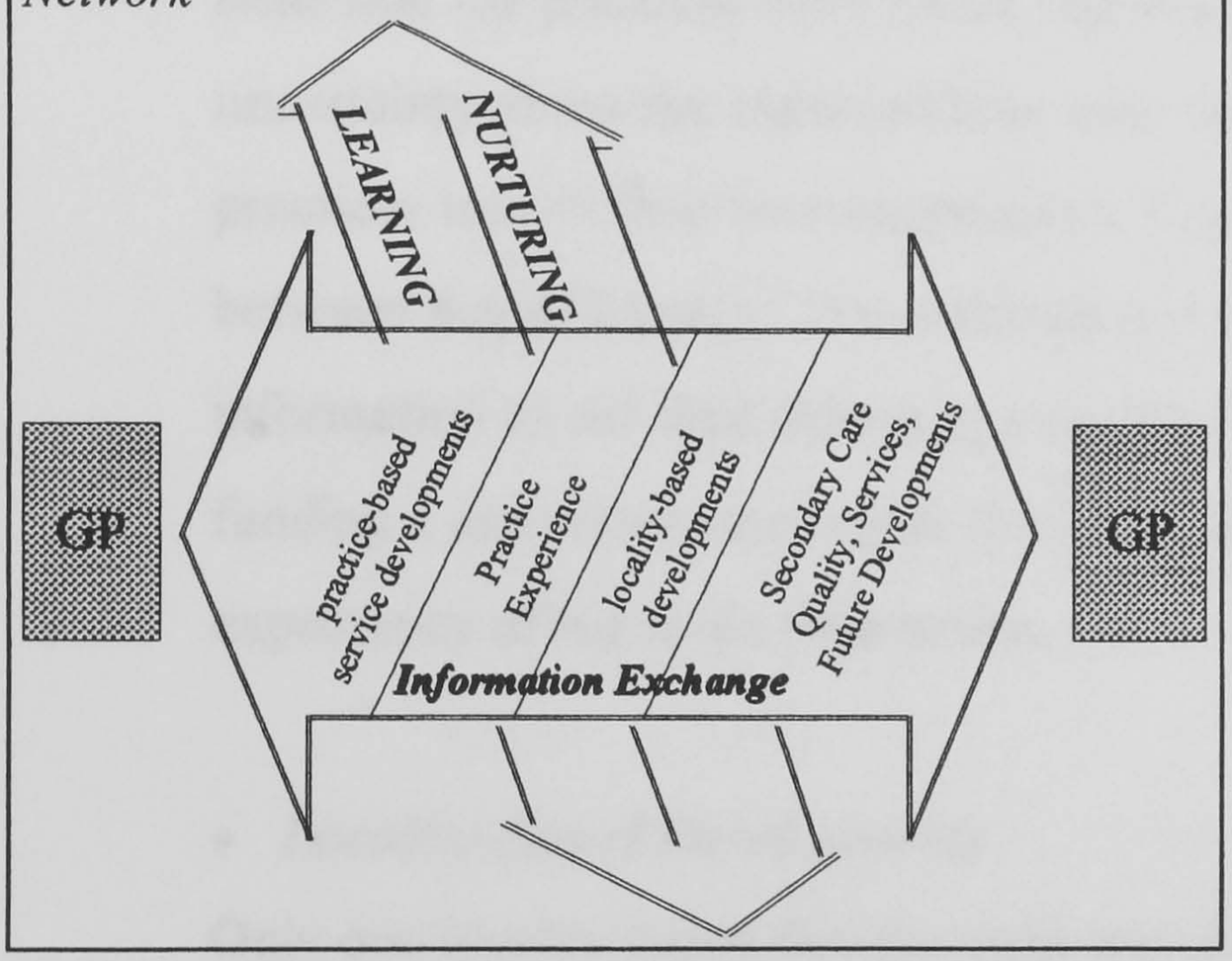
[2] For example, by admitting one new group member, 11 practices would need to share the fixed discount which would reduce the portion for existing group members.
[3] This term is not meant in the pejorative sense.

group.

8.3 The Collaborative Process: A Purchasing Development Network

Analysis of the interviews and observations indicates that practices are forming networks which function as *Purchasing Development Networks*. Practices were meeting together informally and voluntarily to share information and to nurture their own business in a relationship comprising 3 main elements: information exchange, learning and practice nurturing/growth (See Figure 8.1 below).

Figure 8.1: General Practice Purchasing Development Network



8.3.1 Information Exchange

The main process observed was that of information exchange. Four main types of information were identified from the data as being shared by practices:

- service developments at a practice level;
- practice experience;
- developments at a locality level; and
- developments within secondary care services (eg, quality, service range and future developments).

The information exchanged was both formal and informal in nature and came from various sources which are discussed more fully later in this chapter. The nature of the information exchanged during the practice away day is presented below.

- *Practice-Based Service Developments*

One practice intimated their intention to offer chiropody sessions from the practice and that they were arranging this with the Community Trust. GPs from other practices nodded in approval and interest, indicating that they too

were considering offering this service. Although they did not discuss the matter in any depth, that they communicated their intentions was significant because were they to be thinking of using the service as a source of competitive advantage then they would probably have withheld information.

- *Practice Experience*

There was one particular issue about which practices were keen to share their experience - repeat hip operations. Practices reported experiencing considerable variability in the time patients experience between an initial hip replacement and a subsequent re-do. There were no statistics available (at least none that the practices were aware of) which could shed any light on their uncertainty about the expected time span between the two operations and as practices told of their own experiences, it emerged that time spans ranged from between 4 and12 years. The practices had little formal and objective information to aid their debate so suggested the possibility of inviting and funding a consultant to come to the hospital and do some work on the likely expectancy of hip re-do time scales.

- *Locality-Based Developments*

Only one locality-based development was discussed at this meeting. One of the GPs mentioned that the Scottish Office were interested in piloting total purchasing locality fundholding and he expressed his personal interest in the proposal plus his hope that local practices would consider being a pilot site. The practices were cautiously interested and speculated about whether current non-fundholders in the area could be persuaded to join the scheme and stressed that there would need to be a great deal of thought behind any such proposal. During a relatively brief discussion, they headlined key issues such as the nature of proportional representation within a locality scheme, the optimum size of a locality fundholding scheme, the transferability of lessons from smaller-scale fundholding and the potential time commitment. These were flagged as being fundamental to any future collaboration of this type and were noted for future

discussion[4].

- *Secondary Care Services*

Meeting together gave GPs an opportunity to voice informal information which would otherwise be unlikely to circulate (eg, via email, memo or formal Fundholding Association, hospital or health board newsletter). On three occasions such information served as the basis for discussion. The first related to the availability, at the local provider, of certain types of surgery, the second two related to service quality.

- ♦ Local Service Availability: When reviewing minutes of the previous meeting, one GP commented at the item on hand surgery, that he had 'bumped into' a consultant from Trust B (the local trust) in a local DIY store. The consultant had commented that he would like to do more hand surgery but received an insufficient number of referrals to build up the service. The mention of this encounter lead to discussion about the reputation of surgeons elsewhere. GPs quickly indicated an interest in referring to the local trust but had neither enough information about what quality they could expect from the consultant nor any benchmarks against which to measure such information were it to become available. In the absence of formal data, GPs shared the little informal information they had about named consultants practising in the area. Their discussion centred around consultant reputations and did not broaden out to cover providers' overall reputation and service quality or comparative prices.

- ♦ Functional Service quality was a key issue discussed by the group. Practices were concerned (despite previous negotiations with the

[4] Although only one locality-based development was discussed, it was clear from Chapter 7 that a number have been instigated (eg specimen delivery).

Trust) about the time still taken to receive death notifications[5]. One of the GPs commented that he sat on a panel at the local hospital and was therefore acquainted with the hospital's standing procedures on death notification. He affirmed that there was no obvious reason why procedures could not be implemented, so the issue was noted for further discussion with the Trust at the next contract meeting.

- Technical service quality was also raised when a question mark was placed over the quality of particular procedures at a private hospital. Again, lacking any formal information about quality, practices turned to more informal sources. One of the GPs intimated that his wife, an optician, saw a number of post-operative patients who had been treated privately. She was concerned that they had been discharged too early, before their eyes were sufficiently healed. Instead of receiving hospital follow-up, patients were having to pay to attend their local optician. One or two of the GPs were unconvinced, but all agreed that they needed outcome measures against which to compare performance between hospitals.

- Comparative Service Quality was raised during discussions about the relative service quality of Yorkhill Children's Hospital compared with other hospitals who were prepared to perform paediatric procedures. The local provider had expressed an interest in doing more paediatric ENT, ophthalmology and dermatology procedures but GPs were unconvinced of the merits of moving their existing Yorkhill contracts. (This issue was later taken up during a meeting with the Trust (O3) (see Chapter 6).

- Developments in secondary care were also discussed at the meeting, and GPs exchanged ideas an opinions about how these might be taken forward. Two such ideas were the development of a stroke

[5] This issue was raised during the practice-trust discussions presented in Chapter 7.

assessment service and the development of a cath lab.

- The absence of a stroke assessment service was described as being "the biggest hole in the Trust B service" (O1/GP/(7)). GPs had been talking for some time about this potential service and had, as a group, sought to put pressure on the Trust to develop it. There had been little progress so practices exchanged views about how they could progress the impasse. Some felt that it was necessary to continue exerting pressure on the Trust but to couple this with an offer of financial support. Two practices, however, felt that removing their contract would be the best way to stimulate a response.
- The development of a cath lab in another city hospital was also discussed. They were aware (from a discussion with the clinical director) that around £80,000 might be required to fund the service so wondered whether (a), the Trust might subcontract the service to the private sector, or (b) whether between them the practices could offer some financial support for a lab at the Trust. Each of the practices indicated that they would indeed be willing in principle to offer development monies but their funds at that time were limited (the maximum any practice could offer was £4,000). The Trust had said it would need funds from the practices but had not indicated an amount.

8.3.2 Learning and Nurturing

The process of information exchange facilitated two processes: learning and nurturing. GPs who were more experienced as fundholders (particularly with contracting/purchasing), pointed out important issues for the others, explained the implications of what was happening in the locality and offered suggestions about managing practice funds. For example, one of the GPs explained the new equity model which was being advocated by the Community and Mental Heath Services Trust and

which had been accepted and adopted by the Health Board.[6] He raised questions about the methodology on which the model was based, explaining his concerns, and advocated certain points which he felt the practices needed to discuss with the Trust. This particular GP operated as an educator to the less-informed and less-experienced in the group and, as it transpired during one of the group's subsequent encounters with the Trust (O6), sometimes spoke on the group's behalf to the Trust and the health board.

The same GP also encouraged practices to agree an activity level with the Trust when contracting, and then to pass this information (along with the agreed price) to the Health Board. He also endorsed them to take care in finding out how Trusts calculate prices because if practice budgets are to reduce in the future, it is imperative that practices have good baseline data now, in order to contain their expenditure levels and he suggested how they might do this.

The educational / learning aspect of the development network was further illustrated during the interviews when interviewees indicated that they were very keen to learn from those who were more experienced and that they benefited from some form of nurturing:

> …We would love to have a little group here that get together in the same way as the [other area] practices … we were helped by [other fundholder] who were 1½ years ahead of us and so we did feed off them and people did feed off us … I/FMP4/S(8,13)

> …we've been fundholders for years, and obviously we had experience, and then 2 practices … were coming on stream … it made sense if they came along with experienced people, we'd been negotiating with Trust B for 2 years, .. so they joined us and came along, not initially to be seen as 'we're a group', but we'd more experience … I/FPM9/T(11)

> …[becoming a PCP practice] has encouraged us to communicate with other practices more than we would have … we really work together just to help out and to pass on information and things like that … I/FPM5/PCP(7)

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[6] According to the model, community nursing staff will be re-distributed in a way which means this group of practices are net losers.

...[re local collaboration] we're in the early stages because a couple of the practices are fairly new, they're not full fundholding yet ... so there's a lot of concerns about the people that are there, their negotiating skills. So what we need to try and look at is how we can pull together and develop ... I think the key is keeping relationships with other practices and sharing innovative ways of how you are actually operating ... what we do need to do is collectively share how we're doing things and how we see the way ahead ... I/FPM7/S(3,5)

Even where practices didn't collaborate in any structured sense, they still took the view that they ought increasingly to collaborate and communicate:

> ...I think there should probably be more collaboration with practices in an area ... [in terms of inter-general practice referral or advice] ... I/GP14/PCP(5)

> ...I think there has to be a lot more contact between clinicians in various hospitals and general practice ... I/GP16/S(3)

The data presented suggest that GPs were working in an environment characterised by poor information provision which contributed to their uncertainty about the comparability of alternative hospital services and compounded any weaknesses or insecurities they had as immature purchasers. Inter-practice meetings served as an opportunity to collectively reduce some of this uncertainty through informal information exchange and the concomitant learning and nurturing process.

8.3.3 Outcomes of Collaboration

Clearly it is not only the process of collaboration which is important, but the outcomes. The main outcomes took the form of joint and/or co-ordinated activities. Through working together, not only were practices more informed and able to learn from one another's experience, but they were able to pool resources (financial, human and time). Table 8.1 matches some of the items discussed earlier, with their outcomes. Other examples of joint activities not tackled here have been outlined in the previous chapter in the context of the purchaser-provider relationship.

Table 8.1: The Issues and Outcomes in GP Collaboration

Issue	***Outcome***
Chiropody: one practice declares it will introduce a practice-based service, others indicate they may do the same.	***Individual Practice Action*** - to set up a service at some point.
Locality Purchasing: the possibility of combining with all practices in the locality for total purchasing.	***No Immediate Action*** - further discussion subject to subsequent directives from SOHHD which will probably be channelled through formal structures (eg, the Health Board or GPFHA)
Hand Surgery: lack of information concerning consultant's reputation	***No Immediate Action***
Quality • ***Death Notifications***: still not being processed properly • ***Ophthalmology***: lack of information for benchmarking providers and assessing quality • ***Paediatric Provision***: Yorkhill Children's hospital versus other providers - lack of comparative quality indicators • ***Community Nursing***: Concern over the methodology and outcome of the resource allocation model	• ***Group Action*** - to be raised with the provider at subsequent purchasing/contracting meeting. • ***No Immediate Action*** • ***No Immediate Action.*** • ***Group Action*** - to be raised with the provider at subsequent purchasing/contracting meeting.
Practice Budgets and Provider Prices: practices need to become more aware of contract and activity levels in order to contain future expenditure.	• ***Individual Practice Action.***
Secondary Care Developments • ***Stroke Assessment Unit***: a service gap which has been discussed for some time with the provider. • ***Cath Lab***: a new service which requires £80,000 to fund.	• ***Individual Practice Action*** - some practices decided to move the contract elsewhere whilst others decided to offer additional resources. Action was determined by the practice's philosophical stance. • ***Group Action*** - to contact the Trust and find out how much money was required.

It is clear from the table that although the practices collaborated in terms of sharing information and going through some of their decision making processes about contracts and developments, they did not always take collective action. This proved to be an important aspect of the collaborative relationship and indeed, one of the constraints on the extent to which they could and would ultimately collaborate. The items noted in the table do indicate a potential preference for group action when dealing with secondary care providers, but the sample is too small to make any substantive claims of this nature. Some form of longitudinal study would be necessary to further study processes and their concomitant outcomes.

8.3.4 Constraints on Collaboration

None of the interviewees said that they disagreed with the notion that GPs should collaborate and it has already been stated that even those who were not actively involved in collaborative groups supported the ideal of greater collaboration. However, as shown already, collaboration does not imply collective action as a standard outcome. During this study, it was clear that retaining their independent practice status was important to practices who felt they needed to be able to take individual action. As was shown in the earlier examples (Table 8.1), on occasions, some practices decided to move a contract whilst others in the group chose to remain with the provider or even to inject additional funds. The ability to act independently was important to each practice. During the coffee break at the away day, one fund manager, who was keen to collaborate, suggested that more and more practices should seek to combine their funds as a way of reducing what he termed "a great paper chase" (O1/FPM/(11)) but commented that it would be difficult to do because GPs are independent practitioners who like their autonomy and who do not like being told what to do. As one GP explained,

> …it would probably be good to be part of a group for most of our standard work but perhaps certain things around the edge we'd want to negotiate a slightly different arrangement if it suits us better… I/GP12/PCP(8)

Their independent status is one of the likely factors contributing to the capacity for disagreement among GPs. This was voiced as an area of concern particularly because of the current policy emphasis on LHCCs.

> …Interviewer: Do you think that GP practices will be able to agree on the kind of things that they want and need in an area?
>
> GP: No.
>
> Interviewer: That's what everybody keeps saying! Yet that's what the LHCCs rely on to a huge extent. Have you been informed how this is going to go ahead?
>
> GP: Haven't got a clue … I'm certainly not going to get involved with commissioning teams or anything like that. We'll go along to them and we'll chat about them and we'll look at what difference it makes from the point of view of practice income, ehm, but I've got to look at it from a business point of view as well …I/GP15/S(4)

...I think this [working together in a LHCC] is a slightly more problematic area. Whereas as a practice you were able to make decisions, it's going to be more difficult to make them on a Co-op basis where you do have to have a degree of concurrence with your colleagues and it can be difficult enough having the practice agreeing without having different practices agreeing. I think the Co-ops hopefully are going to work ... I think as much as possible should be devolved down to practice level ... I/GP18/PCP(6)

The likelihood of disagreement was manifest in a meeting during which a Trust asked one of the GPs if he would seek the views of his GP colleagues in the GPFHA and come to a consensus. The GP retorted, "GPs are GPs and if there's 50 GPs you'll get 50 opinions" (O6/GP/(4)).

It is important to bear in mind, however, that these potential difficulties need not necessarily be seen as insurmountable for to do so would be to deny general practice an opportunity to develop its future role within the co-operative framework set out by the Government. One LHCC enthusiast who was concerned about the degree to which he would agree with his colleagues, felt that general practice was being faced with a tremendous opportunity to shape the agenda for collaboration via the LHCCs rather than having it thrust upon them:-

> ...Interviewer: You mentioned on the phone about the white paper and how you were a bit concerned that GPs might not be able to work together.
> GP: Well I think this is going to be a big, huge problem ... there are huge changes and you've always got to look at the positive things ... adaptability personally and professionally - there are remarkable changes in people's lives. We've already had a revolution in 1990 so we're having another one! So let's do this. Let's get involved. There are a lot of meetings. I think the feeling is 'right, this is going to happen, let's get ourselves organised and let's facilitate the shape of things by our attitude of mind rather than having it forced upon us'
> ...I/GP16/PCP(6)

It is unfortunate that the Government's policy of LHCCs and enhanced co-operation came out late on in the field work phase because it meant only a few GPs were asked about their views on the policy and it's emphasis on co-operation. Nevertheless, from what has appeared in newspapers and discussions at meetings which I have

subsequently attended during the course of other research activities, the view expressed here has not yet been refuted.

In conclusion then, it would seem from the data presented here that the general practice environment is (and is likely to continue to be) characterised by a cocktail of collaboration, joint activity and investment, some competition and a great deal of independence. In terms of ongoing collaboration within co-operatives, there seems to be the capacity for both extensive collaboration and divergent opinions and a call for independent activity. As one Scottish Office interviewee put it, ...It's actually quite a tricky process allowing, marrying the individuality of an individual practice, with the collectivism of another organisation ... I/SOa(3). Regardless of the degree to which practices ultimately take joint/group action as opposed to individual action, there is little to indicate that the requirement for a development network is likely to dissipate.

The next section goes on now to look more specifically at the forms of information used by GPs as they collaborate with one another and during their interactions with Trusts.

8.4 Information

It is clear from the analysis in Chapters 7 and 8, that the exchange of information is one of the key processes characterising both the inter-practice and purchaser-provider relationships. Following the data analysis, a typology of information exchange was developed. Both *formal* and *informal* information was exchanged. Formal information was the type generally used during purchasing meetings with providers and is categorised as being *qualitative* or *quantitative* and as being exchanged in one of two *modes*. Informal information was mainly exchanged between practices as they collaborated and is identified as having four *sources*.

8.5 Formal Information

It is important to make certain distinctions concerning formal information. The first is that there were 2 types of information: qualitative and quantitative. The second is that there were two modes of exchange: synchronous and asynchronous. Some

information needed to be transmitted and received at the same time (synchronously), for example via a telephone call or face to face conversation, because of the need to interpret and explain it. Other information, however, required little or no interpretation or explanation and could readily be exchanged with some time difference between transmission and reception (asynchronously) eg. via email or post. (See Box 8.2 below.)

Box 8.2: Types and Sources of Formal Information

FORMAL	Quantitative	Qualitative
Asynchronous	waiting times, names of consultants, activity levels	discharge letters, results, death notifications, patient information
Synchronous	contract data, costs, price breakdowns, clinical sessions, volume	perspective sharing, needs analysis, dialogue, explanation

8.5.1 Asynchronous Information Exchange

Waiting times, activity levels, discharge information, and death notifications can be easily exchanged asynchronously since little explanation is required for the information to be meaningful. GPs who talked about their need for and/or use of this type of information felt that it would be particularly helpful if it could be transmitted via electronic computer links direct from the hospital to the GP practice. Indeed, the Scottish Office have set aside considerable sums of money to ensure that practices are linked to hospitals so they can ultimately access waiting time/list figures, test results and so forth. One of the interviewees was particularly keen that online information be made available because it would aid the referral process:

> ... outcome information which is coming, comes on a Scottish-wide basis on big wide tables. You need to have that for all the Trusts that we might possibly refer patients to so that we can make the comparisons ... more than 50% of GPs have got a computer on their desk now so it should be possible to have an airline booking thing. If you see someone with a hernia

you can just call up what's the current waiting lists for hernia surgery, let's look at what the post-operative infection and revision rates are. Then you can decide with the patient on the balance of where it is and all that. And I think costs as well. There should be no reason for not having that information there, it's just a question of putting it onto some kind of relational database and having an electronic link. Then people can make better decisions with better information ... I/GP1/S(8)

Obtaining this form of data for subsequent distribution does, however, present Trusts with some problems. For example, it was clear from the meetings between Trust A and the local group of fundholders, that whilst data on referral rates was collected, it was not possible to determine from the total figures, the proportion that were repeat referrals. This lack of information clearly hampered GP efforts to reduce referral rates and meant the Trust was not fully able to assess the impact of a change in referral patterns upon its own activities.

There was also a feeling that certain (asynchronous) quantitative information is underdeveloped, especially information about hospital services:

...The Trusts are still not very good at really telling us what services they have to offer. We get a booklet from the Health Board "Waiting Times for New Outpatient Referrals"... it's got a section at the front about which consultants have retired, who has come in. Sometimes reading between the lines you can work out that the surgeon Mr A is interested in this kind of work but nobody guides you through it. I think Trust A are about to appoint 2 new consultant gynaecologists to fill 2 retiral vacancies and I'd be very surprised if we get communication ... that introduces these two consultants and says what their particular areas of interest are and that kind of thing. Yet I'd have thought that would have been relatively easy to do ... I/GP12/PCP(10-11)

This problem may not be universal though in that one GP spoke of having received ...lots of glossy brochures ... (I/GP13/N(3) and one of the Trust interviewees was very aware of the need to provide information about services:

...We've tried to get our act together in that sort of situation. We've started to put directories of services together ... I don't know how much they use it - they've probably forgotten 'cause I think every trust did a similar sort of thing, but it was basically just to tell you what services

> we'd got, who the consultants are, how to contact them and that sort of thing. Since then we've launched one or two new services. We've got a service which is called open access chest pain ...we put together a package which had all the referral forms in the back, how to access it, who to contact, all those sorts of things... I think we're learning from that ... I/T1(7)

It is important to bear in mind that the exchange of such information is bilateral. Hospitals, for example, require death notifications from GPs when patients die in the community and require quality referral letters which aid specialist diagnosis.

8.5.2 Synchronous Information Exchange

Other types of quantitative and qualitative information needed to be exchanged synchronously. The synchronous exchange of perspectives, explanations and needs analysis for example have already been discussed at length in the previous chapter. From the discussion it was clear that there was a learning process ongoing during discussions between hospital and primary care clinicians which occurred during their face to face (synchronous) dialogue. It is unlikely that such information would be successfully exchanged in an asynchronous mode because it is embedded within cultures and contexts which need considerable explanation.

It is perhaps less obvious that quantitative contract data was observed to be best dealt with in a synchronous mode. Two of the meetings observed, focused extensively on contract issues, particularly costs and activity levels (O4 and O6), and it became apparent that a considerable amount of discussion was required in order to resolve the ambiguities over contract information.

> ...The practices had received a breakdown of the costs from the Community Trust. There was a considerable problem for the practices in that there was a shortfall between the old prices (based on historical activity and funding) and the new prices which had increased significantly when based on the same activity levels. This 'anomaly' (excessive increase) was due to a dispute between the Trust and the Health Board in an issue over non-core and core pricing. The Health Board had requested pricing information from the Trust in a particular format (ie, a particular split between core and non-core). How the Health Board had interpreted that though in terms of the funds to be allocated to fundholders was the anomaly. .... The discussion was very much taken up by and initiated by [fund manager]

> [who] had done some detailed cross-examination of the budget offer, the prices for 1996/97 and [prices] for 1997/98 as they related to core and non-core services ...[she] found any reconciliation between the data sets impossible ... the fundholders ... cannot accept the pricing offer if they don't have all the information to hand. The [Trust's] Contracts Manager mentioned an interim proposal ... The confusion is largely due to the equity model under which the practices represented here are net losers. [So] The Trust were seeking to establish a principle: would the practices accept being billed on the basis of pre-equity service, thereafter, once they had decided what to do about purchasing (or not purchasing) additional nursing resources from the Trust they would receive a credit note to balance the difference between the equity bill ... and the pre-equity bill? ...(it was clear that both parties were seeking information from one another and struggling because of the lack of congruence between health board, practice and trust financial procedures)... O6/Mgt & FMP/(1-2)

These field notes do not capture the content of the discussion which was often detailed, covering specific activity levels and equivalent costs. However, they demonstrate that there was confusion between the calculations on costs and prices done by the Trust and the Health Board respectively and that this caused confusion at a practice level. As the meeting went on, suggestions were made about having a 'mock' contract to illustrate calculations and the way in which the proposed credit note scheme might operate.

The way in which costs were calculated and apportioned at a very detailed level also required clarification as can be seen in the following two examples:

- Management Costs: As discussed in the previous chapter, one of the fund managers was unhappy that of the 10 psychology sessions they were paying for, 2 were identified as 'management costs'. Considerable discussion ensued in order to clarify the nature and calculation of these costs.
- Mental Health: This was a particularly difficult issue. The Trust offer a multidisciplinary mental health team service. GPs refer patients to the team and the team decide whether the patient should see a psychiatrist, psychologist, occupational therapist (OT), community psychiatric nurse (CPN) or other team member. As one fund manager pointed out however, practices may refer the patient to the psychiatrist but the Trust's monitoring sheets would not identify who ultimately undertook the clinical activity.

> This has a knock-on effect for practice costs because practices pay more for a clinical session with, for example, a psychiatrist than a session with a CPN.

A personal field note read: ...watching this discussion was more like watching an inter-departmental costing exercise. There was little to distinguish organisational boundaries at all ... This comment was made because during the meeting (and so too at O4), the Trust's contract team seemed to empathise with the difficulties the practice was experiencing. There were references to members of the Trust speaking to the Health Board from the practice point of view, and the Trust's contract manager suggested one or two measures which would simplify the process for practices. Ultimately, for some of the practices, the deal was that the Trust would draw up the contract, fill in all the figures (a slight adaptation from the previous year) and all the practice needed to do was sign.

These accounts illustrate why contract data needed to be exchanged in a synchronous mode and further demonstrate the partnering aspect discussed in the previous chapter.

8.6 Informal Information

In addition to formal sources of information, GPs drew on informal information. This was particularly clear during the away day (O1). There appeared to be four sources of informal information: *individual, experiential, collegial and coincidental.* Considerably less can be said about this form of information because there was only one opportunity to observe it and little was mentioned during the interviews. Nevertheless, the findings are indicative of some important decision making sources. Future research may identify the relative importance of these sources and develop the classification of informal sources.

The individual source refers to the GP's own intuition, gut feeling or personal preference. As one GP indicated, intuition is used alongside more formal types of information:

> ...I would say that [hospital/consultant] reputation will tell you some things very well, but it won't tell you other things all that well. It's intuitive. Like many professional decisions you have to weigh up many factors and do the best that you can for the person depending on the

various constraints and variables you're computing at the time... I/GP1/(8)

GPs are of course trained to make independent, clinical judgement. As partners in a practice, they exercise autonomy over referrals, prescribing and certain business decisions so it is likely that they come to rely fairly heavily on their own independent assessments and decision making abilities.

The second source, experiential, is that of the GP's, patients and practice's experience in dealing with a particular hospital. This study, and studies reviewed in Chapter 4, have indicated that GPs are interested in functional service quality (how their patients are treated when they go to hospital) and that they are influenced by patient preferences (eg, the desire to attend a local hospital rather than travel). They are also likely to be influenced by the views and experience of others in the practice (GPs, practice nurses, community nurses etc).

Collegial and coincidental forms were most clearly observed during the practice away day. Collegial information was that which was passed on from GPs to colleagues from other practices (eg, expected times between original and repeat hip operations). This type of information, although unsubstantiated by quantitative practice investigations, does appear to influence the GPs' views of hospital provision.

Coincidental information was the kind acquired during chance encounters (eg, meeting a surgeon in the DIY store, finding out about ophthalmology procedures and support through being married to a local optician, membership on hospital committees which gives GPs access to information and people they might not otherwise have occasion to come across). Sometimes an informal word in the right ear of someone at the Trust during a committee meeting or educational meeting might yield the results that more formal purchasing negotiations do not.

8.7 Discussion

8.7.1 Inter-Practice Competition and Collaboration

The environment in which practices purchase secondary care and provide primary care has been seen here to be characterised by elements of competition and collaboration. Although the political impetus was to encourage practices to compete, the data suggest that this aim has not been fulfilled. Instead, despite competitive tensions, practices are collaborating and sharing information about the ways in which they intend to develop. They see one another as resources from whom to learn and acquire information. It is important, however, to bear in mind that this research looked specifically at the *purchasing* role of GPs and did not look at their role as *providers* of primary health care. The meetings observed and interview topics were selected specifically because of their purchasing focus. Although the findings show that inter-practice collaboration did extend beyond attention to the primary-secondary interface to include discussions about practice development, this occurred still largely within the purchasing context.

8.7.2 Purchaser Provider Relationship

The findings presented in this chapter support previous discussions about **hospital efficiency / resource utilisation** and **x-efficiency** although do not augment them. The concern with resource allocation was principally in terms of the equitable reallocation of existing community nursing resources, not with shifting resources from secondary to primary care. The interest expressed in offering outpatient (chiropody) clinics within the practice setting is consistent with the data presented in Chapters 6 and 7 which suggest that there has been a shift of resources into primary care but that this is typically manifest through an increase in outreach clinics and not, for example, increases in minor surgery (see Chapter4).

GPs appeared to tackle similar issues in terms of efficiency (eg, timeliness of death notification) as they had in purchase-provider meetings. Their discussions did, however, place greater emphasis on **quality** and in particular *technical* quality than was observed during purchaser-provider interactions. Their focus on the clinical outcomes for ophthalmology, hip operations and hand surgery, for example, were

illustrative of their appetite for more formal information in the form of clinical outcome measures and comparative performance. The data does further support the findings presented in Chapter 7 concerning the purchaser-provider relationship. Practices were shown to have discussed working in **partnership** with their provider particularly in terms of **designing services** (eg, in the development of a cath lab and stroke service). The **educational/learning** element of the purchaser-provider relationship can also be identified from the data in that practices recognised their need for further explanation and clarification by the trust of the contract prices. The purchaser-provider encounters during the contracting meetings (O4 and O6) further illustrated the partnership approach.

8.7.3 Information and Transactions Costs

The issue which arose most clearly in this chapter was that of the availability and nature of information and the role of collaboration as a vehicle for information exchange. The network provides an important opportunity for practices to exchange both formal and informal data. Their reliance on informal sources of information (such as intuition, collegial and experiential data) has already been shown elsewhere to be a significant decision making factor (see studies by Farmer and Chesson (1998), Ellwood (1996) and Laing and Cotton (1996) reviewed in Chapter 4). These same studies have shown a lesser reliance by GPs on formal information.

The uncertainty created by a lack of information was evident to a significant degree. At a practice level, there was apparent incongruence between practice and hospital data. The interpretation exercise performed by the Health Board had further confused the correlation between costs, prices and practice funds. The uncertainty about final prices meant that practices could not commit to specific levels of activity and so contracts could not be finalised. The ambiguity was further compounded by the difficulty in applying the equity model because practices were uncertain about what level of community nursing provision they could expect and there were difficulties in paying for the service.

Such uncertainty, according to transaction cost theory, increases the likely transactions

costs. Not only is the available information of poor quality, but there is a considerable degree of pertinent information which is unavailable. This compounds the human characteristic of bounded rationality and, when combined with small numbers, opportunism and uncertainty increases the transactions costs even further. This topic will be discussed in Chapter 9.

8.8 Conclusions

Inter-practice collaboration can clearly be identified as having evolved into a form of purchasing development network. Practices not only exchange information but engage in nurturing and learning as they collaborate. During their collaborations specific group roles such as those of educator and leader are enacted by particular GPs. At the same time, however, the inter-practice relationship exhibits some competitive characteristics and it is clear that the ability of practices to choose whether to contract with providers collectively or independently is yet another manifestation of the importance of professional autonomy.

The chapter has also found that inter-practice collaborations were an important source of informal information exchange. As chapters 3,4 and 8 have shown, reliance on informal information from trusted sources is a function of the social embeddedness of network relations. Formal information is also important but it is important to note that it cannot necessarily be communicated meaningfully in an asynchronous mode. For certain types of formal information, clarification and sense making require direct discussion. Although network relations enable clarification and information exchange between practices and with Trusts, the information currently available is neither sufficiently detailed nor comprehensive enough for GPs who are anxious to obtain data concerning service quality.

8.9 Summary

This chapter, the last of the empirical chapters, has examined the inter-practice dimension of the purchasing network. It has shown that inter-practice relationships are characterised by both competition and collaboration. As regards their purchasing activities, GPs are engaged in collaborations which, through a process of information

exchange, facilitate practice learning and nurturing. The chapter has, in its second section, brought together the types of information and developed a typology of formal information exchange and informal information sources.

The next two chapters develop themes from chapters 6-8 by integrating them with the economic and social theories discussed earlier and then draw together the study's conclusions, implications and recommendations.

Chapter 9

The Social Embeddedness of Purchasing Networks

Introduction

The exploratory nature of this research and its inductive dimension (see Chapter 5), resulted in the emergence and development of a number of issues which are of significance both empirically and theoretically. Whilst it is normal practice to reintegrate such issues with the literature review, it was decided in this case to reserve these themes for discussion at this point both to draw attention to them, and to highlight the importance of the qualitative, emergent and developmental approach of the research process.

Three ***key issues*** are dealt with in this chapter. Firstly, it became apparent that there was an ***NHS ideology/culture*** which was a significant ***motive for,*** and ***'glue'***[1] ***within,*** network relations. Secondly, the network relations which developed ***supported knowledge creating processes*** and ***prevented*** purchasers and providers from incurring the ***anticipated transactions costs***. Thirdly, consideration of the ***group context*** in which contracts were negotiated, highlights certain ***limitations of TCE theory*** and identifies directions for ***future TCE development***. The chapter concludes by illustrating the need for an integrated ***socio-economic perspective*** on networks and organisation.

9.1 The Social Embeddedness of NHS Networks

When the NHS market was originally established, it was envisaged that through neo-classical contracting, GPs would stimulate secondary care efficiencies and resource transfer (Department of Health 1989) (see Chapters 1 and 3). Policy makers took a *dyadic* perspective expecting fundholders to engage in annual contracts and to negotiate for low cost services. They also assumed that primary care relationships would be largely competitive. This study has shown, however, that these policy assumptions were not met.

GP purchasing was instead, relational and socially embedded within sets of

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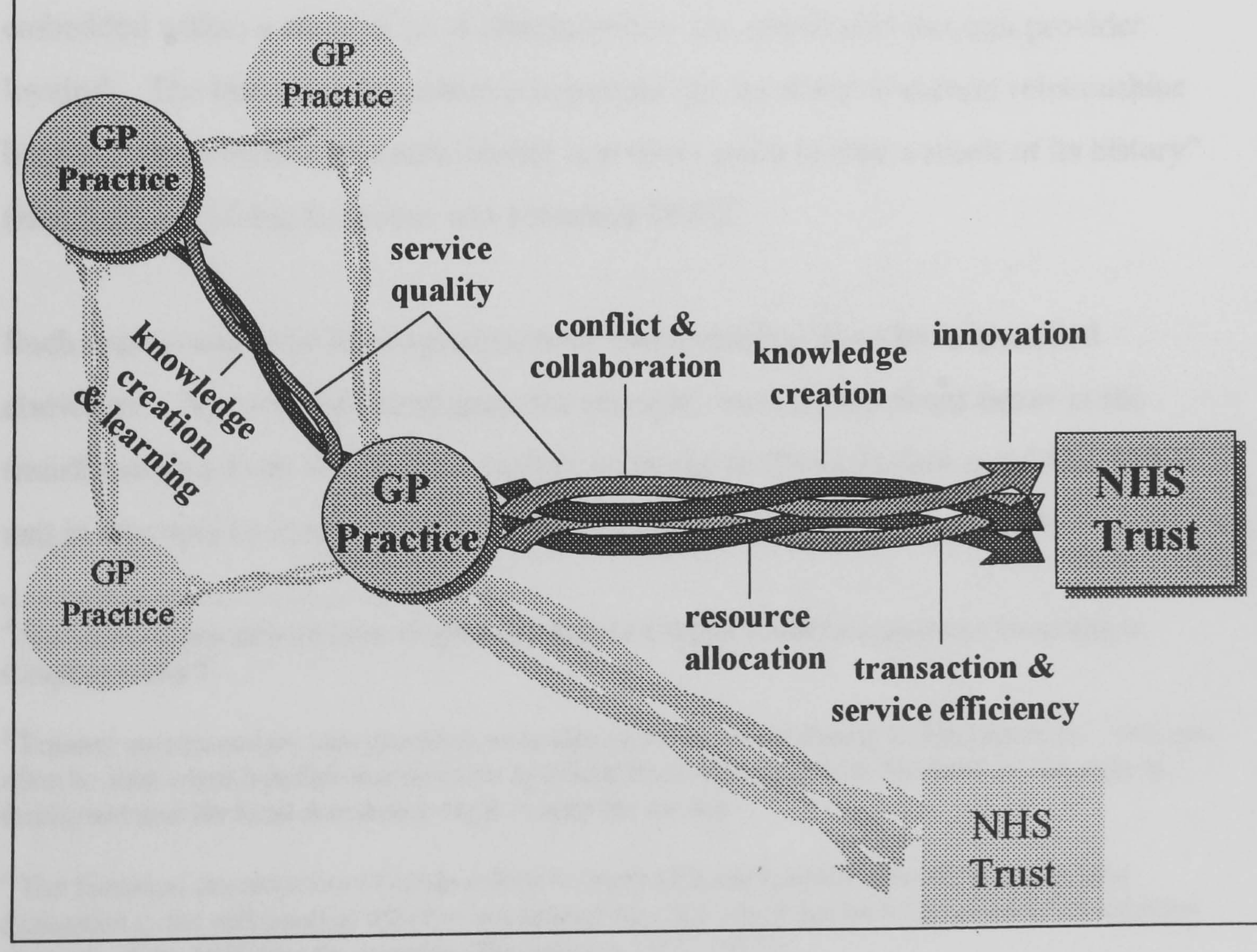
[1] The term 'glue' is used by Jarillo (Jarillo 1990) when describing trust as being something which "holds the network together" and which "organizes the economic activities going on inside". It is used here to attribute those same properties to ideology/culture.

collaborative relationships which developed at a primary and primary-secondary care level. The relationships exhibited typical network characteristics such as interdependence (Hakansson and Johanson 1993), longevity (Powell 1991), mutual adaptation, and complementarity (Johanson and Mattsson 1991; Hakansson and Johanson 1993). The relationships in this study also exhibited a strong *ideological/cultural* dimension which is little discussed within the theory on inter-organisational relations and which has not previously been discussed in any detail in the context of NHS purchasing[2]. This served as a motive for, and 'glue' within, purchasing networks which, as this chapter goes on to discuss, were not only the locus for improving resource allocation and service quality (see Chapters 7,8 and 10) but facilitated *knowledge creation* and were also the locus for stimulating efficiencies by preventing otherwise high transactions costs[3] (See Figure 9.1).

Figure 9.1: Network Processes in Purchasing



[2] The study by Lapsley et al (1997) found that Scottish GPs identified strongly with the aims of the NHS but did not integrate that aspect with the theories used here.

[3] It was also the locus for stimulating service efficiency (see Chapters 6, 7 and 10).

9.1.1 Ideology / Culture

This study (see Chapters 6 and 7) and earlier studies (see Chapter 4) have found that GPs' referral decisions were socially embedded. GPs were, to a degree, locked into purchasing with a particular provider because of an *unwillingness* to move, except when the move was *to* a local provider. This unwillingness to move appeared to be because of provider loyalty which existed on two levels: NHS system and local. Firstly, GPs were keen to engage with *NHS* providers, with private sector provision being sought as an unfavourable[4] last resort. Secondly, practices sought to support their *local* provider. GPs took the view that working with their local provider was important and actively pursued collaboration despite the obstacles.

This ideology/culture derives from the original (historical) ideology and values of the National Health Service and the professional/occupational culture of medicine, and is embedded within a sense of local identity which was manifested through provider loyalty[5]. The historical dimension is important for the study of current relationships because "the structure of a relationship is at every point in time a result of its history" (Blankenburg Holm, Eriksson, and Johanson 1996)[6].

Such system and local ideological/cultural characteristics[7] have been identified elsewhere. System level ideologies, for example, were an important factor in the transformation from command to market economy in China (Boisot and Child 1996) and in attempts to modernise Kibbutzim (Simons and Ingram 1997). Both

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[4] See notes on private provision of ophthalmology in Chapter 8 and discussions on switching in Chapters 6 and 7.

[5] Primary and secondary care providers were also aware of patient loyalty to local services. This can often be seen when hospital closure (such as that of Rottenrow Maternity Hospital in Glasgow) is threatened and the local community fight to keep the service.

[6] The historical development of relationships between GPs and hospital specialists is an added dimension to the relationship which is not tackled here but which has been discussed in sociological accounts of the NHS (see for example (Honigsbaum 1979, 1993)).

[7] This chapter uses the terms ideology and culture together. This is to convey that the characteristic being considered includes an ideological dimension because of the NHS values (eg equity and a free service at the point of use) that are upheld politically, nationally and professionally.

transformations were resisted and modified because of historically and ideologically/culturally embedded attitudes and behaviours.

The regional/local level at which ideology/culture exists has been considered by, for example, Carnevali (1996). Carnevali found that Italian banks invested in businesses which originated from a close regional area and they relied on regional networks for information to aid their investment decisions. She notes that actors in a regional network "share a common history, … share the same set of cultural points of reference … share physical proximity from a very early stage and experience collectively the changes to the social, economic and political fabric of the region. In other words, they share in the making of the history of their locality …" (ibid.).

In the NHS, clinicians exhibit NHS system, local and professional loyalties and ideological/cultural characteristics. One of the few articles to integrate these dimensions with economic theory does so at the institutional/professional level of analysis. Jones et al. (1997) introduce the term *macro-culture*, which they define as "a system of widely shared assumptions and values, comprising industry-specific, occupational, or professional knowledge, that guide actions and create typical behaviour patterns among independent entities." (ibid). They suggest that macro-culture is instrumental in co-ordinating activities and is diffused through institutional means, such as socialization through professions and crafts, trade journals and industry events. Their proposition fits well with the NHS context where clinicians do consider their work as an art or craft, and where professional (trade) journals such as the British Medical Journal (BMJ), organisations such as the British Medical Association as well as conferences play an important role.

An understanding of this ideological/cultural dimension is important for developing theories of NHS network engagement and formation. Chapters 6-8 have shown that ideology/culture (or macro-culture) was a driver behind the desire for GPs to work collaboratively with hospitals. In other words, it was a motive for engaging in

networks[8]. Although most studies identify the motives for collaboration as being of an 'economic' nature (Ebers 1997)[9], recent review of motives for network engagement acknowledge that more 'social' motives are increasingly being recognised. Oliver[10], for example, identifies six motives for network formation (see Box 9.1) some of which reflect the importance of cultural / ideological factors and Smith Ring (1997) makes specific reference to culture: "Network relations are ... frequently operating in environments that are naturally bounded, or artificially created, by kinship, political, or cultural considerations ..." (p116).

Box 9.1: Motives for Network Formation

"(1) necessity, when organizations are mandated through law or regulation by higher authorities to establish relationships;
(2) asymmetry that allows one party to exercise power or control over another one or its resources;
(3) reciprocity, when through co-operation organizations can pursue common or mutually beneficial goals or interests;
(4) efficiency, when through co-operation organisations can achieve higher input/output ratios;
(5) stability, when through co-operation organizations can better forestall, forecast, or absorb uncertainty affecting their activities; and
(6) legitimacy, when through co-operation organizations can establish or enhance their reputation, image, prestige, or congruence with prevailing norms."

(Oliver, 1990)

Ideology/culture was also important though for the *ongoing* development/ formation of networks. Even where GPs had experienced difficulties in working with providers (and to an extent with one another), they persisted with their collaborative efforts because of their belief in sustaining and developing nationally funded, locally-based, quality services.

9.1.2 Knowledge Creation

That purchasing relationships were socially embedded also shaped a process of knowledge creation, a characteristic which has previously been associated with networks (see for example Hakansson and Snehota 1989; Johanson and Mattsson

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[8] Note: it is not the purpose of this discussion to consider ideology/culture as the only motive. There are also 'resource' motives. GPs need access to the specialist knowledge, expertise and perspectives of their hospital colleagues. Hospital clinicians on the other hand rarely have any experience of general practice and so need access to the knowledge, expertise and perspectives of their primary care colleagues (see 3.14.1 and 7.3).

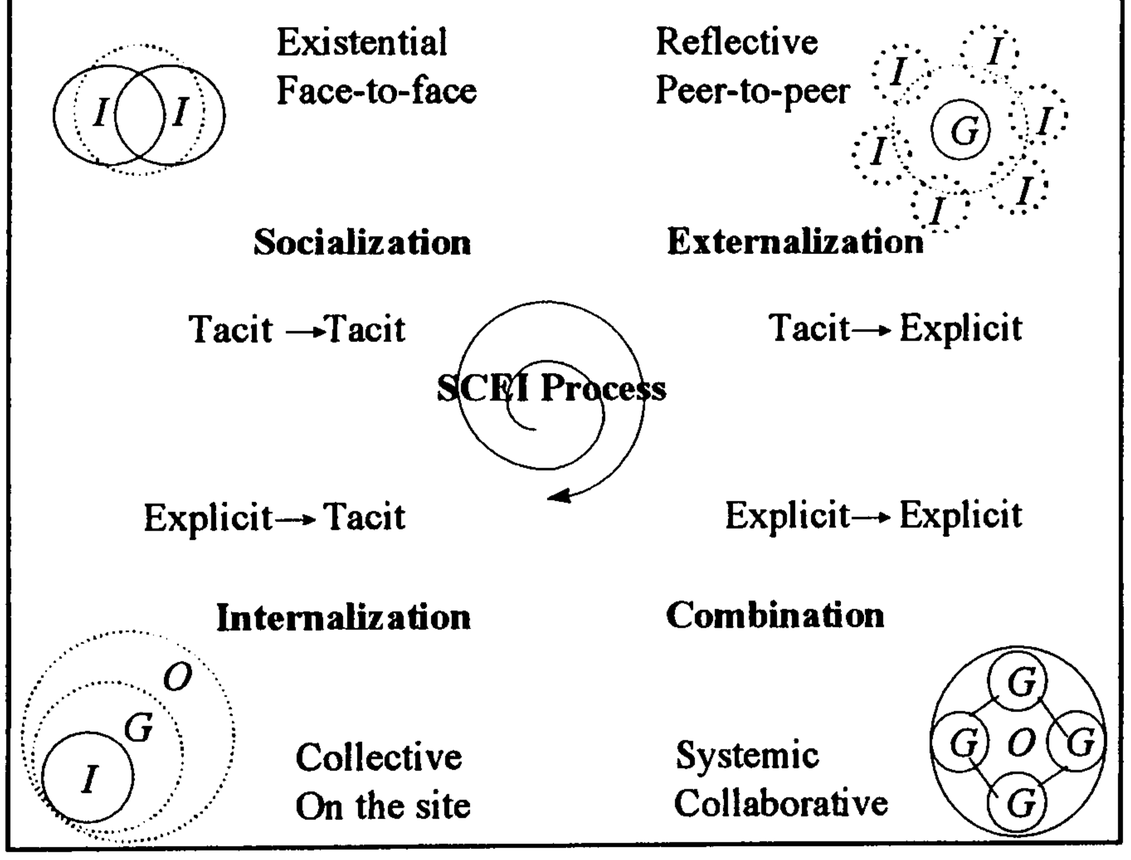
[9] Ebers' (1997) review identifies two sets of commonly stated motives for collaboration: the pursuit of increased revenue and the pursuit of cost reduction (including reducing transactions costs and appropriating skills and learning).

[10] Oliver, C. 1990. 'Determinants of Interorganizational Relationships: Integration and Future Directions'. *Academy of Management Journal*. 33: 503-19.

1991; Alter and Hage 1993) but which has not previously been discussed or observed within the NHS purchasing context.

Knowledge sharing was quintessential in the network relationships identified. Not only was the *process of interaction* an important source of knowledge (Johanson and Mattsson 1991), it was also a means by which tacit and explicit forms of knowledge were created. The interactions between primary care purchasers and with providers discussed in Chapters 6-8, demonstrate four knowledge creating processes (or "conversion modes") recently identified by Nonaka et al (1998) (see Figure 9.2 below).

Figure 9.2 SECI Self-transcending Process
Source: Nonaka, Reinmoeller, and Senoo 1998



Socialization is the process of sharing individuals' tacit knowledge where "Sharing experiences is a key to understanding others' ways of thinking and feeling. *Externalization* is the articulation of tacit knowledge and its translation into forms understood by others as individuals listen and contribute to one another. *Combination* is the conversion of explicit knowledge into more complex sets of explicit knowledge. "To diffuse fragmentary knowledge, editing and systemizing such knowledge are the keys to this conversion mode. Here, new knowledge generated in the externalization stage transcends the group." (ibid). *Internalization* is the conversion of newly created explicit knowledge into individuals' tacit knowledge. Learning by doing, training and exercises are important here.

Together the inter-practice and the purchaser-provider interactions involved all four of the processes. Staff within practices shared experiences (face-to-face) through a process of socialization during which they shared tacit knowledge (see Chapter 8). In larger peer group settings (formal (eg, through total fundholding) and informal (see Chapters 7 and 8)), individual knowledge became available to the group - the process of externalization. At inter-practice and purchaser-provider meetings, knowledge was

combined, providing the opportunity for the final stage where collective knowledge could become internalised by each individual. As Chapter 7 has discussed, this knowledge creating process (evidently integral to service design and learning as discussed in Chapter 7) often resulted in service innovations. Podolny and Page (1998) explain this relationship between knowledge creation and innovation as follows: "rather than simply facilitating the transfer of information between two nodes, the existence of an enduring exchange relationship may actually yield new knowledge. In effect, the network becomes the locus of innovation rather than the nodes that comprise the network."

9.1.3 Conflict and Collaboration

The co-existence of conflict and collaboration within NHS networks (see Chapters 7 and 8) was an important dimension of the knowledge creation process and, it has been argued, is an important ingredient for cohesion in networks (Alter 1990). Conflict between primary and secondary clinicians was not surprising given the historical dynamics of the generalist / specialist relationship (Honigsbaum 1979) and the more recent opposition that many had to fundholding (see Chapter 2). There was also conflict within primary care, as GPs expected not to agree upon decisions about service provision (see Chapter 8). Whilst this potential for disagreement, and thus conflict, was voiced as a concern, there is reason to consider that it may be a necessary ingredient for collaborative success (Alter 1990; Dubois and Hakansson 1997). Alter (1990) argues that inter-organisational symbiosis marked by "concerted action" can be brought about only by a "necessary" combination of conflict and co-operation, ie. that "conflict and co-operation are system-integrative...".

Related to that, this study has also provided evidence that conflict can be a creative tension (Alter 1990; Carney 1998) which results in service innovations (see previous section and Chapter 8). During their meetings, GPs and hospital clinicians exhibited conflict when designing services because of their regard for their own professional/clinical autonomy. Efforts by GPs to extend the scope of their autonomy were met by boundary defence from hospital clinicians (and visa versa), yet their debates often resulted in pilot studies or service innovations.

9.2 Social Embeddedness and Transactions Costs

The social embeddedness of GP purchasing relations also has a bearing on the degree to which transactions costs were incurred. This was due again to the ideological/cultural dimension of the relationship and also to the group context in which purchasing occurred.

9.2.1 GP Purchasing and Transactions Costs

Chapters 2 and 4 identified the likelihood of high transactions costs yet, as this chapter noted earlier (and as indicated in Figure 9.1), purchasing networks were found in this study to be the locus for stimulating efficiency and a means for preventing the realisation of high transactions costs. The study's findings indicate a number of ways in which the network relationships may have lowered transactions costs.

- *Search costs* were restrained by the fact that GPs were largely *unwilling* to change their supplier[11] not only when they were encouraged during the first year to maintain a steady state, but also in subsequent years.[12]
- *Monitoring costs* were incurred when GPs met together to discuss their purchasing intentions and their purchasing experience. However, it is clear from this study and previous studies, that purchasing contracts were not well defined, detailed documents. Contracts rarely specified quality outcomes (beyond those of waiting times, timeliness of discharge letters) and so did not require concomitantly high levels of monitoring. By collaborating, practices were able to share information which reduced the cost to any individual practice of having to find that information in isolation, ie, it reduced duplication of monitoring effort.
- *Renewal Costs*, the evidence suggests, were lower than expected because GPFHs did not consider removing contracts in under extreme

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[11] It could be argued that such unwillingness was *due to* high transactions costs, but the evidence presented in this study (see Chapters 6 and 7) and in the studies reviewed in Chapter 4 strongly suggests that unwillingness is due to provider loyalty and not search costs.

[12] In transactions cost terms, this constitutes an *ex ante* condition of small numbers bargaining because practices did not begin by setting out a range of alternative providers and considering their relative merits.

circumstances. Some negotiations did take place but were marginal, in that they were more often to do with clarity over existing figures rather than the renegotiation of prices. It seems that the subsequent process of renewing the contracts was straightforward and relatively costless because the Trust simply updates activity or pricing levels on existing contracts, prints them out and obtains the GPs' signatures.

Whilst transactions costs may have been prevented, however, it is nevertheless important to consider that the networks were not costless. Purchasing meetings, for example, represented a direct cost[13] and an opportunity cost given what GPs, consultants and managers might otherwise have done with their time. Networks also typically incur bargaining costs, "the costs of safeguarding against possible opportunistic behaviour by networking partners, or conflict resolution costs" (Ebers and Grandori 1997) although such costs are likely to have been minimal given the strong ideological/cultural factors. Other network costs are associated with setting up and sustaining relationships and include investments in assets (eg, new computer systems) which often underpin new ways of working (Ebers and Grandori 1997). Such investments may, however, be non-marketable, ie, they cannot be deployed elsewhere[14]. At this point, the analysis of network and transactions costs (and asset specificity in particular) becomes problematic because conventional TCE analysis addresses a single transaction between two parties but GP purchasing is conducted in a *group* context the subject of which is a *set* of transactions.

9.2.2 Group Buying and Asset Specificity

TCE theory considers transactions costs and asset specific investments as they relate to a single buyer and a single supplier (Williamson 1985). TCE analysis then addresses a single transaction between these parties. Any transactions costs or non-marketable investments are borne by the buyer or supplier as are returns on investments. In this study, however, purchasing involved a *group* of buyers whose negotiations concerned

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[13] For example, O6 involved 2 hours of time for 2 GPs, 4 fund managers, and 7 Trust staff (5 of whom were at management or director level).

[14] This is the problem of asset specificity identified by Williamson (1985) and discussed in Chapter 3.

a *set* of transactions. How then should transactions costs, non-marketable investments and returns on investment be appropriated between the transacting parties?

Of the five types of asset specific investments identified by Williamson (1989) (see Box 9.2), only human asset specificity was identified in this study[15]. Pactices spent time working with providers through knowledge exchange and the creation of a shared understanding and language[16] (Williamson 1985). These activities would have encouraged individual and institutionally-specific trust and learning, reinforcing existing relationships which, Williamson would argue, would have cost-bearing consequences. However, not all practices participated to the same degree, as some took a greater role in co-ordinating group activities, convening meetings, and 'debating' with clinicians. It cannot therefore be assumed that investments and returns on investments (such as learning by doing) were equally apportioned and appropriated. Returns on investment may also differ because, as earlier discussions have pointed out, not all firms have the same absorptive capacity (Cohen and Levinthal 1990). This is particularly likely as in this study practices were at different stages in their own purchasing experience (see Chapter 8) and were potentially less able to absorb and exploit new knowledge and skills.

Box 9.2: Asset Specificity

"(1) site specificity - where successive stations are located in a cheek-by-jowl relation to each other so as to economize on inventory and transportation expenses;
(2) physical asset specificity, such as specialised dies that are required to produce a component;
(3) human asset specificity that arises in a learning-by-doing fashion;
(4) dedicated assets, which are discrete investments in general purpose plant that are made at the behest of a particular customer; and
(5) brand name capital."
(Williamson 1989:143)

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[15] Some practices did invest savings in hospital equipment but physical asset specificity did not occur because the equipment was neither tailored for the purchaser nor unique to the provider but instead added to the existing stock of standard machinery and was of the kind used in other (public and private) hospitals across the city. Such, investments therefore tied in neither the buyer nor the supplier.

[16] NB: not all practices enjoyed collaborative, face-to-face provider encounters.

Consideration of the group context can therefore be seen to give rise to the following questions which require further research and further development of transactions costs theory:

- To what extent are returns on investments made to the *group*?
- What is the loss to an individual practice if they cease trading (ie, are investments non-marketable)?
- What is the loss to the group if a more 'involved' practices leaves the group?
- If a practice decides to buy from another provider, what are the set-up costs if a group purchasing arrangement already exists and the practice is free to join? Can the practice "piggy-back" on other practices or accelerate learning processes and so benefit from learning and economies already accrued in that setting?

9.3 Conclusion

The NHS networks studied here have not only exhibited characteristics generally associated with networks (eg. mutuality, reciprocity and conflict) but they have exhibited a strong ideological/cultural dimension. This ideology/culture has served as a powerful motive for, and 'glue' within, network relations. The network relations which have developed have been the locus for knowledge creation and innovations through a social process of collaboration and conflict. The networks have also been the locus for stimulating cost efficiencies via the prevention of anticipated transactions costs, a finding which supports the views of network proponents like Jarillo (1990) and Carney (1998), and studies of relational contracting (Sako 1992)[17] which argue that networks are an efficient mode of governance (see Chapter 3). Although consideration of the degree to which networks are efficient has been restricted because of limitations in TCE theory, suggestions have been made concerning future TCE theory development so that the costs and investments pertaining to group based negotiations and sets of transactions can be analysed.

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[17] Jones et al (1997) suggest that macro-cultures facilitate efficient exchange.

The discussion has also illustrated the need for an integrated socio-economic perspective on the NHS in particular and on inter-organisational relations more broadly. As regards the NHS specifically, a better understanding of the nature and role of ideology/culture is required in order that future policies might introduce more appropriate mechanisms and incentives, thereby increasing the likelihood of inducing desired behaviours and delivering desired outcomes. In terms of organisation theory, this discussion supports the views of Granovetter (1985), Powell (1991)and others (eg Ebers 1997; Jones, Hesterly, and Borgatti 1997) who argue against purely economic explanations of market activities and inter-organisational relations and endorses Jones et al.'s call for a better understanding of 'macro-culture' within network formation.

9.4 Summary

This chapter has developed certain emergent themes arising from the study and has considered their implications for economic and social theory and for studies of, and policies for, the NHS. It has offered explanations for the formation of NHS networks and has discussed in detail their economising and creative properties. In so doing, the chapter has also discussed a number of ways in which the NHS purchasing context presents challenges to, and informs, network and TCE theories.

This chapter was deliberately positioned after the empirical chapters in order to highlight the developmental and emergent qualities of qualitative research as well as to draw specific attention to the issues discussed, highlighting their importance within this study. It precedes the final chapter, Chapter 10, which now goes on to draw the study to its conclusion and to develop recommendations for policy makers, practitioners and future academic research.

Chapter 10

Conclusions, Implications & Recommendations

Introduction

The purpose of this research was to explore the role that GPs are performing as purchasers and to identify which of the purchasing-/market-related issues are of particular concern to them. More specifically, it sought to consider whether GPs were seeking to stimulate secondary care efficiency and resource transfers from secondary to primary care; to understand the relationship between GPs and their providers; and to derive from the findings, a number of policy and managerial implications. Pursuit of this aim has not only confirmed the findings of previous studies but has enabled this study to make key contributions concerning the social embeddedness of the NHS purchasing process, the content of, and processes within purchasing networks and the motivational factors which influence GP behaviour.

This chapter begins by ***drawing together the findings*** from this study and then stating their ***relationship to the research aims*** and their ***contribution to the research gaps*** identified in Chapter 4. It then goes on to consider the ***policy and managerial implications*** which arise concerning organisational and information networks in the current, post-market, NHS system. The chapter then turns to the ***conclusions and implications*** concerning TCE and network ***theory*** and comments on certain ***methodological issues*** and ***research limitations***. The chapter concludes by discussing ***directions for future research***.

10.1 Understanding GP Purchasing

The notion of an NHS market was prompted by a need to improve NHS efficiency in order to contain government spending (Teeling Smith 1986; Maynard 1994; Glennerster 1995). Its implementation followed in the wake of previous, less radical, administrative/structural and managerial reforms aimed also at improving NHS efficiency but, through *non-competitive* measures. Ongoing demands for increased government spending on health, however, resulted in a review of the NHS in the late 1980s and recommendations for a market solution (see Chapter 1). Proponents of a market solution such as Enthoven (1985) and Teeling Smith (1986) believed that through a neoclassical contracting mechanism, purchasers (GPFHs and HAs/HBs) would put pressure on providers to lower prices. This would in turn fuel provider

competition and thus improve the efficiency of resource utilisation, improve service quality and encourage resource transfer into primary care from secondary care (see Chapters 1 and 3 for discussion).

This study set out to explore the nature of the GP purchasing role and found that GPs were indeed actively involved in stimulating efficiencies and resource transfers. However, these policy objectives were being achieved not through a neoclassical contracting system as expected, but rather through a network of socially embedded, co-operative relationships within primary care and between primary care purchasers and secondary care providers.

These networks were multiplex and were characterised by a strong ideology/culture which served as a motive for engaging in, and as a 'glue' for, the ongoing formation of, these inter-organisational networks. Purchaser provider relations involved learning, service design, purchasing and partnering and were supported by primary care networks, which facilitated learning and nurtured less experienced purchasers. Purchasing networks also served as an important locus for knowledge creation, innovation and economising.

As these findings have already been discussed in depth in chapter 6-9, this chapter draws them together in a summarised form as they relate to the research objectives of this study and the research gaps identified in Chapter 4.

10.1.1 A Synthesis of the Research Objectives and Research Findings

In order to understand the role of GPs as purchasers, this study pursued three objectives which were as follows:

1. to consider whether GPs were seeking to stimulate secondary care efficiency;
2. to find out whether GPs were seeking to initiate the transfer of resources from secondary to primary care; and
3. to understand the relationship between GPs (as purchasers) and hospital Trusts (as providers).

The findings from this study as they relate to those objectives are stated below.

10.1.2 Objective 1: GPs as Drivers of Efficiency

GPs did not set out to stimulate improved efficiencies (see 6.3) even though many recognised that improved efficiencies were necessary. However, when engaged in service design activities, GPs stimulated a number of improved efficiencies (see 7.8.1). These efficiencies were, therefore, the **outcome of a collaborative process** rather than an objective in themselves, a **by-product of service (re)design activities**.

Rather than pursue efficiency improvements, GPs concentrated on improving service quality (see 6.3.3). In the early stages of purchasing their focus was on functional quality (operational aspects of how the service was delivered) (see 6.3.3 & 7.8.3), but later there was a growing interest in technical (clinical) quality (see 8.7.2). This is of particular importance because although practices did not intend switching provider, they used quality as a measure to improve deficient providers. In the absence of adequate formal information, informal sources played a particularly important role in this evaluation process.

10.1.3 Objective 2: GP Purchasing and Resource Transfer

GPs were pursuing and successfully initiating transfers of resource from secondary to primary care (see 6.5.3 & 7.8.1). The process though was problematic and there were more examples of changes in the *locus* of activity than of substantial shifts of *financial* resource from secondary to primary care (see 6.5.2 & 6.5.3). In the short-medium term, efforts were being made by GPs to do more within primary care which, coupled with increased use and range of direct access services, would mean fewer resources being spent on secondary care services (a marginal transfer of financial resource). Mobilising large amounts of secondary care money though was a longer-term objective because this scale of resource is locked into acute hospital beds and is something which practices are unlikely to be able to tackle alone and in the short term (see 7.8.4). As with economies, such resource transfers were often realised through, or initiated as part of, the **service (re)design** process, although resource transfer was being more

deliberately pursued as a priority than was secondary care efficiency[1].

10.1.4 Objective 3: The Purchaser Provider Relationship

As Chapters 7 and 8 have shown, the GPs in this study cannot be readily viewed as ineffective or impotent purchasers. Previous studies have not considered in detail the *content* of the purchaser provider relationship (see 4.6 and Table 10.1) and consequently have not identified the fact that, and the ways in which, GPs have been stimulating efficiencies (see 10.1.2), resource transfer (see 10.1.3), quality improvements (see 7.8.3), service innovations (see 7.4) and knowledge creation (see 9.1.2).

This study has found that GPs have been involved in all these processes because of the socially embedded, collaborative nature of the purchasing relationship they have developed with their providers (see Chapter 7) and with one another (see Chapter 8). These networks have been mutually supportive. Learning, service design, partnerships and purchasing at the primary-secondary interface have been supported by the primary care level networks within which GPs have exchanged information about secondary care services and through which less experienced practices have been nurtured as purchasers (see 8.3).

The networks exhibit the range of characteristics generally associated with networks (see 3.14) such as reciprocity (see 3.14.4 and 7.5), learning and adaptation (see 3.14.6 and 7.3) co-operation and conflict (see 3.14.1; 3.14.7; 7.2.1-7.2.2 and 9.1.3). However, three characteristics emerged as being of particular importance here:

- *Ideology/culture*: the strong sense of loyalty to the NHS and comprehensive, equitable service provision combined with a professional culture and loyalty to local providers to serve as a strong motive for engaging in network relationships and contributed to the ongoing formation of purchasing networks through learning, service design, partnering and purchasing (see 9.1.1). It also contributed to the process of knowledge

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[1] Greater success was being achieved in terms of reallocating resources within primary care (see 6.5) for example, by reallocating ***existing*** primary care resources through more cost-effective prescribing (see 6.5.1).

creation, innovation and the prevention of high transactions costs (see 9.2.1 and below).

- *Knowledge creation*: this occurred because of the face to face (synchronous) formal and informal information exchanges (see 8.4-8.5) and learning encounters between GPs and between GPs and hospital providers (see 7.3 and 9.1.2). Such knowledge concerned service quality and service developments, innovations, and perspective sharing.
- *Efficiency*: two kinds of efficiencies were associated with purchasing networks. Purchasing networks were a locus for stimulating efficiencies in service delivery (see 10.1.2). They also prevented the expected high transactions costs from occurring because GPs were unwilling to switch provider (preventing search costs and renewal costs) and did not engage in detailed contracts which would require high levels of monitoring (see 9.2.1).

At the level of the individual 'organisational units' within the networks, this study found that practices had a strong sense of individual identity. GPs preserved and sought to enhance their professional autonomy (see 6.1). This was exhibited in their encounters with providers (see 7.2.1) and in their decisions about when to take collective action in purchasing matters and when to act individually (see 8.3.3). It was also clear from the study that GPs collaborated for the purposes of *purchasing* rather than service provision and they expressed concerns about the scope for collaborating to *provide* services (see 8.3.4)[2].

10.1.5 Contribution to Research Gaps

These findings contribute directly to the research gaps identified earlier (see 4.6). The research gaps are summarised in Table 10.1 below and are paired with the findings from this study.

[2] This is discussed in more detail later (see 10.2.1).

Table 10.1: Research Gaps and Research Findings

Research Gaps Identified in Chapter 4	Research Findings
(1) Limited knowledge concerning rationale for lack of provider switching.	GPs are loyal to the National Health Service and to local providers due to ideology/culture and are reluctant to switch provider (see 6.4 & 9.1.1).
(3)[3] Apparent lack of attention given to hospital efficiency but rationale for this is unknown.	GPs are not pursuing improved efficiencies as a primary objective and many are sympathetic to the pressures on hospitals (6.3.1). However, efficiencies are being stimulated as a by-product of service (re)design (see 7.8.1 & 10.1.2).
(4) By what means are GPs stimulating improved service quality?	Improvements in functional quality were pursued as a specific objective (see 6.3.3) and occurred via service (re)design (see 7.8.3). Process improvements were regarded as being a dual responsibility and were sometimes reinforced by mutual penalties (see 7.5). Improvements in technical/clinical quality were only beginning to be addressed (8.7.2)
(5) To what extent are GPs seeking to improve x-efficiency?	Evidence that x-efficiencies had been specifically pursued did exist (see 6.9.3) but the evidence was limited. Such efficiencies were stimulated along with service (re)design but the evidence suggests that care should be taken to consider the underlying factors which contribute to what may appear to be x-inefficiencies (see 7.8.2).
(6) Is the release of secondary care monies for primary care developments a specific priority for GPs?	GPs are pursuing resource transfer as a specific objective (see 6.5.3)
(7) Is the transfer of resources both possible and occurring?	Resource transfer is being addressed directly during service (re)design (see 7.8.1) but efforts to release large amounts of resource are proving problematic (see 7.8.4).
(8) What are the relative strengths of individual and consortia purchasers?	It was perceived that collaboration increased fundholders' influence as buyers (see 6.4.1) although they were reluctant to exercise power (see 6.4). They also felt that other influences (eg HB commissioning and Scottish Office priorities) combined with buyer influence so it was difficult for them to assess their relative influence as individual fundholders (see 6.4.2).
(9) What is the content of the purchasing relationship and the nature of the interaction process.	The relationship is multiplex comprising learning, service design, partnering and purchasing processes. It is characterised by knowledge creation (see 9.1.2) collaboration and conflict (see 9.1.3), mutuality, reciprocity and other 'typical' network characteristics (see 3.14 and 9.1).
(10) Are GPs concerned about the levels of transactions costs and are they trying to lower them?	There was a mixed response to this issue[4]. Some were opposed to fundholding because of these costs (see 6.1.3), others considered them as being relatively incidental (see 6.6.2). However, Ch 9 has discussed ways in which the social embeddedness of NHS purchasing actually prevented high transactions costs from being realised (see 9.2.1).

[3] This table omits research gap number 2 concerning GP prescribing due to reasons explained in sec 4.6.5.

[4] Note: the concept of transactions costs encompasses, for example, search and monitoring costs whereas it was generally only the administrative costs of the contracting and fundholding systems to which GPs referred.

(11) Little is known about fundholding/purchasing in Glasgow and about the extent to which it differs from other areas of Scotland and from England.	This study has focused on Glasgow and so has considered GGHB purchasing in detail. The decision making characteristics and purchasing behaviour are similar to accounts of GP purchasing elsewhere in Scotland although all the Scottish studies have differed in the degree to, and perspective from, which they have studied purchasing (see 4.5.2).

These findings make a particularly important contribution to understanding GP purchasing and evaluating its impact upon efficiency and resource allocation because they challenges the conclusions that were inevitably drawn from the existing body of evidence reviewed in Chapter 4. Following the review of the empirical studies in Chapter 4, it would have been difficult to conclude that fundholding had been a mechanism through which the desired secondary care efficiencies and resource transfers had been stimulated. Furthermore, as fundholders had made only short-term improvements in their prescribing, had done little to change their referral patterns or specify and enforce quality improvements, and could claim only improved communications, it was little wonder that when reviewing a recent purchasing report[5] that Jennifer Dixon wrote that purchasing was the dog which "not only failed to bite, but didn't even bark loudly enough to wake up providers." (Dixon 1998)

The insights gained in this study, however, show that GPs were actively stimulating hospital efficiencies and resource transfer. These outcomes were undoubtedly influenced by the pressures on providers from the Health Board and Scottish Office, but, as this study has shown, the *key* means by which these outcomes were achieved was through socially embedded purchasing networks and the collaborations therein.

It can therefore be said that the policy objectives of *"Working for Patients"* in terms of stimulating hospital efficiency and resource transfer were being met but not through a market form of contracting but through a network of collaborative relationships. That these networks have exhibited collaboration, conflict and creative and economising characteristics, and that network actors exhibit economically and socially motivated behaviours gives rise to important policy and managerial implications concerning

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[5] Light, Donald W. *Effective Commissioning: Lessons from Purchasing in American Managed Care*. Office of Health Economics, 1998

current health policy as the next section goes on to discuss.

10.2 Policy and Managerial Implications : Networks and Current Health Service Policy

As Chapter 1 outlined, the Labour government's opposition to the market philosophy has resulted in a new organisational arrangements (see 1.5.1 and box 10.1 for summary). Still with the intention to contain NHS costs, the new framework is based upon collaborative relationships between HBs, Trusts and GPs (see 1.5.2 and 1.5.3) where service developments and priorities are agreed through a system of planning rather than contracting (see 1.5.3). The findings from this study have implications for three types of network relations proposed within the current policy: primary care networks, purchaser-provider networks and information networks.

Box 10.1: Main Characteristics of Post-Market NHS Organisation.

- the separation of planning and hospital care provision;
- the retention of NHS trust status;
- the abandonment of GP fundholding in favour of locality-based co-operative groups;
- new co-ordinated planning processes at Trust and HA/HB levels; and
- national bodies to evaluate new technologies and measure performance.

10.2.1 Primary Care Networks

The first set of implications concern primary care networks and in particular their purpose, formation and organisation:

- *Network Purpose:* This study found that GPs worked collaboratively together in order to facilitate the purchasing process (see 10.1.4). Policy makers have recognised this *spirit* of collaboration which has emerged between practices and with providers (The Scottish Office Department of Health 1997), but have proposed, and are implementing primary care networks with an altogether different *purpose*, that of service provision.

This distinction in network purpose is important because primary care provision is an area over which GPs have traditionally exercised considerable discretion and autonomy and as this study has further highlighted, professional autonomy is

something which GPs preserve and seek to enhance (see 10.1.4). There is some evidence of successful GP co-operation as regards out-of-hours service provision (Hopton and Heaney 1999) but these services do not impinge on decisions about prescribing, secondary care services or the day-to-day running of the practice. Where practices have discussed the provision of patient care, they have encountered considerable conflict (D'Souza 1995). It is worrying, therefore, that policy makers seem not to have recognised the potential differences between types of co-operative arrangements as the following statement from *"Designed to Care"* implies: "General Medical Practitioners and their teams are increasingly aware of the advantages of working together to plan and deliver new services in different ways. Out-of-hours schemes, primary care purchasing groups and locality arrangements are examples of such collaborative working." (The Scottish Office Department of Health 1997).

Indications of likely conflict as well as potential collaboration need not necessarily be of concern because of the creative tensions and system integrative properties they may generate (see 9.1.3.) However, the need for parties to cede a degree of autonomy when collaborating is a factor which, given the high value GPs have been shown to place upon their professional autonomy (see 10.1.4), perhaps presents the greatest challenge to GPs and managers within LHCCs and PCTs.

- *Network Formation*: A second important distinction is that purchasing networks were the result of ground level or 'bottom-up' initiatives whereas LHCCs and PCGs have been brought about by parliamentary design. What this may mean in terms of their success is unclear. As earlier chapters have discussed, networks are based on trust, mutuality, interdependence, ceding of autonomy and long-termism (among other principles) (see 3.14). The extent to which these characteristics are present will depend upon the degree to which the GPs themselves agree with the co-operative philosophy as it relates to service provision and clinical practice. As with any change initiative, if GPs have some sense of ownership of the changes, this will increase the likelihood of success. It is encouraging therefore, that some interviewees felt they had an opportunity to shape the future of the LHCCs and

PCTs and that there was an opening for GPs to set the agenda (see 8.3.4). Their optimism is likely to have been encouraged by the Government's stance against imposing any kind of LHCC blueprint (The Scottish Office Department of Health 1997), the minimal amount of Scottish Office executive guidance, and early, positive accounts of Lothian LHCC experience (Hopton and Heaney 1999).

It is important, therefore, that efforts are made to understand the motives and incentives that do inform GP behaviour and that GPs are given the opportunity to influence their own LHCC formation and activities therein otherwise they may become disengaged from the changes or even actively opposed to them. It is also important to give GPs the opportunity to share perspectives and learn from each other because their experiences, needs and practice populations are likely to differ across LHCCs.

- *Network Organisation:* In whatever way inter-practice relations develop, it is likely that organisational issues will be of increasing importance within LHCCs and PCTs. GPs will become employed by PCTs and subject to the managerial structures therein. Coupled with organisational issues within the LHCC, the organisational agenda looks set to be a significant element of daily life. Evidence from recent discussions with those currently involved in the new arrangements confirm that much time is being spent agreeing articles of association and setting up the many PCT/LHCC committee structures. Studies of GP consortia (Laing and Cotton 1997) confirm that new (collaborative) structures and processes are accompanied by organisational politics, managerial conflicts and the many other organisational dimensions (eg, team dynamics) which are characteristic of organisational life - characteristics to which general practice (particularly non-fundholders) have previously been only limitedly exposed.

It is important that PCT and LHCC members ensure that the weighty organisational agenda does not swamp issues of service delivery and that adequate human and financial resources are devoted to not only maintaining existing service provision

within LHCCs but to improving services through the innovative capabilities which have been identified within the purchasing networks.

10.2.2 Primary-Secondary Care Networks

The interface for primary-secondary care relations under the new NHS structure is that of the annual planning process and in particular, formulation of the Joint Investment Fund (JIF). The JIF is to become the mechanism for stimulating innovations, knowledge transfer and service design and to "encourage co-ordination of services at the interface between primary and secondary care" (The Scottish Office Department of Health 1997:18) (see 1.5.3).

Clearly, the extent to which this is a truly interactive and fruitful process will depend upon the planning processes which are established. It is not clear at this stage in the PCT developments what shape this JIF planning process will take but in what may be an attempt to counter any accusations of unnecessary bureaucratisation, executive guidance (The Scottish Office Department of Health 1999) states that "making the JIF work .. is not a matter of drawing up formal protocols for inter-Trust negotiation. Its success will depend far more on developing a culture of collaboration, in which the voice of primary care clinicians is given equal weight to that of their secondary care colleagues...".

This collaborative culture has been found in this study not only to be of importance but to already be in existence. The challenge therefore, is not so much to develop a culture but to build on the existing culture and collaborative primary care clinician-secondary care clinician relationships which have developed and not to constrain them within a bureaucratic planning paradigm which is detrimental to creativity and thus service innovations, knowledge creation, service quality and ultimately patient care.

10.2.3 Information Networks

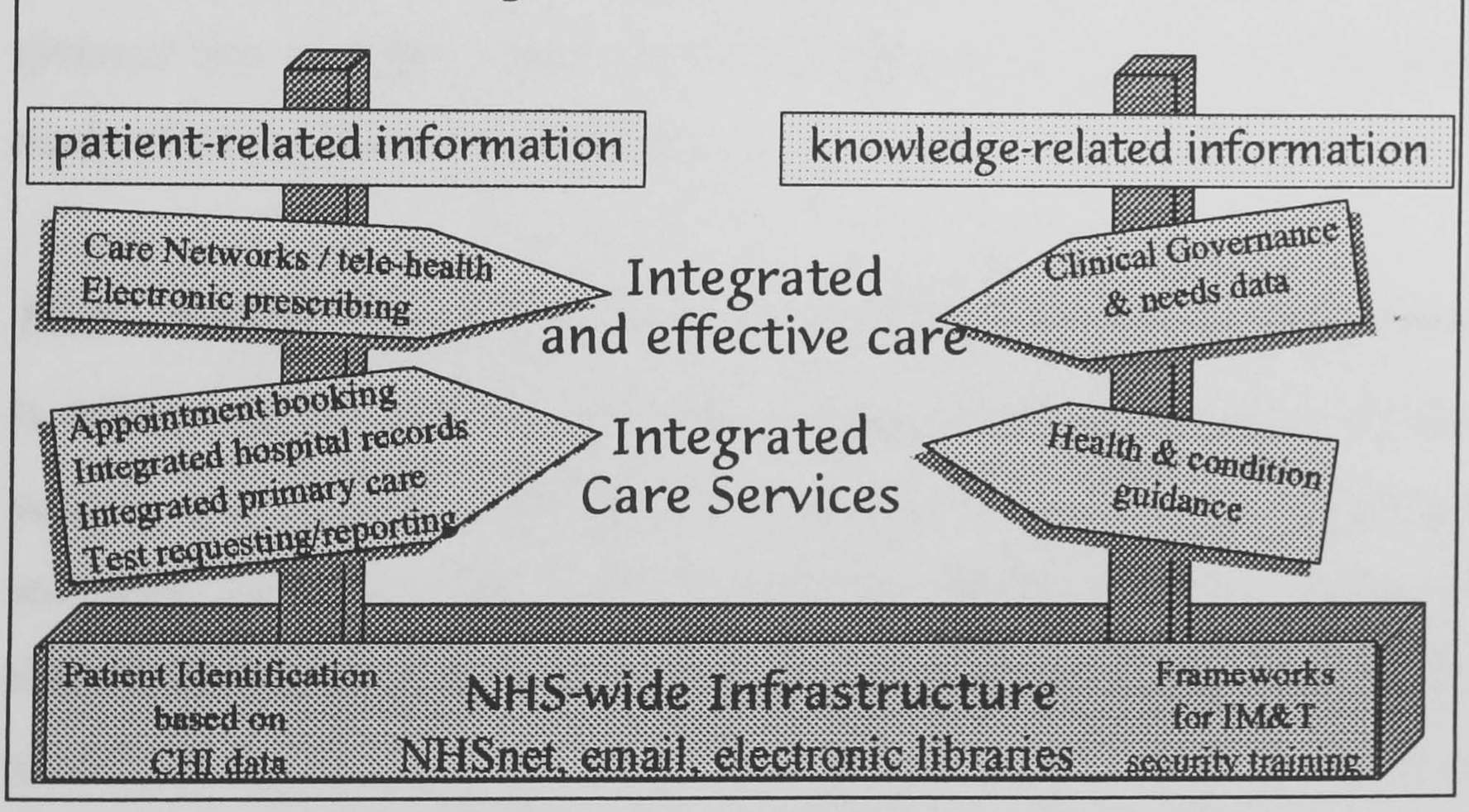
One of the central themes in current NHS policy concerns the provision of information and the use of IT. IT networks are being advocated as the means by which to improve the provision of certain 'formal' information (see 8.5). At the same time, the government is setting up organisations such as Scottish Health Technology Assessment

Centre (SHTAC)[6] to make recommendations concerning the cost-effectiveness of innovations in health care (this includes new drugs, therapies and procedures).

More efficient provision of this 'formal' information is to be realised by way of the following:

- an NHS-wide electronic super-highway;
- modern computer software for GP practices;
- integration of currently separate hospital IT systems to create consolidated information about patients;
- electronic transmission of outpatient appointments, referral and discharge letters and test requests and results between hospitals and GPs; and
- access for healthcare staff to email and electronic libraries of knowledge. (National IM&T Programme Board 1998) (see Figure 10.1)

Figure 10.1: NHS in Scotland, Information Infrastructure
Source: National IM&T Programme Board 1998



This will clearly be beneficial to GPs, trusts and patients and will free up the clinical and administrative time currently devoted to pursuing late or missing letters, records and test results.

Plans concerning the potential development and exploitation of formal sources of information IT-based transmission should, however, take into consideration the need

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[6] The English equivalent is NICE, the National Institute of Clinical Effectiveness.

for the synchronous exchange of qualitative information to make sense of formal data (see 8.5.2). They should also recognise the preferences indicated in this study, and in earlier studies, for GP preferences towards informal sources of information. As Chapter 4 discussed, GPs are dubious about the value of league tables (Ellwood 1996) and their concerns are unlikely to be readily allayed following recent studies showing that league tables are difficult to obtain and difficult to use for comparing clinical aspects (Marshall and Spiegelhalter 1998; Parry et al. 1998; Sanderson and McKee 1998). This study (see 8.6) and those reviewed earlier (see 4.4.4) have shown that formal sources of information such as evidence-based publications and even the advice of local advisory boards tend to bear far less influence on purchasing decisions than do personal experience, local knowledge and other informal, often serendipitous sources.

It follows, therefore, that the use of IT systems and the scope for their development must be carefully researched and evaluated. Furthermore, as GPs are heavily reliant on informal sources of information to guide their decision making, thought must be given to how such patterns of decision making can be altered so that greater use is made of evidence-based information.

10.3 Network and TCE Theory: Conclusions and Implications

In addition to the contributions made by this study to understanding NHS purchasing, contributions have also been made to the use and development of organisation theory and research methodology. One of the central themes within organisation theory is that of seeking a greater integration of economic and social theory. This study has shown just such a 'marriage' in the formation of network relations for example by identifying the combination of economic gains (eg practice savings) with social values (eg professional autonomy) and by identifying economising and social characteristics of purchasing networks. Specific contributions are presented below.

10.3.1 Network Theory

This study has made four contributions to a theoretical understanding of networks. Firstly, it has identified and discussed the integration between system and local level ideology/culture (see 9.1.1). This finding supports the work of Jones et al (1997) who

identify the influence within networks of macro-culture and who call for a greater recognition of its existence within the theory. Secondly, it has identified ideology/culture not only as a motive for engaging in networks but as a powerful factor in the ongoing formation of network content and process even in the face of considerable difficulties (see 9.1.1). Thirdly, this study has added to the explanations previously given that networks are held together by trust which serves as a 'glue' between parties (Jarillo 1990) by identifying that ideology/culture may also be a powerful 'glue'.

The fourth contribution lies at the intersection between network and TCE theory. Networks have been associated with economic efficiencies such as the lowering of transactions costs (see 3.15.1 and Ouchi 1991; Powell 1991). Ebers et al. (1997) however, recently highlighted difficulties in analysing internal and external network costs because of the lack of frameworks with which to do so. By drawing on a framework developed for the analysis of market transactions (namely the TCE framework), however, this study has identified ways in which network relations have prevented high transactions costs (see 9.2.1). Consequently, when drawn upon in tandem with the growing body of network studies, these findings can aid the development of frameworks for analysing network costs.

10.3.2 Transactions Cost Theory

The use in this study of TCE theory has lead to a further theoretical contribution by way of highlighting certain limitations within TCE theory. These limitations were identified because of the group context in which purchasing occurred (see 9.2.2) and concerned the ways in which investments and returns on investments were apportioned and appropriated. Four key questions which were identified, and which indicate directions for the development of TCE theory, are as follows:

- To what extent are returns on investments made to the *group*?
- What is the loss to an individual practice if they cease trading (ie, are investments non-marketable)?
- What is the loss to the group if a more 'involved' practice leaves the group?

- If a practice decides to buy from another provider, what are the set-up costs if a group purchasing arrangement already exists and the practice is free to join? Can the practice "piggy-back" on other practices or accelerate learning processes and benefit from learning and economies already accrued in that setting?

10.4 Research Methodology and Research Limitations

Before going on to consider some areas for future research and drawing this final chapter to an end, it is important to reflect on certain aspects of the research methodology and some of the limitations of this study.

10.4.1 The Importance of Observation

A further contribution of this study concerns the adoption of a non-participant observation method of enquiry. As Chapter 5 has discussed, two approaches were taken in gathering data: interviews and non-participant observation. It was the adoption of the latter which lead to the greatest insights in this study. The interview data alone, for example, led to the conclusion that GPs were doing little to stimulate efficiencies and resource (re)allocation (see 7.8.1) and GPs made little or no mention of any of the processes identified in Chapters 7 and 8 during interviews unless prompted[7]. The interview material contributed to confirming much of the evidence from earlier studies and identified the importance of professional autonomy, but, did not provide in-depth insight into the nature of purchaser provider interactions.

The observations however, provided new insights into, and allowed for a more informed interpretation of, provider and inter-practice interactions. The processes of learning, service design, partnering and knowledge creation were all identified through observations of purchaser provider and inter-practice meetings. This in turn amplified interview and material concerning conflict and collaboration.

Had such observations not occurred, it is highly unlikely that these insights would have

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[7] It was of course only those interviewees who were interviewed during and after the observations were taking place who could be prompted to discuss processes of service design etc.

been gained. This was confirmed when feeding back the study's findings to GPs and contract managers as it was apparent that they had not previously appreciated the multiplex nature of their network relationships. This is not surprising because unlike an observer, they are caught up in these events and relationships and have little time to sit back and consider more objectively the phenomenon of which they are a part. The researcher as observer, however, has both the time and opportunity to reflect and is equipped with theoretical frameworks which can aid interpretation of the data, again a privilege not necessarily available to the subjects. As a result, both the researcher and the subjects can benefit from observation and feedback. As Kvale puts it, the qualitative researcher may, "...through conversations ... lead others to new understanding and insight as they, through their own story-telling, may come to reflect on previously natural-seeming matters of course in their culture." (Kvale 1983:4).

In conclusion, as a consequence of using non-participant observation, this study was able not only to identify that networks exist, but to analyse them in terms of process and content thereby enabling the study to offer insights which go beyond the scope of previous studies.

10.4.2 Research Limitations

As with all research, there are certain limitations to the application of these research findings. Chapter 5 has already discussed, these limitations in terms of the interview and observation methods that were used (see 5.7) so this section considers the empirical and temporal limitations of the study and comments on how these have been addressed.

There are two specific 'empirical' concerns related to purchasing in GGHB:

1. GGHB is an area which demonstrated a reluctant uptake of fundholding when compared with other areas (see 4.4.2 and 5.3.1) although PCP fundholding was taken up in significant numbers in 1997. As such, the fundholding, and hence purchasing profile of GGHB differs from other areas in Scotland and the rest of the UK. It is difficult to address this particular aspect. Where appropriate, reference has been made to similarities with other Scottish studies although comparability is limited due to the differing nature of the studies (see 4.5.2).

2. Purchasing experiences differed within GGHB. Not all GPs who were interviewed had developed such collaborative, socially embedded relationships with their providers (see 6.4). It cannot be assumed therefore, that efficiency improvements, service innovations and knowledge creation were generated city-wide. However, that they expressed a desire to work with their purchasers goes to support earlier discussions concerning ideology/culture.

There was also a 'temporal' limitation related to the NHS context. The NHS has been characterised by continual periods of change during the course of this study. Given that such changes take time to have an effect, it becomes difficult to identify causality. For example, because action is often taken to counter the effects of or to develop earlier policies, it is difficult to identify whether the behaviours which follow are in response to this action or would have occurred anyway. As well as affecting the subjects' behaviour, such changes also affect their agenda. In this study, for example, fundholding was topical at the start, was considered to have received a 'death sentence' at the time this fieldwork began, and by the end of the fieldwork GPs were preoccupied with future LHCC developments.

As these policy influences are not only integral to the subject under study but could not be avoided, the interview schedule was designed to be flexible so that changing policies and agendas could be taken into account. This has meant that as well as offering an analysis of the market mechanism this study has been able to comment on current health policies thereby increasing its relevance and contribution to knowledge.

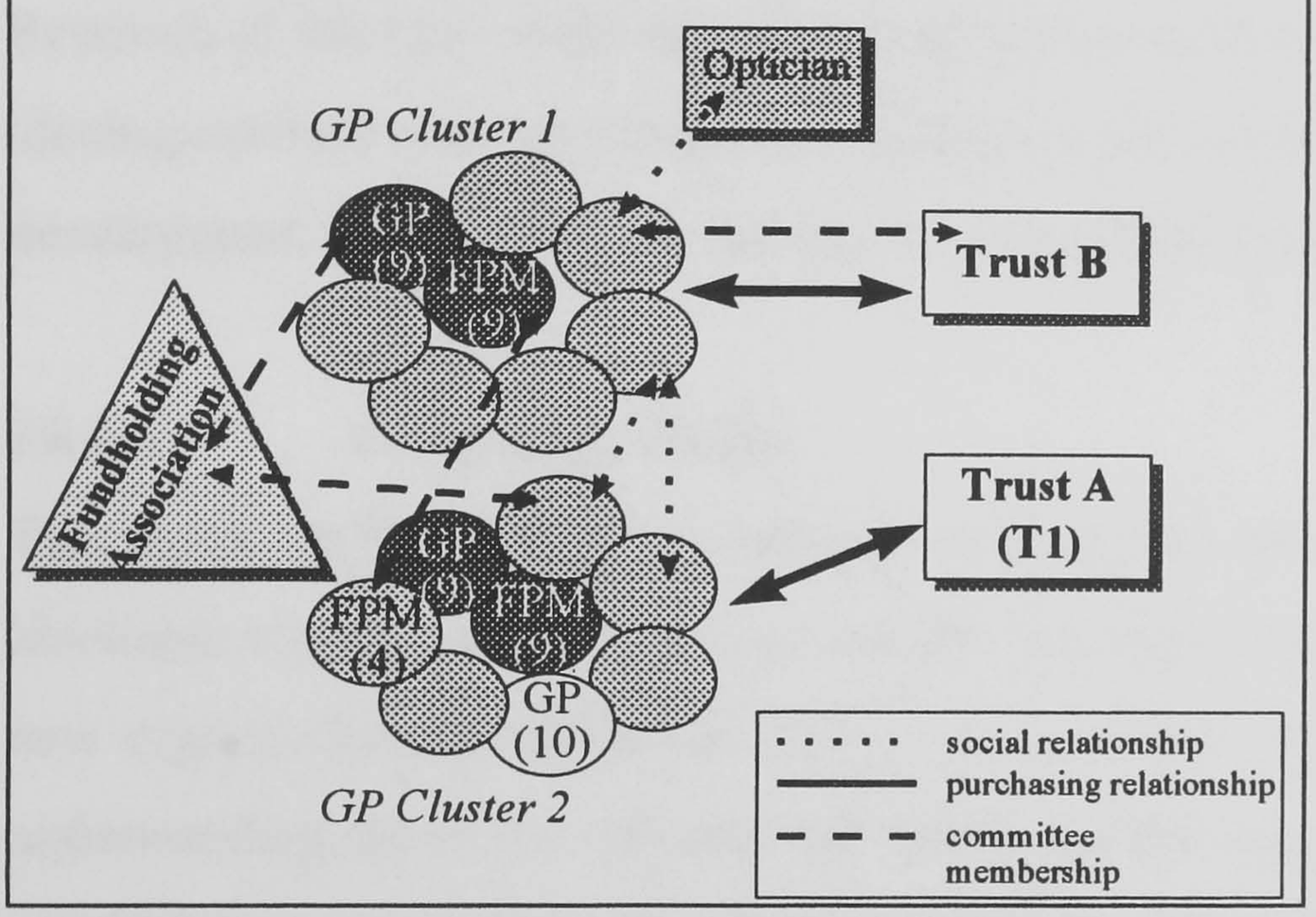
10.5 Future Research

Following discussion of the conclusions and implications arising from this study, the final section of this thesis identifies two areas for future research which follow directly from this study. As consideration has already been given to future theory development (see 10.4) this section concentrates on future research directions for the study of GP and primary care networks.

10.5.1 Social Networks and the Strength of Network Ties in Primary Care

This study drew on network theories, to consider one specific set of network relations - purchasing networks. In so doing, it identified further sets of overlapping social networks which had an influence upon purchasing decision making and in particular, knowledge creation. Some of these overlapping networks are identified in Figure 10.2.

Figure 10.2: Formal and Informal Networks in Purchasing



The diagram identifies the following:

- a social relationship (marriage) between one GP and a community optician;
- a social relationship between three practices because the practice manager in cluster 1 was formerly a community pharmacist and thus knew GPs in the area, some of whom joined Cluster 2;
- two GPs held formal positions in the Fundholding Association
- at least one GP from cluster 1 was on a hospital committee; and
- at least two of the practice managers met through the practice managers' association (see Chapter 8).

Given that GPs are now organised within primary care networks (LHCCs), research is required concerning the role of these new 'formal' or organisational networks in relation to knowledge creation and service provision. The role of related social networks such as those indicated in Figure 10.1 and others in which GPs are involved[8] ought also to be studied in relation to knowledge creation and service provision because as Granovetter (1973, 1982, 1985) has discussed, the density of social

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[8] Other networks can be professional (eg BMA), organisational (eg, GPFHA), local (eg, LMC), educational (eg PGEA training), and medico-political (eg membership of hospital committee).

networks and the strength of the ties within them have implications for innovative capabilities and thus for the processes of service design and knowledge creation. Furthermore, in light of this study's emphasis on knowledge creation, explicit consideration should also be given to the ability of practices to capture, create, absorb and exploit knowledge this new knowledge, ie. their absorptive capacity (Cohen and Levinthal 1990).

Research of this kind could also further advance understanding about the role of ideology/culture and knowledge in relationships and would contribute to theoretical development, policy direction, managerial and clinical practice.

10.5.2 Complexity Theory

This thesis has highlighted the influence of economic and social motives, in particular ideology/culture, on GP behaviour and the emergence of purchasing networks. As new organisations (LHCCs and PCTs) are developed, it is important to gain further understanding about the influence of these social and economic factors. One approach would be to use complexity theory to explore and explain the emergence of new organisational forms and network arrangements.

Complexity theory advocates that behaviour in organisations is influenced by *internal models*, ie unstated rules or models which guide people's actions and help people to anticipate and predict events (Miller et al. 1998). As Miller at al go on to explain, GP practices "are complex adaptive systems; each practice has its own shape and is a non-linear web of relationships capable of self-organisation and co-evolution. But what creates and maintains that shape?".

Complexity theory seeks to explain the dynamics[9] of non-linear systems from a systemic perspective (Stacey 1996; Miller et al. 1998). Within non-linear systems there are existing hierarchies, rules and ways of behaving and feedback systems which influence actor behaviour and such *complex adaptive systems* must be considered as

[9] ie, the "patterns of change that a system displays over time … and … the conditions leading those patterns to be stable or unstable …" (Stacey, 1996: 248)

interacting with the environment and adapting to changing conditions (Stacey 1996).

A complexity theory approach could, therefore, further inform theories about individual GP behaviour and could explain the evolution of different 'shapes' of organisational form as manifest in LHCC developments. Such a study is of particular relevance as it is thought that GPs in Scotland have considerable scope to develop their organisational arrangements, moreso than their English counterparts. This complexity perspective would also contribute to theories about individual and organisational learning and would enable policy makers and managers to recommend and design appropriate incentives and organisational structures.

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Appendix I

Fundholding Statistics for Scotland, England & Wales

Appendix I

SCOTLAND

Table 1: Fundholding Status 1990-1998

	1990	1991	1992	1993	1994	1995	1996	1997	1998
All fundholding practices	**12**	**18**	**69**	**132**	**162**	**286**	**408**	**501**	**514**
Fundholding practices as % of all practices	1.1	1.7	6.4	12.4	15.1	226.8	38.6	47.5	
Total purchasing	x	x	x	x	x	20	21	33	18
Standard	21	18	69	132	162	162	170	175	180
Primary care purchasing	x	x	x	x	x	104	217	293	316
Patients in fundholding practices as % of all patients	1.9	2.7	10.9	18.7	22.0	33.4	45.2	53.4	x[1]

Source: ISD Scotland (General Medical Practitioner Database).

(The data include practices in preparatory or pilot phase.)

[1] Statistic not provided by ISD with the other figures.

SCOTLAND

Table 2: Fundholding and Non-fundholding by Health Board at April 1996

Health Board	Fundholding				Non-Fundholding	
	Practice %	Rank Order	Population Covered %	Rank Order	Practice %	Population Covered %
Ayrshire & Arran	11.1	13	11	13	88.9	89.0
Borders	43.5	2	53.2	2	56.5	46.8
Argyll & Clyde	24.8	11	25	11	75.2	75.0
Greater Glasgow	27.2	9	30.9	9	72.8	69.1
Highland	26.7	10	25.6	10	73.3	74.4
Lanarkshire	34.4	4	42	4	65.6	58.0
Grampian	49.4	1	66.2	1	50.6	33.8
Orkney	0	15	0	15	100	100
Lothian	29.6	7	31.2	8	70.4	68.8
Tayside	35.4	3	45.9	3	64.6	54.1
Forth Valley	30.9	5	35.3	6	69.1	64.5
Western Isles	13.3	12	18.6	12	86.7	81.4
Dumfries & Galloway	27.8	8	32.1	7	72.2	67.9
Shetland	0	15	0	15	100	100
Fife	30.2	6	40	5	69.8	60.0
TOTAL	**29.23**	-	**35.7**	-	**70.77**	**64.3**

Source: Information and Statistics Division (ISD) of the Common Services.

SCOTLAND

Table 3: Fundholding Types within Health Board Areas at 1st April 1996

Fundholding Status	**Health Board**															
	Ayrshire & Arran		Borders		Argyll & Clyde		Greater Glasgow		Highland		Lanarkshire		Grampian		Orkney	
	n=	%	n=	%	n=	%	n=	%	n=	%	n=	%	n=	%	n=	%
Total	0	0.0	0	0.0	0	0.0	3	1.3	2	2.7	1	1.1	7	7.9	0	0
Standard	5	7.9	3	13.0	12	11.4	28	12.5	6	8.0	16	17.2	32	36.0	0	0
PCP	2	3.2	7	30.4	14	13.3	22	9.8	12	16.0	14	15	5	5.6	0	0
Preparatory	0	0.0	0	0.0	0	0.0	8	3.6	0	0.0	1	1.1	0	0.0	0	0
Non-GPFH	56	88.9	13	56.5	79	75.2	163	72.8	55	73.3	61	65.6	45	50.6	15	100
Total	63	100	23	100	105	100	224	100	75	100	93	100	89	100	15	100

Fundholding Status	Health Board													
	Lothian		Tayside		Forth Valley		Western Isles		Dumfries & Galloway		Shetland		Fife	
	n=	%	n=	%	n=	%	n=	%	n=	%	n=	%	n=	%
Total	8	5.9	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Standard	22	16.3	15	19.0	4	7.3	0	0.0	4	11.1	0	0.0	6	9.5
PCP	10	7.4	13	16.5	13	23.6	2	13.3	6	16.7	0	0.0	12	19.1
Preparatory	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	1.6
Non-GPFH	95	70.4	51	64.6	38	69.1	13	86.7	26	72.2	11	100	44	69.7
Total	135	100	79	100	55	100	15	100	36	100	11	100	63	100

ENGLAND & WALES

Table 4: Fundholders in England & Wales between 1st April 1991 and 31st March 1996

Year	Number of Fundholding Practices	Fundholding Wave
1992/93	300	1st
1993/94	590	2nd
1994/95	1248	3rd
1995/96	1836	4th
1996/97	2221*	5th

* Represents 41% of the patient population.

Fundholding rates vary across the country, however. For example, at 1st April 1995 there were 93 fundholders in Essex and 87 fundholders in Kent but only 1 in Camden and Islington and 3 in Sunderland.

Source: (Audit Commission 1995)

Appendix II

Original Interview Schedule

GP FUNDHOLDER QUESTIONS

CONTEXT..

Practice Location Number of Patients Fundholding Date

Efficiency of Allocation of Resources

(1) It has long been said that resource allocation has favoured the secondary sector (particularly high-cost technologically advanced medicine). To what extent have you witnessed a move of resources into primary care activities?

(2) In your experience how have you changed the pattern of provision of secondary care to your patients?

(3) Why is it so important to actually have control over your own resources? (As opposed to eg, non-fundholding association activities advising HB or RHA purchasing).

(4) What incentives are there for you to shift resources from intervention (eg, prescription, or referral), to health promotion activities such as asthma clinics?

Can you give me some examples of what you would consider 'bad' resource allocation under the 'centrally planned' pre-purchaser/provider split?

Efficiency of Use of Resources

Concerns have been expressed (Propper in Glennester) about the asymmetry of information (providers having greater access to information required by purchasers. What action has been taken and is still required to ensure the adequacy of information relating to

(a) provider activities & costs, and
(b) the needs of practice patients?

What 'unit of measurement' would you use as a way of demonstrating an improved use of resources?

Can you give me some examples of what you would consider 'bad' resource usage under the 'centrally planned' pre purchaser/provider split?

Can you give me some examples of good resource usage which you consider to be a direct result of your status as a fundholder?

Primary Care-led

What do you understand the phrase 'Primary care-led' to mean in practice?
Range:

influence (eg GP advised purchasing) ---------->direct decision making power

Do you think that a purchaser provider split is necessary to facilitate this?

Would you say that some kind of market mechanism is required?

Purchasing & Contracting

Commentators have said that for a market mechanism of some kind to work effectively that there needs to be 4 key elements:-

(a) consumer demand
(b) a price mechanism for expressing consumer preferences
(c) alternative sources of provision/supply
(d) good information upon which to base decisions

From your own experience, would you say that each of them have been present?

Many practices believe they can contribute to strategy and purchasing decisions via joint HB commissioning, or locality commissioning. What do you think of these alternative approaches?

The Practice as a Small Business

Do you view your practice as a small business? If so why, if not, why not?

You attract funding, and thereafter must allocate scarce resources. How do you do this? How do you prioritise?

Is there scope for business development?

Do you think that there is any way in which practices can differentiate themselves or focus their services?

Is there evidence of competition between GPs? On what basis do they compete?
If not, can you envisage it every being the case?
On what basis would/could they compete?

Does your practice have a mission?

Do you write a business/practice plan each year?

Do you ever discuss with your partner(s) the strengths and weaknesses, opportunities and threats relating to the practice?

What is the nature of financial pressures on your practice?

Can you foresee a time when GPs will refer patients to other practices?

Strategy

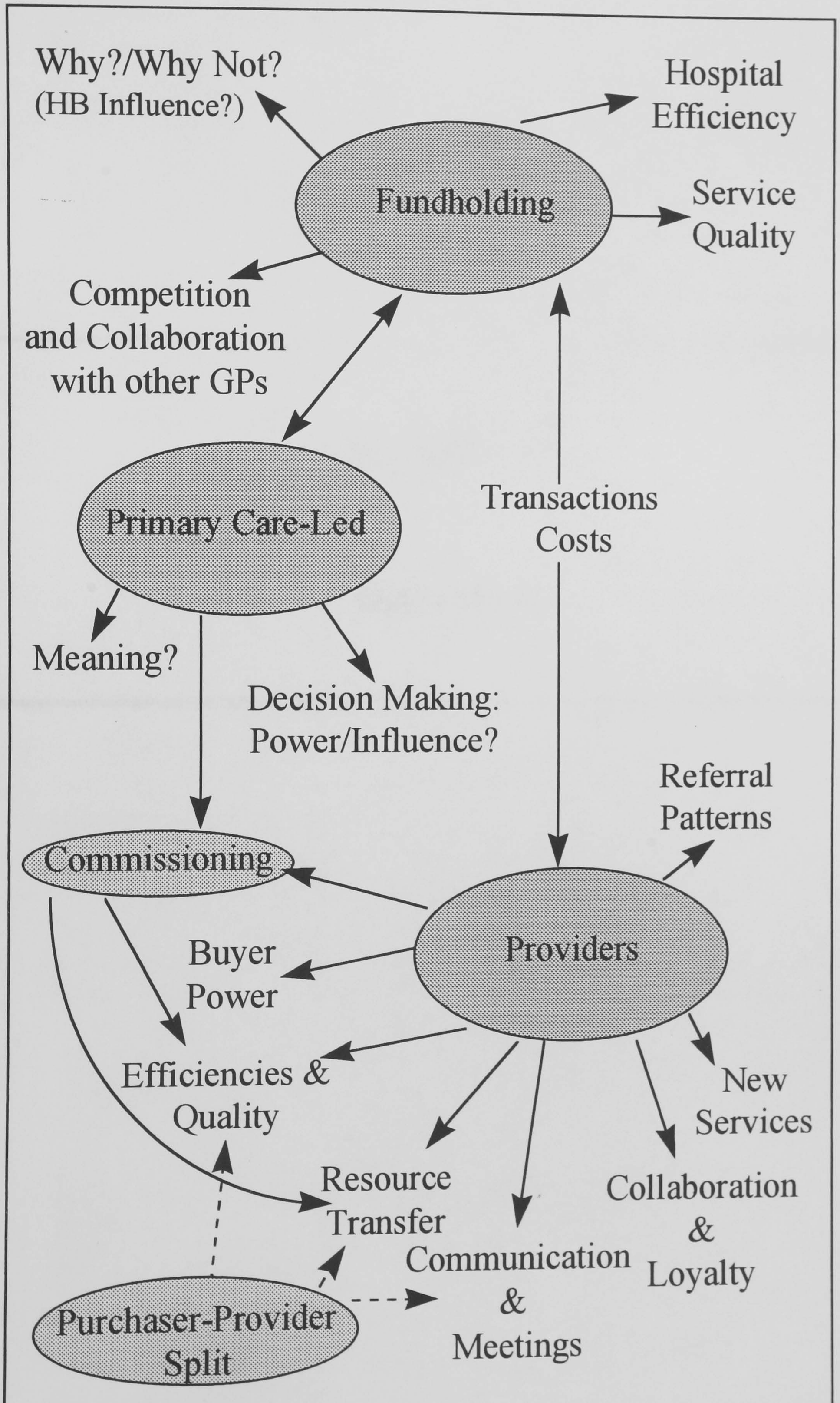
Each Health Board needs a strategy for provision of primary care services. How do you reconcile a need for area based needs assessment and planning, with the local or practice sensitive needs and knowledge?

The Future

How do you anticipate that purchasing will develop in the next 2-3 years?
Do you think that there will always be a mix of fundholders and non-fundholders?
Do you think that some fundholders will give up their fundholding status because of the attraction of non-fundholding commissioning?

Appendix III

Thematic Interview Guide


Why?/Why Not?
(HB Influence?)
Hospital
Efficiency
Fundholding
Service
Quality
Competition
and Collaboration
with other GPs
Primary Care-Led
Transactions
Costs
Meaning?
Decision Making:
Power/Influence?
Referral
Patterns
Commissioning
Providers
Buyer
Power
Efficiencies &
Quality
New
Services
Resource
Transfer
Collaboration
&
Loyalty
Communication
&
Meetings
Purchaser-Provider
Split

Appendix IV

Data Maps

By + Large — Happy to collaborate .. but, divided over details of commissioning

"at the end of the day money, unfortunately, talks" (JC,16).

if not contracting together, at least ensuring quality standards

But control @ practice level within that setup. ⇒↑ power

Competition + Collaboration GP ↔ GP

Competition

"no not at all" (JC,14)

not much comp. between GPs.. (SOTHO,8)

v. good quote.

Cooperation generally (p9)..

Collaboration

Collaboration but still individual practice control.

Recognise limits of GP-GP practice

Comp. exists

Comp — yes.. diff. to know how

under surface

cause upheavals

not over enough.

Comp — patients. So fluid. (11)

Quite intense (F5).

Love to get together (11) pp

Joint contracts can be helpful to go as a group (GP-PH + non.)

Wise to be part of group (GP)

Stay-finish a newspaper

due to 1990 contract.

..for patients.. due to ↑consumerism

Fragmenting-tend to have rather insular view.

Helped by Chief; Practice.. "head of them"

Pass on info

going PCP encouraged ↑communication

PCP practices team-based (SF,3)

need to pull together and develop

..through "networking and discussion"

"what kind of competition would there be?"

"I think the key is keeping relationships with other practices and sharing innovative ways of how you are actually operating..."

Collaborative initiatives (PH,3)

problematic getting GPs to work together (5)

Comp.. very locally, yet.. not for patients

Value added stuff.

No comp. - loyal patients

N-group — talk about what they're doing for.. things they'd like, developments.

Started of themselves. group acty.

Other joined critically to learn from/part etc. (10)

Not really in competition.. historical pattern of patients

Good work (P17).

No Other practice in the locality. Centre-do everything together.. No competition over! (15)

Why become a Fundholder

Decision seems to vary between a philosophical stance, and a purely functional (financial?) decision.

Contribute to d.m.

- both referred to service the Hosp commitee structures make changes hard to make... commitee problem | cancer commissioning
- commitee shd present re commissioning
- reduce emergency admissions:
  - to look stage back what caused UI health TOTAL GP Fd
  - Red Book gms - very restrictive
  - so as to meet patient need.
  - to develop the practice (FS)
- internal + external.
- (FS) control of work environmt
- frustration - Western - re GI endoscopy.
- have contract elsewhere
- + autonomy (free from HB)
- also... control over referrals..
- improve services (TC)
- Power.
- Savings + manag+ allowance.
- Financial (SF).
- attractive re: (TC) immediate effect but
- v. short term 50%.
- says that selfishly GP would make like career for him
- buy services + make it happen.
- money will run out at some points
- HB keeping Trusts afloat
- money through as well
- but this is not efficient
- GPs will be no different
- also... to go better bargaining
- weren't getting what they wanted...
- wanted to have influence ...ownership
- more staff to develop services.
- attractive mainly... new + improved services will run out
- not prepared for full-time ..unorganised
- have influence over & in practice staff
- more control over practice org + develop.
- examples of what one area is encouraged.
- like idea of being in purchasing group
- also having some influence.

Why become a Fundholder (or not!)

- (PE) unfunded ... diff. to cope at present
- financial incentive
- no incentive
- (PE) greater say over staff attached to practice (control?)
- (GP) "too good to refuse"
- (PW) fun!
- financially reasonable
- attitude to practice need
- (PE) in health service
- (FS) ? bit more control - staff
- (ots of KHA work...)
- no perceived patient benefit
- savings on prescribing (short term gain)
- computing improvements.
- freedom
- developing services (chiropody @ practice)
- mgt allowance ..win win situation
- Control of staff
- lots of computers
- scheme didn't address true problem area (geriatrics)
- business development
- new opportunity
- develop the practice
- some savings
- leverage to improve practice mgt
- deliberately decided - NE to fundholding philosophical decision

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