

**Evaluating the Significance and Determinants of Relationship
Marketing Strategies within the Former NHS Internal Market: a
Comparative Analysis of NHS Trust and District Health
Authority Perspectives in England**

Thesis submitted for the degree of Doctor of Philosophy

at the University of Leicester

by

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April 2000

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Evaluating the Significance and Determinants of Relationship Marketing Strategies within the Former NHS Internal Market: a Comparative Analysis of NHS Trust and District Health Authority Perspectives in England

Keith Edgar Gray

This thesis evaluates the extent to which relationship marketing (RM) strategies were prevalent within the former NHS Internal Market and the determinants of such strategies. The research achieves its aims through the analysis of a postal survey of NHS Trust hospitals and District Health Authorities in England and case studies of the Warwickshire and Dudley health markets.

The impetus for the research is the paucity of literature evaluating RM in the NHS context, resulting from the predominance of the traditional economics perspective on the purchaser – provider relationship. The latter is unable to systematically evaluate relational behaviour within quasi – markets given its adversarial contracting focus.

Subsequently, the Relationship Marketing Paradigm is used to design a framework appropriate to evaluating relational oriented behaviour within the NHS Internal Market.

To further investigate the determinants of NHS Trust hospital's RM strategies a series of hypotheses were developed and tested using Logit modelling techniques. These hypotheses sought to explain contract augmentation, contract customisation, loyalty discounting, default contracting and the use of cost – sharing contracts.

In addition the case studies further examined the role of 'trust' within the purchaser – provider relationship through evaluation of contractual, competence and goodwill trust typologies. Equally, the case studies investigated the negative impact of RM strategies from the perspective of purchasers, providers and service users.

The key conclusion is that RM was significantly more widespread than the literature suggests, indicating the centrality of relational oriented contracting. Furthermore, the nature of and determinants of the identified relationship marketing strategies were found to be mature and complex. Moreover, this weight of evidence questions Government policy's success in generating a competitive environment within the NHS Internal Market based upon adversarial contracting.

To explore the likelihood of RM remaining an important phenomenon within the "new" NHS arrangements, evidence is drawn from the case studies and predictions from the Logit analysis.

ACKNOWLEDGEMENTS

I have benefited from the help, support, and advice of a number of people in researching and writing this thesis. First I must acknowledge the considerable time, effort and encouragement of my supervisor, Professor Dr Peter Jackson, Director of the Management Centre at Leicester University. On several occasions he provided a spark of genius in guiding my research activities. I also thank Professor Alain Enthoven of the University of Stanford, USA, for his helpful correspondence.

In addition, I am grateful to my colleagues Dr Deb Ghosh and Dr Mark Bailey at Coventry University for helpful comments regarding the LOGIT models presented in Chapter 5. I am also grateful to Dr David Morris, Dean of Coventry Business School, who has funded this research.

Lastly, I thank the numerous anonymous NHS health professionals who completed the survey questionnaires, and those who agreed to be interviewed face to face for the Case Studies.

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CHAPTER 1

Introductory Chapter

1.1 Introduction

This chapter has a number of objectives. Primarily, it provides the context for the current research, and clearly justifies the selection of the central research hypothesis and related research objectives. In addition it defines quasi – markets from both a theoretical perspective and also in respect of real world models of quasi – markets in health care. Moreover, it evaluates the ideological context surrounding quasi – market reforms in the UK, and critically appraises the case for and against their imposition. Lastly, this chapter provides a restatement of the central research hypothesis, and also summarises the structure and contents of the remaining chapters of the thesis.

1.2 The Context of the Study

An important phenomenon in the public services in Britain since the late 1980's (Le Grand, 1991), especially in state health care, has been the replacement of bureaucratic planning structures with a quasi – market. A detailed evaluation of the latter's structural form is considered below. However, a generic definition of quasi – markets is pertinent here: "They are markets because they replace monopolistic state providers with competitive independent ones. They are 'quasi' because they differ from conventional markets in a number of key ways" (Le Grand & Bartlett, 1993, p10).

Furthermore, according to Le Grand and Bartlett (ibid) they differ from conventional markets in one or more of three ways. In essence, these are that consumers are represented by agents; that not for profit organisations compete for contracts, and finally that consumer purchasing power is typically centralised in a single purchasing agency.

Additionally, as Le Grand and Bartlett (1994) argued,

“The fact that ... quasi – market changes appear to be part of a much bigger social phenomenon makes it certain that they are going to be a prominent feature of the British welfare state throughout the 1990’s”, (p11).

These social phenomenon are considered in detail later in this chapter, however, it is important to note that the quasi – market reforms in the British welfare state were part of a wider paradigm shift in how public sector resources should be allocated. Particular support for this paradigm shift emanated from the United States (Enthoven, 1985a; 1985b; 1991; Gaebler & Osbourne, 1992), and Glennerster and Le Grand (1994) contend that,

“Renewed interest in quasi – markets or market type behaviour in public administration was an international phenomenon” (p. 3).

Moreover, as demonstrated in Chapter 3, the “new public management” (Flynn 1993; Self 1993) provided the opportunity for applying a whole series of theories to quasi – markets (Forder, 1999). These have included developments of the Neoclassical paradigm, e.g. the so called Theory of quasi – markets (Le Grand & Bartlett 1993), and Contract Theory (Grossman & Hart, 1986; Milgrom & Roberts, 1990; Kreps, 1982, 1990). Furthermore, possibilities for applying theories have been extended to include New Institutional Economics (Simon, 1955; Cyert & March, 1963; Williamson, 1985; 1996), Relational Contracting (Dore, 1983; Sako, 1991; 1992), and Relationship Marketing (Kotler, 1994; Stone & Woodcock, 1995; Gray & Ghosh, 1999a; 1999b). Thus the market reforms have encouraged theoretical developments, and enabled cross – comparative evaluation of theories in terms of endogeneity of governance structures, their assumptions about human rationality, and the necessary conditions for the “success” of quasi – markets (Forder, 1999).

Additionally, over the last decade and running parallel to the development of the ‘new public management’, there has been “a major directional change in both marketing theory and practice”, (Morgan & Hunt, 1994). The extent of this shift has been described by Morgan and Hunt (ibid), citing Kotler (1991) as, “a genuine paradigm shift” (Morgan & Hunt, 1994, p. 20). This paradigm shift is towards relationship marketing (RM), the latter being considered in depth and justified as the most appropriate method for evaluating

NHS Trusts relational strategies in Chapter 2. However, in essence RM involves, “attracting, maintaining, and in multi – service organisations, enhancing customer relationships”, Berry (1983, p25).

The issue of quasi – markets also continues to be a contentious one. There is rigorous academic disagreement regarding why renewed interest in quasi – markets has arisen (Le Grand & Glennerster, 1993; Flynn, 1993; Self, 1993). Moreover, this disagreement is extended to include what the necessary conditions for quasi-markets success are (Le Grand & Bartlett, 1993; Forder, 1999). Lastly, considerable debate remains regarding the net benefits of quasi – markets (Appleby et al 1994; Ferlie, 1994; Le Grand & Bartlett, 1994; Propper, 1995a; 1995b; Patton, 1998; Whynes, 1995; Wistow et al 1996).

Within the public services, the encouragement of market type behaviour was considered an anathema by many professionals, especially in health care (Mooney, 1994). Whether national policy was successful in instilling market behaviour rather than simply market rhetoric (Propper 1992; 1994) will be returned to in Chapters 3, 5, 6 and 7. However, it is important to note that health professionals feelings were still negative towards market behaviour even at the dissolution of the NHS Internal Market. One of the Commissioning Managers of a district health authority interviewed for the current research commented, “some of the language of the market was absorbed, and more emphasis was given to competition and efficiency issues. However, the word ‘marketing’ remained a dirty word for many managers and clinicians alike”.

Lastly, in terms of contextual points, it is emphasised that the possibilities for eclectic research based upon economics and marketing has improved. The literature is increasingly highlighting synergies between these disciplines, rather than focusing upon some of the apparent contradictions (Soloman, 1992; Bleake & Ernst, 1993; Gray and Ghosh, 1999a; 1999b). Recent studies have evaluated the similarities in respect of key concepts (Doyle et al, 1996) and methodology (Morgan & Hunt, 1994) in the area of relational research. However, in terms of evaluating exchange relationships, it is recognised in Chapters 3, 4 and 5 that the interpretation of relevant concepts, and the nature of causal relationships differ between economics and marketing (Alderson, 1965; Solomon, 1992; Morgan & Hunt, 1994).

1.3 Aims and Objectives

1.3.1 Primary Aim

The primary aim of the current research is to identify the extent to which NHS Trust Hospitals in England, operating within the NHS Internal Market, deployed relationship building strategies with purchasing agents based upon relationship marketing principles. Moreover, the use of national postal survey questionnaires and supporting case studies enables an assessment of the extent to which specific types of purchasers, i.e. district health authorities and GP fundholders experienced relationship marketing strategies deployed by NHS Trusts.

It is perceived that the theoretical literature and applied research has tended to under emphasise the importance of relational behaviour within the NHS Internal Market. The limited theoretical consideration to date is understandable, given the predominance of Neoclassical economics in the evaluation of quasi – markets, particularly the so called Theory of quasi – markets developed by Le Grand & Bartlett (1993). A critique of their theory, as a basis for evaluating relational behaviour in quasi – markets is provided in the proceeding chapter, along with a critical review of alternative theories. However, at this juncture, it should be emphasised that the extent of relationship building behaviour by NHS Trusts within the NHS Internal Market has important implications in the context of the Theory of quasi – markets.

As the current research evidence will demonstrate, the operation of relationship marketing strategies has important implications for the nature of competition, risk, uncertainty, transaction costs and motivation in local health markets. These factors are deemed necessary conditions for quasi – markets to achieve their supposed benefits (Le Grand & Bartlett, 1993), i.e. greater efficiency, responsiveness, choice and equity relative to the former pre-1991 bureaucratic NHS. Thus from a theoretical perspective, evaluation of the degree to which NHS Trusts deployed relationship marketing strategies is readily justified.

Meanwhile, in respect of the applied literature, there has been a failure to systematically evaluate both the extent and determinants of relational behaviour in secondary health care

in the NHS Internal Market. This is driven by the general opinion among economists, critically evaluated in Chapters 2 and 3, that marketing behaviour was insignificant within the NHS quasi – market. This view is typified by Paton’s (1998), who perceived a “comparatively low priority that trusts have given to developing the marketing function within their unit”, (p 74). Furthermore, Paton (1998) identified that from the Health Authority perspective, the choice of contracting partner was determined in equal measure by cost, quality, existing patterns of contracting, and geographic location. No reference was made of the extent to which relational strategies influenced Health Authorities perspective. This view predominated, despite earlier evidence (evaluated in Chapter 3) from Ferlie and Pettigrew (1996), who used network analysis to demonstrate that relational strategies were highly likely to develop within the NHS Internal Market.

Subsequently, the current research systematically evaluates the extent to which NHS Trusts in England deployed relational strategies through the application of the relationship marketing paradigm (RM).

In addition, however, it is vital that the causal factors behind prevailing relational strategies are explained. Consequently, the current research uses two complementary research methods to explore these causal factors:

- a) The development of Logit models relating to specific relationship marketing strategies. These are contract augmentation; contract customisation; loyalty discounting; cost – sharing clauses; and lastly, default contracting. The analysis is based upon empirical estimates from the national NHS Trust postal survey.
- b) A series of supporting Case Studies enabling causal factors to be considered from both the NHS Trust, District Health Authority and GP fundholder perspective.

This approach enabled a critical comparison of the determinants of relationship marketing to be made, from the perspective of *a priori* reasoning, empirical analysis, and Case Study findings.

Furthermore, the justification for identifying the causal factors behind NHS Trusts relationship marketing strategies, should be seen in light of the dearth of studies

systematically evaluating the extent of relational behaviour within the NHS Internal Market posited above.

1.3.2 Secondary Aims and Objectives

In addition to identifying the extent to which NHS Trusts deployed relationship marketing (RM) strategies, and the causal factors behind this strategic behaviour, the current research has a number of related aims and objectives.

Firstly, the Case Study analysis is used to explore the role of trust and opportunism within the contracting process from the perspective of both English NHS Trusts and District Health Authorities. This was justifiable because contract theorists (Kreps, 1982; 1990), relational contract theorists (Dore, 1985; Sako, 1991; 1992; Fukuyama, 1995), and supporters of the RM paradigm (Casson, 1991; Kotler, 1994; Stone & Woodcock, 1995; Morgan & Hunt, 1994) demonstrated the importance of trust in shaping the pattern of governance. Furthermore, Sako (1992; 1992) emphasised that trust is, “an intangible capital asset which economises on the costs of bargaining, monitoring, insurance, and dispute settlement”, (p 450).

In order to systematically evaluate the nature of trust within the contracting process, Sako’s (1991; 1992) framework was adopted. This enables an evaluation of goodwill, contractual and competence trust, the former providing further indirect evidence of the extent of relationship marketing behaviour. Furthermore, this qualitative analysis provides insight into whether the local health economies studied through the Case Studies were principally based on Arms Length Contractual relations or Obligated Contractual relations. These concepts, developed by Sako (ibid), are useful in identifying the extent of success of national health policy objectives, given the 1989 White Paper attempted to develop a quasi – market based primarily on the Classical contracting model. The latter is similar conceptually to Sako’s (1991; 1992) model of Arms Length Contractual relations.

Additionally, the Case Studies allowed a qualitative evaluation of the negative aspects of NHS Trusts relationship marketing strategies. Whilst from a theoretical perspective, and on the basis of empirical evidence it is possible to intimate what the likely costs of such relational strategies are, it is important to provide direct evidence.

Lastly, it is intended to use the Case Study interviews, and also predictions based upon the Logit models to make some tentative predictions regarding the likelihood of relationship marketing strategies becoming more or less prevalent under the “new” co-operative NHS arrangements associated with the 1997 White Paper.

1.4. Defining Quasi – markets in Health Care

1.4.1 A Generic Definition

Quasi-markets in health care involve the separation of state finance from state provision of health care, and the introduction of competitive provision by independent agencies. A more detailed consideration of the nature of competition in quasi-markets in health care, and the nature of the resulting market is provided below. In brief, however, the central features of quasi – markets in health care are as follows:

- (i) A clear distinction between purchasers and providers
- (ii) An emphasis on perceived health needs rather than historical demand for health care
- (iii) An emphasis on the nature of the contractual relationship between purchasers and providers. As we will see, this raises significant academic debate regarding whether the relationship is modeled upon a transaction cost approach, a contract theory model, relational contracting, or as argued in this thesis, relationship marketing.
- (iv) The devolution of budgetary control away from Local District Health Authorities
- (v) An emphasis upon consumer choice (Le Grand, 1993; Hudson, 1994)
- (vi) An increasing focus upon inadequate economic frameworks within health care. This is perceived to result in perverse incentive mechanisms resulting in inefficiency (DoH, 1989),

“It has become increasingly clear that more needs to be done because of rising demand and an ever – widening range of treatments. It has also increasingly been recognised that simply injecting more and more money is, by itself, not the answer”

(pp 2-3, Working for Patients, DoH, 1989).

Whilst these key features of quasi-markets in health care are recognised by many authors (Bosanquet, 1986; Le Grand & Bartlett, 1993; Hudson, 1994), there remains no definitive definition of a quasi-market.

1.4.2 Theoretical Models

There were a whole series of theoretical models of quasi-markets suggested prior to the imposition of the NHS Internal Market in 1991. (Enthoven, 1985, 1991; Bosanquet, 1986; Butler & Pirrie, 1988; Bevan, 1988). Complete coverage of these competing models is beyond the scope of this section. However, it is appropriate to consider the original model identified by Enthoven (1985a), often cited as the architect of the quasi-market in the NHS (Tilley, 1993; Hudson, 1994).

Enthoven (1985a) stressed the primary reason justifying the development of an internal market in UK health care was the predominance of perverse incentive mechanisms within the existing NHS. In a letter to the author he stated,

“When I looked at the NHS I could see masses of perverse incentives”.

In particular, his aim was to improve efficiency at the point of delivery of health services (1985a; 1985b). In his famous Nuffield paper (1985a) he identified the following perverse incentives operating within the NHS:

- (i) Capital spending by District Health Authorities above £100,000 being controlled by Regional Health Authorities
- (ii) Limited capacity of hospitals to carry over financial reserves
- (iii) No right to sell District Health Authority assets without permission of the Regional Health Authority
- (iv) Medical staff employed/trained directly by the Department of Health and Regional Health Authorities, with staff pay and numbers being directly controlled by these authorities.

- (v) Regional Health Authorities acting paternalistically by providing land, equipment and buildings “free” to District Health Authorities.

More specifically, Enthoven (ibid) identified the following as significant problems within the bureaucratically organised pre- 1989 White Paper NHS.

Firstly, he focused upon power relations within the principal agent relationship between consultants and patients. Enthoven (1985a) was convinced that consultants used waiting lists as a means of maximising utility, because private patients would use their services to queue jump. Moreover, consultants refused to operate consultant diary schemes as in the US, whereby patients are treated in terms of a) the severity of their condition, but also b) the patients private time constraint. Within the NHS it was a case of waiting x amount of time given a particular patient had condition x, which is fundamentally at odds with the objective of improving consumer choice.

Additionally, Enthoven (1985a) argued that the GP structure was rigid. There was little incentive, according to Enthoven (ibid), to keep patients away from secondary care. The GP was being used as a cost filter to “weed out patients” not requiring secondary care.

There were also perceived failings in respect of managerial incentives. He sited the basic problem of all business organisations being the need to meet competitor’s quality standards and prices. Subsequently, he argued that there was no credible threat of job losses if the hospital managers did not meet these criteria, and furthermore, that it was politically impossible to close inefficient hospitals because of political embarrassment. Indeed, drawing upon his US Defence Industry experience, Enthoven (1985a) stressed that within bureaucratic organisations there are managerial benefits gained from inefficient practices. A Directly Marginal Unit, for example, might not get a new hospital ward unless there was an increase in hospital waiting lists! The following quotation re-emphasises the central argument,

“General: Mr Secretary, I am sorry to have to tell you this, but that \$m you gave us was spent on left shoes. Now we need another million for right shoes. We will both be embarrassed if you don’t give it to us” (1985a, p 62).

Finally, he stressed the significance of divisive performance indicators, calling for an improvement in the quality of managerial information. For example, costs per day per treatment fall as the length of hospitalisation increases; throughput of cases can be manipulated by an increase in non-essential admissions; and average costs can be reduced by increasing the number of admissions of emergency cases.

In summary, Enthoven's (1985a) proposed model aimed to increase efficiency through removing perverse incentives. Its key features, similar to alternative theoretical variants, were as follows:

- a. DHAs were to receive a *per capita* revenue
- b. DHAs would provide health services for resident patients
- c. DHAs would be compensated for treatment of patients from outside their health boundary on a standard price basis for emergencies, and negotiated prices for non-emergencies
- d. Consultants and GPs would contract with DHAs
- e. DHAs would have borrowing rights from the Department of Health at long run rates, and be able to retain reserves
- f. Directly Managed Units (DMUs) would be able to sell/buy assets to/from each other and DHAs.

1.4.3 Problems Associated with Generic Purchaser – Provider Models

A number of writers have identified a range of problems associated with all purchaser – provider models (Enthoven, 1991; Bevan, 1989; Hudson, 1994).

Foremost are matters relating to the dynamics of the model. Bevan (1989) stresses the significance of spare capacity within the internal market. Too little spare capacity results in limited levels of competition, and identifies the importance of measuring supply

elasticities within health care provision. Given the extent of asset specificity within health care treatment, e. g. regarding specialist laboratories, then low supply elasticities will be compounded by low capacity amongst providers. Meanwhile too much capacity results in inefficiency.

A related issue is the extent of market exit (Hirschman, 1970). Theoretically, providers can be forced out of business, implying hospital closures. Whether a large number of hospitals would be allowed to close is, according to Whynes (1993, p9) “a moot point”. In respect of economic theory, if exit were not permitted for political reasons then the internal market would not function efficiently in the long – run. Whynes (ibid) also highlights that the threat of closure, especially if perceived as a credible threat would result in inter-provider collusion given the latter would allow:

- (i) Risk spreading, for instance allowing surplus and excess capacity at different units within the consortium to be covered
- (ii) Increased bargaining power of purchasing agents
- (iii) Increased opportunities for scale economies, e.g. through bulk purchasing from suppliers; through joint data analysis and reductions in ex – ante transaction costs
- (iv) Contracting for a wider range of medical services.

Continuing to focus upon the dynamics of the model, US evidence suggests the importance of continuous quality improvement (CQI) to management processes (Enthoven, 1991). In particular, Enthoven (ibid) cites Dr Berwick of the Harvard Community Health Plan who identified the importance of:

- (a) Focusing upon the consumer’s needs and wants
- (b) The need to improve service quality, even if the latter cannot be easily defined in the context of health care (Drummond & Maynard, 1993; Gray, Harrison & Barlow, 1998)

- (c) Changing processes and their effects rather than effectiveness of specific human capital
- (d) Accepting that whilst an “optimum” cannot be identified it is vital to establish what represents movements away from it
- (e) The need to establish an “employees charter”, enabling them to identify and solve the problems within existing managerial processes. This is especially important in formerly bureaucratised systems.

The overriding emphasis was not upon the static allocation of scarce health resources but a process of continual enhancement in the efficiency of resource allocation.

Secondly, there is the distinction between the real dynamics of the model and the political rhetoric. Consumer sovereignty is a myth in a system where managers control the supply of health care, since choices are limited to certain contracted hospitals and services. Evidence from the US (Propper, 1994) emphasises the importance of “preferred provider” relationships with purchasers, which has had a limiting effect upon the extent of consumer choice.

A further generic problem relates to pricing and costing. If a Diagnosis Related Group (DRG) system is used, who sets the relevant prices? Does the central health authority impose them or are local DRGs used? Alternatively, are unit managers allowed to impose marginal cost pricing? Given the centrality of DRGs to purchaser – provider models, a number of technical problems should be identified. The most pertinent are as follows:

- (i) DRGs encourage the process of DRG “creep” whereby managers continually re - categorise care to gain higher levels of remuneration
- (ii) If DRG remuneration is fixed there is the opportunity for unit managers to increase the volume of treatments, which with fixed funding implies that, for example, the length of stay is reduced. This may ultimately affect the quality of patient life

- (iii) Typically, DRGs do not include full costing associated with patient care. In particular, they do not include out patient care costs, the latter being significant with respect to specific diseases, e.g. Rheumatoid Arthritis (Gray, Harrison & Barlow, 1998). Furthermore, they typically do not include physicians costs (Bevan, 1989)
- (iv) The informational requirements are extensive. Enthoven (1991) identifies the need for longitudinal data on patient outcomes in order to establish patients long term reaction to specific treatments. He cites the US where consumer oriented groups, e.g. the Rand Corporation (Health Insurance Experiment) was used as a pilot study to the imposition of DRGs focusing upon key measures of consumer satisfaction. These included the accessibility of follow up stages in the episode of care, and the levels of re - infection in particular diseases.

The final concern amongst commentators regarding generic purchaser – provider models relates to more general information requirements. A number of those relating to costing and prices have already been considered above. Meanwhile, Enthoven (1991) stressed the need for hospital units to share cost data, at fine levels of definition, including elements relating to intermediate products such as urinological testing as well as final output costs relating to secondary care. As argued below, in reality management's focus within the NHS was upon providing that cost data which the Department of Health required legally as part of Trust status rather than that which would increase the Sector's efficiency. Indeed, this has proved to be a problematic and resource intensive activity. Moreover, it seems reasonable to assume that management would in any case be reluctant to share detailed costing data because of its competitive nature within an internal health market. Superior technical knowledge reflected in lower costs identifies the essence of hospital's competitive advantage. Notably, however, evidence from the current research will demonstrate in Chapter 5 and 6 that NHS Trusts and District Health Authorities often engaged in sharing potentially competitive data relating to contracting.

Finally, in respect of informational problems, a number of writers have called for detailed analysis of risk adjusted measures for the outcome of treatments. These would be similar to perinatal mortality data (Enthoven, 1991). The intention would then be to publish these statistics in "league tables" for different hospital units to increase patients access to

information. Clearly, these informational requirements are exhaustive, and there is the problem of the bounded rationality of patients. There is also the question of the political will of ministers to support such league tables given the potential public response to adverse statistics. Presumably, Drs may also be reluctant to see detailed risk adjusted figures on the success of treatments. As Adam Smith said in *Lectures in Jurisprudence* (1776, quoted in Gaynor, 1994, p 120)

“A physician’s character is injured when we endeavour to persuade the world he kills his patients instead of curing them, for by such a report he loses his business”.

Notably, the election of the Labour Government in May 1997 has resulted in increasing emphasis upon the use of health league tables, with growing emphasis on the provision of health outcome data.

1.4.4. Defining the Market in Health Care: Some Wider Issues

So far we have focused on defining quasi – markets in health care, and considered the problems associated with purchaser – provider models. However, to gain deeper insight into quasi – markets in health care we must focus upon the fundamental question “what is a market in health care?” In particular, we focus upon what orthodox economics defines as a market, and compare this with the realities of markets in health care provision.

The general equilibrium theories of Alfred Marshall (1920) and Leon Walras (1954) explained the allocation of scarce resources in terms of the free interaction of demand and supply. Consumers attempt to maximise utility by equating marginal utility with the price of a good or service, whilst producers seek to maximise profits by equating costs and revenue at the margin. Whilst the principal competing general equilibrium theories differ in their composition, for example regarding whether they make explicit the relationship between costs and supply, they all emphasise the existence of constant returns to scale.

Neo-classical extensions of these theories have focused on the relationship between the market, and the individual firm. This is an issue given more thorough consideration when analysing the significance of transaction costs in quasi-markets. Of more importance here

is the identification of just what a market is in health care, and the relevance of the general equilibrium approach outlined above.

The first pertinent question is, “a market for what?” Health care products are highly differentiated in terms of who receives the benefits of treatment, how treatment is delivered, who delivers the treatment, and the different health needs being satisfied. Moreover, it is argued that there is no definitive single product, but a whole range of related and inter-dependant products, where consumption is often not a one off event but a series of treatments. For example, a care episode may involve seeing a family doctor, then a consultant, a general surgeon, and finally a number of out - patient visits. Furthermore, the benefits of improving health are not consumed instantaneously at one point in time, but are spread out perhaps over many decades.

Clearly this bears little relationship to the homogeneous products of general equilibrium theory which are consumed instantaneously. Moreover, the nature of some sub-products in health care, e.g. the surgical stage of cataract treatment allows the possibility of increasing returns to scale. More generally, Harrison and Prentice (1994) site evidence regarding the possibility of reaching minimum efficient scale in acute emergency services providing there is a catchment area of around 2 million people. This would suggest the existence of natural monopoly in acute emergency services, and precludes the possibility of contestability. Additionally, application of Penrose (1959) theory of the “learning firm” would also refute the existence of constant returns to scale, and provide an interesting application to health care analysis. Penrose (ibid) emphasised that firms produce products and knowledge jointly. Knowledge increases the potential capacity of the firm without limit, based on economies of expansion and the more traditional scale economies. The former are the consequence of experimentation and innovation in the production process. This theory may in part explain the increasing expansion, specialisation, and innovation within Acute type NHS Hospital Trusts.

The second and related question is “who is in the market?” From the treatment examples given above, it is clear that health care produces many intermediate products, which may be sold to different parties (although the final output is not sold). Many commentators (Drummond & Maynard, 1993; Harrison & Prentice, 1994) argue that the general equilibrium approach is inappropriate because the final output of health care systems can

be as nebulous as the good health of the nation, i.e. that there is no market equilibrium as a reference point.

However, in defence of the orthodox economic approach, it should be stated that such a reference point could be established in non-clinical areas, e.g. through competitive tendering of cleaning and launderette services in hospitals. Furthermore, it may be possible to establish markets with an end output at each intermediate stage within an episode of patient care.

A further feature of health care products, highlighting the limited relevance of general equilibrium theory, is joint products. In respect of non-primary care, treatments are often comprised of inputs from research, teaching and physical care. Moreover, cost minimisation of one joint input in pursuit of maximising profit will have a knock-on effect on other joint inputs. For example, minimising the cost of physical care may reduce the opportunity for research, the latter representing a long - term investment.

Additionally, it is worth focusing upon the role of signalling in resource allocation. In general equilibrium theory price acts as the signal for resource allocation. Even assuming health care markets were entirely dominated by private markets, there is good reason to believe that price would not be the best signal to resource allocation. As Penrose (1959) argued price is not the key signal regarding the true opportunity cost of resources to society. In a private market for health care this is because the price of treatments would reflect combinations of inputs and different production processes which would vary between different health care providers. Thus the value of resources would not be equalised across all health care providers (as general equilibrium theory predicts) through a process of competition. The principal reason for this is the importance of asset specificity, which may be especially significant in health care, e.g. in terms of consultancy practice in rare disorders, or capital equipment such as CAT scanners.

Moreover, as evidence presented in Chapter 5 suggests, District Health Authorities typically identified non-price competitive factors as more significant than price in determining the selection of exchange partners.

Finally, general equilibrium theory can be criticised in the health context because it assumes perfect knowledge. On the supply side of the market, Penrose's (1959) work provides some useful insights in the context of health care. She sees the firm as a team with boundaries, based on the assumption that one individual cannot carry out all the necessary tasks towards final output, i.e. the individuals suffer from bounded rationality. This is obviously true regarding continuing episodes of care, for example in terms of the treatment of cancer patients. Moreover, not all objectives from clinical interventions can be achieved at once: patient's treatment is typically confirmed by clinics to be a "continuing episode of care" (Mooney, 1994).

Meanwhile on the demand side it is clear that asymmetry in information is a central problem, emphasising the need for agency relationships in many areas, e.g. the relationship between patient and GP, and provider organisations and health care purchasers including DHAs. The principal arguments and difficulties raised by this information asymmetry is considered in more detail below.

1.5 The Reform of NHS Health Care in the UK: Overview of Reforms and Rationale

This section begins with a brief overview of the actual purchaser – provider model selected by the UK government.

On the supply side Government created separate legal entities, i.e. Trust Hospitals out of Directly Managed Units (DMUs), the latter remaining within the District Health Authority's control. Trusts were given the powers to manage state owned assets, and compete with other NHS Trusts and DMUs in the provision of secondary primary health care. As Propper states (1995, p.1683)

"Essentially, health service providers in the public sector changed from being of the departmental administration form to free-standing entities with borrowing rights from central government".

Meanwhile, on the demand side, purchasing authorities were established replacing local authorities who had been responsible for delivery of secondary health care services. Two groups of purchasers were established by the reforms, i.e. District Health Authorities

(DHAs), and General Practice Fundholders (GPFHs). Whilst a detailed structural analysis of the reforms is to be found in Drummond and Maynard (1993), it is vital here that we consider the rationale for marketisation.

1.5.1 The Ideological Context: an Overview

In defining the NHS Internal Market it is essential to consider the ideological context behind its development. In essence the question to be answered is why was it introduced in the UK?

A detailed consideration of this question is provided by a number of writers (Flynn, 1993; Self, 1993; Glennerster & Le Grand, 1994). This section aims to critically consider the most pertinent arguments relevant to the 1989 NHS reforms. However, there are two initial points to note. Firstly, quasi-markets are neither a new concept, or unique to the UK. In respect of the latter, Glennerster and Le Grand (1994) stated,

“Renewed interest in quasi-markets or market type mechanisms in public administration was an international phenomenon” (1994, p7).

Evidence of this is the proliferation of literature published in English considering the quasi-market in health care in other European countries, especially Holland and Italy (see for example numerous papers by the University of York, Centre for Health Economics).

There is also clear evidence that it is not a new phenomenon for the UK. Victorian governments provided part funding and regulation of Church Schools under the 1870 Education Act, and similarly provided part financing of mental health care in the late 19th Century.

Meanwhile, Hudson (1992) stressed that quasi –markets in health care were not “plucked out of the air” and bolted onto the bureaucratic planning model associated with the pre-1989 White Paper reforms. Rather, marketisation was built upon a number of initiatives, which had already heralded the move away from welfare towards markets in state health care. The most influential of these was the Griffith Report of 1983, i.e. the NHS Enquiry

Report, which highlighted the following weaknesses of the NHS bureaucratic planning structure (Barrett & McMahon, 1990):

- (i) The NHS lacked systematic measurement of outputs and evaluative performance measures
- (ii) There was a need for clearer statement of management's objectives so that outputs could be compared with objectives and budgetary performance
- (iii) The need to focus more upon relationship building within the NHS, including the identification of patients needs and expectations. One fundamental necessary condition for achieving the latter was developing managers and clinicians awareness of patients as consumers.
- (iv) The requirement for clear managerial roles at hospital unit level, District level and Regional level

These recommendations were built upon by the establishment of the NHS Management Board in 1985 designed to provide an appropriate organisational environment for efficiency gains in personnel planning and financing. Other pre NHS Internal Market reforms included the hospital's Resource Management Initiative (RMI) focusing upon the costing of activities to raise financial awareness within the NHS, and the development of 'cost improvement programmes' which had to be built into DHAs short-term annual planning statements from 1984/85 onwards.

1.5.2 The Ideological Context: the Central Arguments for Quasi-market Reforms

One of the fundamental arguments for the development of quasi-markets is the rolling back of the state associated with Government of Margaret Thatcher. Glennerster and Le Grand (1998) argued there was a clear emphasis upon the centrality of the free market and individual choice within Thatcherism, building upon the arguments of Hayek (1979). Moreover, there was increasing emphasis on both sides of the Atlantic upon the role of innovation and entrepreneurship within welfare systems (Gaebler & Osborne, 1992)

“The state must not only be smaller, but different; it must become market oriented and fired by the spirit of entrepreneurship”, (p 3).

A principal mechanism for achieving this objective was the process of “opting out”. In the UK this included the Local Management of the Schools scheme under the Local Government Act of 1988, and of more relevance the development of NHS Trust status hospitals funded directly by the Department of Health, and based on formula funding.

However, there are a number of problems with this argument. Firstly, it may be argued that the *raison d'être* for quasi-markets is not related to the extent of Government, using the levels of State funding as proxy measure for the size of government. It is more importantly to do with the physical organisation of government, the levels of economic efficiency, and the nature of incentive mechanisms (Bartlett, 1991).

More obviously, it may be questioned why, if rolling back the state was so central to Thatcherite ideology, did the Conservative government wait until 1988 to establish appropriate conditions for the operation of quasi-markets in the public sector?

Furthermore, Glennerster and Le Grand (1994) emphasised that the “rolling back of the frontiers of the state” during the 1980’s was also associated with Left and Centrist governments in Europe. In support of this view they cited a series of policies including GP Fundholding, vouchers for pre-school education, and loans for undergraduates. Many of these policies were perceived to be unique ideological attributes of Thatcherism (Glennerster & Le Grand, 1994).

A related ideological argument is that the development of quasi-markets in health care would reduce bureaucratic power. For example, in the context of NHS Trust Hospitals the DHA is removed from having financial control over the individual hospital unit. This has important implications for bureaucrats themselves, accepting the Public Choice theory tradition, whereby these agents are aiming to maximise utility by maximising budgetary spending (see Buchanan, 1989; Downes, 1957; Niskanen, 1968). Significantly, however, evidence suggests that the number of bureaucrats (using administrators as a proxy measure) increased by 4600 to bring the NHS total to 13000 during the two years period prior to the imposition of the White Paper reforms!

Moreover, Glennerster and Le Grand (1994) questioned whether bureaucrats were passive, simply accepting the impact of quasi-market reforms on their utility functions. The basis of “naive” Public Choice theory would suggest that *de facto*, budget maximising bureaucrats would suffer a loss in utility with a loss in budgetary control associated with financial devolution towards NHS Trust hospitals. They argued that bureaucrats are more inclined to budget shape rather than budget - maximise. This in turn implies that the impact of quasi-market reforms on bureaucrat’s utility will be lessened and is congruent with the theory of non-profit institutions relating to hospitals (Newhouse, 1986). In the latter’s model, the bureaucrats in non-profit hospitals shape the objectives of the organisation through control of boards of trustees.

Perhaps the most often cited reason for the marketisation of health care, as briefly referred to above, is the desire to reduce overall spending in health care (Propper, 1995). This is principally to reduce the fiscal pressures arising from two sources. These are, firstly, the rapid and undiminishing growth in the demand for health care services (Glennerster, Le Grand, 1994), and secondly, the argument that the macroeconomy is not growing sufficiently to support rising real spending in the health area (Self, 1993; Connolly & Munro, 1999).

We have already argued, citing Bartlett (1991), that this argument is spurious because of the emphasis of quasi-market reform being efficiency gains and changes in physical organisation rather than being related to reducing real spending in the health programme area. Additionally, the contracting procedure which the NHS Internal Market was built upon has its own associated costs. Contracting incurs costs associated with the initial bargaining stage, exchange of contract stage, and post treatment stage where disagreements have arisen regarding whether the contract has been fulfilled, and whether the quality was of the requisite standard. Glennerster and Le Grand (1994) cites Government estimates that between the imposition of the 1989 White Paper’s proposals and the last quarter of 1994 above, the NHS incurred £400m additional costs which must be included in any cost-benefit assessment of the net gains of health reforms.

Furthermore, although the Conservative Government’s November 1995 budget announced the intention to lever in private investment to the NHS via the Private Finance Initiative (PFI), which has been considerably extended by the 1997 Labour Government,

the latter administration still continues its commitment to funding the NHS through general taxation.

It is also noted (Hudson, 1994) that in Europe, where more pluralistic purchaser-provider models were in operation before the UK's, cost containment proved difficult. Indeed, according to Hudson (ibid), groups of purchasers and providers were successful in organising pressure groups to lobby against funding cuts.

Two final arguments remain. Firstly, *de facto*, quasi-markets in health care are more consumer choice oriented than planning bureaucracies (Saltman & von Otter, 1992). Secondly, the “villain view” that quasi-market reforms represent one means of undermining, i.e. replacing the welfare state through privatisation of welfare by stealth.

In summary, Saltman and von Otter (ibid) argued that

- (i) There is a high voter preference for education and health services (with demand being highly income elastic)
- (ii) Voter's preferences reflect the importance they place upon free and equitable access
- (iii) Voters resist tax increases to fund high quality services and maintenance of equitable/free at the point of use services

The focus on consumer sovereignty would seem an appropriate response to the emergence of more sophisticated health consumers. However, as considered in section 1.4.4 above, there are numerous conceptual and theoretical difficulties associated with the act of consumption of health care within a quasi-market.

Finally, in this section, we shall consider the “villain view”. As Glennerster and Le Grand (1994) argued, quasi - markets might be a short - term solution to a long - term objective of privatising the NHS. It represents one means of marginalising purely state funded/provided health services to the use of “the very poor; very old; and the very sick” (p17). Ironically, as will be seen, Enthoven (1985a; 1985b) had emphasised that his proposed reforms were market socialism rather

than privatisation. Moreover, as Enthoven, (1985b) stressed one of the prime aims of his proposed reforms was to reduce waiting list times for non-emergency treatment. This actually poses a competitive threat to private health care providers who have developed a market niche with patients wishing to queue - jump on the basis of their relatively high marginal valuation of time.

1.5.3 The Central Economic Arguments for Market Reforms in State Health Care

1.5.3.1 Efficiency

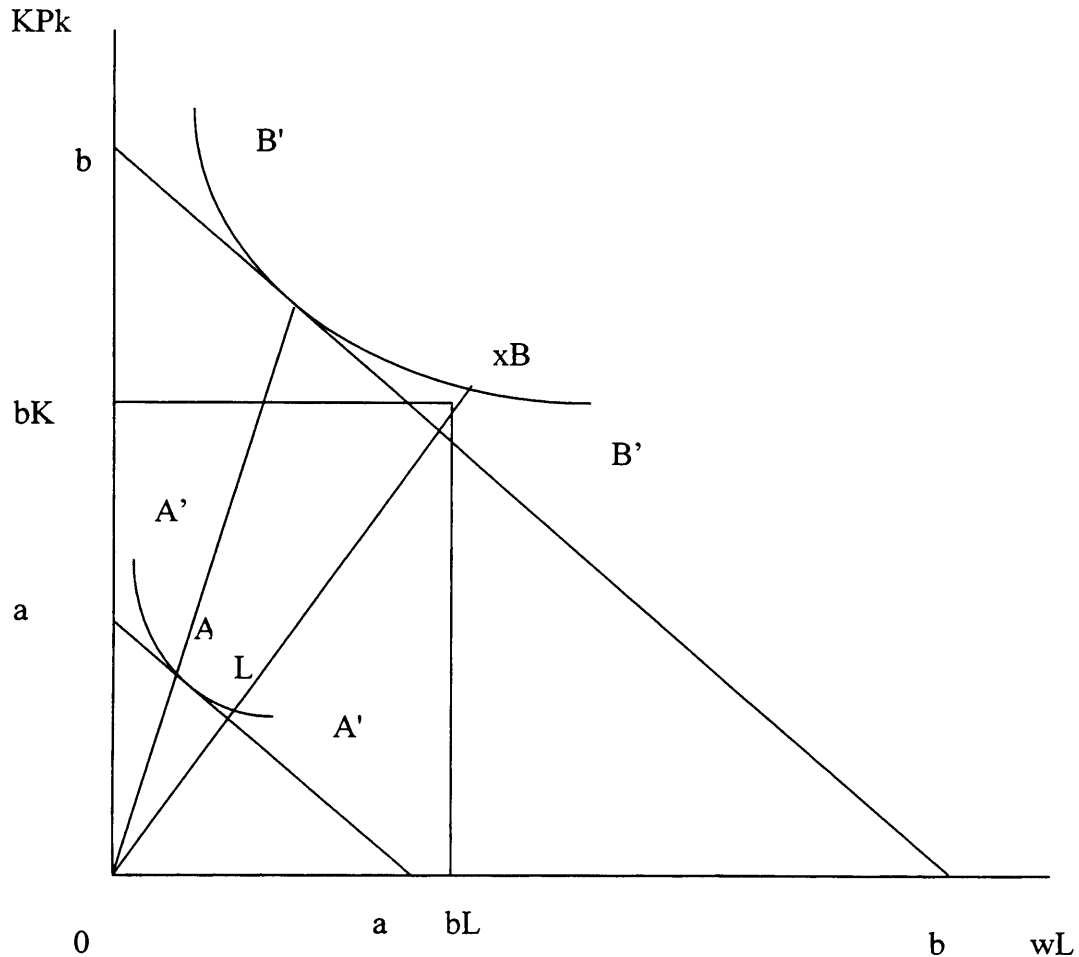
The first argument for marketisation is that encouraging competition in health care services will increase efficiency. It is vital here that researchers recognise the significance of different definitions of “efficiency” in the context of health care. Generally, health economists distinguish between “crude” and productive efficiency measures, the former identifying minimum total expenditure but making no reference to the quality of service provision. Meanwhile, the latter relates quantity, and quality to the cost of service provision.

It is, however, vital to make a more detailed analysis of the meaning of efficiency, traditional economics distinguishing between technical, allocative, and scale efficiency.

Relative technical efficiency would imply that, for example, Trust hospitals have a production function which for every possible ratio of factor prices requires lesser amounts of factor inputs to generate one unit of output than a Directly Managed Unit (DMU). Meanwhile, relative allocative efficiency would occur if for an NHS Trust, it selects its minimum cost combination of factor inputs for a given set of prices, whilst for example, a competing NHS Trust does not. Finally, an NHS Trust would enjoy relative scale efficiency if it selects the optimal (least cost) scale of production whilst, for example, a DMU did not.

Assuming constant returns to scale, and perfect knowledge of the most efficient production function, technical and allocative efficiency can be separately identified as in the following figure:

Figure 1.1 Relative Technical and Allocative Efficiency of NHS Trusts Using Isoquant Analysis



Where KPk represents capital inputs, increasing away from the origin, wL represents labour inputs increasing away from the origin; aa bb represents the isocost lines facing two hospital units, i.e. A and B respectively. The slope of these isocosts reflects the relative price of factor inputs.

If as assumed hospital units A and B know the most efficient production functions then there is an isoquant $B'B'$ of the same family $A'A'$. If unit B were at point x_B there is allocative inefficiency, but no difference in relative technical efficiency. If, however, hospital unit B represents a competitively disadvantaged DMU, and A is a competitively advantaged NHS Trust (because of better quality technical knowledge acquired through relationship building with the

local DHA, for example), then B will not be operating on B'B' at all. Thus for example unit B employs b_L , b_K to produce o_L target output. It is clear from the above analysis that:

- (i) The ratio OL/OB represents the relative technical efficiency of hospital unit A compared to hospital unit B (assuming unit B does operate on isoquant B'B')
- (ii) The ratio OA/OL represents the relative allocative efficiency
- (iii) Overall, relative efficiency is given by the product of these, i.e. OA/OB .

Potential differences in capital productivity between hospital units A and B could reflect relative technical efficiency, and/or relative allocative efficiency.

The principal difficulty with this analysis is that the information requirements are exhaustive. Information on relative prices of factor inputs is not readily available, and more importantly, in order to construct the isoquant of the more efficient hospital unit (unit A) would require precise estimation of the production function for A.

Furthermore, these difficulties would be magnified in attempting to estimate efficiency ratios on average across a cross-section of Directly Managed Units for example, compared to a matched cross-section of NHS Trust Hospitals.

Mooney (1994) questions whether economists sufficiently understand the internal behaviour of health organisations to accurately estimate their production functions, or additionally estimate the utility functions of clinicians. He sees the latter as vital if economists are to identify how perverse efficiency incentives within the NHS can be identified, and reduced/removed. The over-riding difficulty according to Mooney in this area is the lack of information on costs at anything but the organisational level (*ibid*, p 156).

In addition to the above analysis researchers should recognise the need to estimate social efficiency or global efficiency (Brazier et al, 1993). This involves identifying the allocative efficiency of resources used in health care compared to other programme spending areas in the public domain, e.g. education, defence, and social services.

Moreover, it is recognised that in a tax financed system such as the NHS it is ultimately a political decision determining the most efficient relative allocation of resources between spending areas.

A number of researchers (Williams, 1989; Culyer, 1989) have focused upon the relationship between economic efficiency and medical ethics. In particular they refer to the so - called “myth” of the bioengineering approach to resource allocation within the NHS. According to Culyer (ibid) the predominant view in the NHS has been:

- (a.) Public health spending should be driven by need
- (b.) Needs should be determined by health professionals
- (c.) Resource allocation decisions have been “captured” by clinicians

He argued that this means key economic questions have been ignored. These would include, for example, “is the marginal product of health per £ spent positive or negative?” and “is the marginal product in different health areas different?”

Moreover, agreeing with Williams (1989), Culyer (1989) argued that efficiency and medical ethics are inextricably linked. Whilst clinicians would identify that their principal aims are to deal justly with patients, and do no harm, these actions have clear economic consequences and related welfare consequences for patients if the link between ethical behaviour and efficiency is ignored. Of course clinicians may not recognise this link simply because of the bounded rationality identified by Simon (1962), and emphasised by Williamson (1985). Their behaviour may not be related to opportunistic behaviour in any way, but reflect their lack of relative information or inability to process it.

Williams (1989) argued for example, that using resources wastefully clearly reduces the welfare of some patients, and dealing “justly” with patients implicitly assumes the recognition of opportunity costs involved in medical treatment.

It should be noted, however, that clinicians have recognised that absolute clinical freedom has never been possible, and that the imposition of medical ethics necessarily has important resource implications,

‘There is no such thing as clinical freedom, nor has there ever been. Nor for that matter should there be’,

(R. Hoffenberg, President of the Royal College of Physicians, quoted by Williams, 1989, p 16).

At this juncture, it should be stated that the difficulties in practice with defining and measuring resource efficiency in the health sector has led to a focus upon cost – effectiveness analysis. This indicates the relationship between target output and the least cost method of production. In the context of health care it involves maximising the benefit to patients at a specific treatment cost or achieves a target level of benefit to the patient at the minimum treatment cost.

Brazier et al (1993) identifies two broad approaches adopted by researchers. Firstly, the “welfarist” approach, and secondly the “extra - welfarist” approach. The former assumes that the patient is the best judge of her welfare and uses willingness to pay (or phantom prices) to identify health needs. Cost effectiveness of specific treatments or providers is then measured in terms of profitability; the more profitable a provider, the more cost effective it is. A crucial implication of this is that the system does not require complex and costly information systems such as Diagnosis Related Group methods, which identifies the effectiveness of specific treatments for different groups of patients and then compares the benefits of treating different patient groups. The latter is necessary for the extra-welfarist approach, which is based on a principal – agent relationship between the clinician and the patient.

Lastly in this section, it is apparent that the issue of efficiency measurement in welfare services is extremely contentious. According to Le Grand and Bartlett (1993), “The idea that the criterion of efficiency be applied to the provision of welfare services is an anathema”. Furthermore, they argue that this view remains so predominant amongst health care managers, health professionals and academic researchers that the direction of research in this field is constrained, and the resulting analysis value laden.

1.5.3.2 Responsiveness

The second case for marketisation is to increase the responsiveness of health care to users demands. The Government White Paper “Working for Patients”, (DOH, 1989b, p 3-4) states,

“The reforms are intended to give patients better health care and provide rewards for those working in the NHS who successfully respond to local needs and preferences”.

Implicitly, the desire for increased responsiveness is founded in acceptance of Public Choice theory, best associated with Buchanan (1989). The principal tenet of this theory is that political collective decisions have negative external effects, generated by the pursuit of self - interest by politicians, and bureaucrats whose objective functions differ from those of other agents in society.

In the context of health care, supporters would argue that administrators within a bureaucratic, hierarchical planned NHS system attempted to maximise an objective function, which was in conflict with those of patients, health care professionals and politicians. Furthermore, administrator’s attempts to maximise utility resulted in allocative inefficiency. More particularly, such behaviour resulted in the wrong mix of health care outputs, which meant global output was below that technically feasible given the scale of resource input to the NHS. The latter is especially significant in the face of the ever - increasing demand for medical services in the UK (Drummond & Maynard, 1993; Connolly & Munro, 1999).

The lack of responsiveness of health care bureaucrats to the needs of patients is clearly related to the lack of appropriate incentives within a hierarchical planned system of provision. The existence of dynamic and X-inefficiency (Liebenstein, 1966) implies that there is no residual from economic activity, which in turn implies the non-existence of entrepreneurship. The implications of this view, particularly for relationship building within a quasi – market are considered further in Chapter 2.

15.3.3 Patient Choice and Access

The third argument in favour of marketisation of health care services is that it will improve choice, and access for patients. Working for Patients (DoH,1989b, p3) claimed reforms would provide, “greater choice of services available”. The latter should be considered in the context of the New Right’s general emphasis on individual’s rights for improved choice of welfare services (Flynn, 1994). However, there are a number of key difficulties regarding the evaluation of choice in this context: firstly, greater choice for whom? Is the emphasis on purchasers, providers or the ultimate users of health care services? Secondly, does increased choice represent a goal in itself, or is it a facilitator for other objectives, e.g. improved equity, efficiency or access?

Moreover, it should recognise that greater choice can be given to patients by means other than encouraging competitive forces in health care. One alternative is so called “voice” mechanisms. These can take a number of different forms including suggestions/complaints systems; the establishment of collective pressure groups; insisting on all-party membership of hospital boards; or finally, as has occurred in the UK, the formulation of a Patients Charter. Opinion and constitutional rights can then direct resources towards the areas of perceived greatest need.

It is also important to note that if increased competition within the NHS was intended to increase patient’s choices then it required the transition towards “consumerism” among patients. Commentators have argued (Hibbard & Weeks, 1989) that the patient role is based on trust, compliance, dependence and passive behaviour within the principal – agent relationship with their GP or clinician.

Moreover, there are a number of specific problems in developing such consumerism. Firstly, there is a lack of research in the pertinent area. As Hibbard & Weeks (ibid) argued, “while there is general recognition of the need for access to information, there is almost no empirical evidence on if and how consumers use information in making health care decisions”, (p 159).

Additionally, it is argued that consumers must become more pro-active within the principal – agent relationship. However, consumers (i.e. patients) typically assume that

GPs will process information to provide specific outcomes, i.e. diagnosis, treatment etc in the same way that a patient would with their own career related technical knowledge. However, it is argued that GPs knowledge is not perfect, is probabilistic, and according to some research (Mooney, 1993), class and gender biased. In other words there are considerations relating to the competence not just of consumers in maximising the potential benefits from increased choice, but also the technical competence and ethics of clinicians.

A related concept to choice is the accessibility services: having a wide range of potential treatments is of limited merit unless the patient has ready access to these alternatives. There are a range of issues to be considered here including the following:

- a) The costs associated with increased accessibility. The net benefits of enabling purchasers to send patients across DHA boundaries must clearly reflect the physical costs, e.g. the transport costs incurred by the patient. In addition, some estimate of opportunity cost should be made, e.g. reflecting foregone earnings for the self - employed, and also un - priced value elements including the ability of in-patients to receive visitors. The latter in turn affects recuperation rates from surgery.
- b) When assessing accessibility researchers should allow for different rates of utilisation by patients reflecting different types of treatment. Harrison and Prentice (1994) cited evidence that utilisation is higher, for example, for in-patient care than out - patient care, and is inversely correlated with the distance travelled to the treatment location.
- c) The significance of access also depends on the acuteness of the illness. The health economics literature often refers to “the golden hour” in the context of acute emergency treatment. In-patients prospects for recovery are statistically greatly improved if emergency treatment is received within one hour of being taken ill (Harrison and Prentice, *ibid*).

1.5.3.4 Equity

The final rationale for marketisation is the aim of improving equity in health care provision. *Caring for People* (DoH, 1989a, p5) stated that resources should, “concentrate on those with the greatest need”. This perspective was further underlined by the then Prime Minister’s forward to *Working for Patients* (DoH, 1989b) which emphasised the importance of open access and prioritisation on the basis of need rather than ability to pay.

Furthermore, Tilley (1993) cites US evidence relating to marketisation of health care as raising important issues regarding equity objectives. Indeed, its importance was recognised by the UK government’s Social Services Committee (1989, No. 5)

“The House of Commons Social Services Committee noted that evidence from the USA suggested that markets are good for hospitals but bad for patients unless closely monitored. The proposal to establish National Health Service Trusts to compete with Directly Managed Units as producers of health care would give rise to considerable ‘gaming’”, (p 37).

The identification of need is problematic in the area of health care, the debate best developed in the context of QALYs, i.e. quality of life indices (Drummond & Maynard, 1993).

There are additional problems caused because the White Papers referred to above do not explicitly define equity or “need”. Equity is generally defined as fairness and should not be confused with equality. Moreover, in the context of health care it is especially important to distinguish between horizontal equity, based on equal treatment of patients with equal need, and vertical equity based on unequal treatment of unequal individuals in terms of ranking health status (Jackson & Brown, 1987).

Moreover, there exist a whole series of technical problems relating to equity, firstly, in terms of population characteristics. These include the geographic focus, age profiling, care group focus and socio-economic groups under investigation. Furthermore, there are considerable problems in defining just what it is that should be equitably distributed

(Mooney, 1994). More specifically, should it be access to services, utilisation rates for services, improvements in the quality of health status, or spending per capita?

1.5.3.5 Conclusion Regarding the Economic Arguments for Market Reforms

In concluding this section, it should be emphasised that although economists and other interested commentators have defined a set of objectives for marketisation of health care, particularly gains in efficiency, equity, accessibility and responsiveness, these may have been selected arbitrarily. Tilley (1993) stressed that the architects of the Government's 1989 White Paper were less specific about the reform's objectives, i.e.

“Ministers have gone on record as saying that the success of the reforms will be that in 5 years time the NHS will look very different from how it looks now. It is not so much what the differences will be that interests ministers but rather the fact that there will be differences”, (p 40).

This view is further examined by Bevan et al (1988). They argued that the strength of specific belief systems has shaped reform in the NHS. In particular Bevan et al (ibid) contended that policy maker's belief in the free market related closely to patients beliefs about how to improve their health status,

“Just as victims of cancer, when conventional treatments offer no hope, turn to nostrums, so policy makers have turned to ‘free enterprise’, competition and the profit motive – rhetorical symbols which give great comfort. The belief in efficiency stems not from the evidence which as always points both ways, but from the acutely felt need for a solution”, (Bevan et al, 1988, p 4).

1.6 The Primary Aim of the Current Research: A Restatement

Having set the context for the current research, identified in detail the principal research aims and related objectives, and evaluated the arguments seeking to explain the imposition of the NHS Internal Market, it is vital to restate the central hypothesis to be tested by the current research. The current research seeks to test the hypothesis H_1 , i.e. that the extent of relationship marketing behaviour by NHS Trusts within the NHS

Internal Market has been under - estimated, with the subsequent need to identify the determinants of such relationship marketing behaviour.

Meanwhile, the null hypothesis, i.e. H_0 , is that the extent of relationship marketing behaviour by NHS Trusts within the NHS Internal Market has not been under estimated, such that there is little justification for evaluating the causal factors behind NHS Trusts relationship marketing strategies.

1.7 Summary of the Structure and Contents of the Remaining Chapters

This section outlines the structure and contents of the study's remaining chapters.

Chapter 2 explains and then critically assesses the relevance of the predominant Theory of quasi – markets (Le Grand & Bartlett, 1993) to an evaluation of NHS Trusts relational strategies within the NHS Internal Market. In order to achieve this objective, the analysis draws upon literature on New Institutional Economics, Contract Theory, and Relational Contracting. In addition, this chapter introduces and then justifies the selection of the relationship marketing paradigm as the most appropriate for investigating the extent of, and determinants of NHS Trusts relational strategies. Whilst the RM paradigm is identified as the preferred paradigm, a number of important caveats are considered.

Meanwhile, the literature review is continued in Chapter 3 which provides a critical assessment of how the Theory of quasi – markets, and competing theories, have been applied to evaluate the purchaser – provider relationship within the NHS Internal Market. The chapter evaluates studies based upon Neoclassical economics, the Transformational literature, Relational Contracting, the New Industrial Sociology, and the Relationship Marketing paradigm.

The research continues with Chapter 4, which identifies the research methodology adopted by the current research. Justification is provided for the use of a joint methodology; the use of, and selection criteria used for the Case Studies; the sampling criteria used for the national postal surveys; questionnaire design and timing of the postal surveys, and the selection of statistical techniques to analyse the resulting data. Throughout the chapter, the caveats associated with the adopted methodology are thoroughly considered.

Chapter 5 presents the comparative findings from the national postal survey of NHS Trusts and District Health Authorities in England. The results are presented in respect of four of the cornerstones of RM strategies identified by Stone and Woodcock (1995), i.e. contract augmentation, contract customisation, market segmentation and direct communications strategies. For the NHS Trust survey, there is also presentation of findings from the Logit models: these provide insight into the likely causes of relational strategies, and through a sectoral analysis, identify the likelihood of specific relational strategies occurring in a range of different health market scenarios. Lastly, an executive summary of the key findings is offered, enabling a comparison to be made between NHS Trust and District Health Authority perspectives on the extent, and importance of relationship marketing within the NHS Internal Market.

In Chapter 6, the findings from the two case studies are presented. These include results from the face to face interviews with NHS Trusts and District Health Authorities, and also the results from the supporting postal surveys of GP fundholders in the areas selected. The evidence presented enables an exploration of the extent of, and determinants of Sako's (1991; 1992) goodwill, competence and contractual trust within the purchaser – provider relationship in secondary health care. Moreover, the chapter also evaluates the downside of NHS Trusts relationship marketing strategies. Throughout, there is an emphasis upon a comparison of findings between purchasers and providers within each case study, and also cross - case study comparisons.

Finally, Chapter 7 presents the general conclusions of the current research. These highlight the most significant findings of the current research, and its contribution to the literature. Additionally, the Logit modelling, and evidence from the case studies is used to predict the likely importance of relationship marketing strategies to NHS Trusts operating within the “new” co – operative NHS arrangements (DoH, 1997). Finally, this chapter provides a series of recommendations for future related research.

CHAPTER 2

Literature Review: Theoretical Studies

2.1 Introduction

The primary aim of this chapter is to provide a critical literature review relevant to an evaluation of the relationship marketing strategies of NHS Trusts within the former NHS Internal Market. The literature review begins with a critique of the so - called Theory of quasi – markets developed by Le Grand and Bartlett (1993). Its selection and detailed evaluation is justified on two counts. Firstly, it has been predominant in the theoretical literature on quasi-markets, and secondly, (as demonstrated in Chapter 3) because it has been the predominant framework adopted by economists in evaluating the nature and impact of the 1989 White Paper's reforms upon the NHS.

In critically assessing relational aspects of the Theory of quasi - markets a number of alternative theories have been drawn upon including Neo – classical theory, New Institutional Economics, Porter's Model, game theory and Contract theory (including the Theory of property rights and Reputation theory). However, it is argued that none of these theories provide a systematic framework for evaluating NHS Trusts relational behaviour in the context of the contracting process for secondary health care.

Subsequently, the Chapter introduces and assesses relational based theories. In particular, a critical evaluation of Relational Contracting theory is provided focusing upon the work of MacNeil (1974; 1978; 1980; 1983), Dore (1983) and Sako (1991;1992). This evaluation is then used as a foundation for the critical evaluation of the hybrid Relationship Marketing paradigm (Berry, 1983; Jackson, 1985; Morgan & Hunt, 1994).

The chapter continues by critically assessing the relevance of relationship marketing (RM) to the NHS Internal Market. This clearly identifies the relative superiority of the RM paradigm in satisfying the current research's primary aim and related objectives. However, in order to present a balanced perspective, a number of caveats associated with this chosen paradigm is considered.

2.2 Le Grand and Bartlett's Framework: A Theory of Quasi-Markets?

The best cited framework identifying the key prerequisites for quasi-markets in welfare services is that of Le Grand and Bartlett (1993). Their framework identified four key factors central to the efficient operation of quasi-markets:

1. A market structure which is competitive or contestable
2. Low levels of transaction costs
3. Information of sufficient quality to allow informed decisions by purchasers
4. Motivation should be such as to encourage purchasers to respond to the needs of users, and minimise the opportunity for purchasers to behave opportunistically by “cream skimming” patients.

These are deemed essential if the benefits of quasi-markets evaluated in Chapter 1 are to be achieved. The following sections examine each of the pre-conditions in turn to identify key concepts, issues, and difficulties facing researchers. As far as possible, the critique focuses on relational issues.

2.2.1 Market Structure

Le Grand & Bartlett (1993) perceived the strength of competitive models in health care to be improved responsiveness, efficiency and choice which we have seen to be central aims of recent NHS market reforms (DoH, 1989a). Alternatively, Le Grand and Bartlett (1993) argued that health markets, which were contestable (Baumol 1982), would offer similar benefits. Within a market setting, resource allocation would be determined by the interaction of demand and supply with prices acting as the signalling mechanism. Moreover, in terms of the supply side, there would be a clear identification of property rights ensuring absolute rights to consume the rewards from production. The central limitations of this orthodox analysis in the context of health care were considered in Chapter 1 above, but here our focus is on market structure.

It is clear that in reality the market for health care provision in the UK bears little resemblance to the idealised competitive market structure. Moreover, the existence of imperfect competition may result in some gains which Le Grand & Bartlett (1993) have under-estimated.

In terms of purchasing the District Health Authority (DHA) typically enjoyed a local monopoly. The principal arguments in favour of retaining this structure on the demand side in preference to a competitive structure include the following. Firstly DHAs enhanced ability to negotiate batch contracts with providers, which implies benefits in terms of lower average total costs per treatment. Secondly, DHAs provide countervailing power which is essential given that NHS Trust hospitals typically enjoy a local monopoly of secondary care (Harrison & Prentice, 1994). In addition, it is argued that DHAs are better able to establish need in local communities because of the size of their statistical database on the health status of the local population.

However, there are a whole series of counter arguments. Monopoly power may be abused, for example DHAs may strike hard bargains with providing organisations which according to Le Grand and Bartlett (1993) “sours” relationships, and may effect the extent of competitive tendering for contracts. Additionally, in claiming that DHAs provide countervailing power, that represents an implicit criticism of monopoly providers of local secondary care. However, it may be argued that on the supply side there are considerable benefits from monopoly supply.

The development and increasing expansion of general hospital complexes has brought a range of benefits (Harrison & Prentice, 1994) including the growth in a number of specialised clusters of medical skills in UK hospitals. However, it is clearly difficult to establish the relationship between the growth in these clusters and the performance of hospitals given that the input mix often varies re surgeons, support staff etc and that there is intra-specialisation within clusters. Furthermore, evidence suggests (Drummond & Maynard, 1993) that the minimum efficient scale varies between different episodes of care, and between different illnesses. For example where there is the possibility of forward planning in elective surgery, cost savings achieved through scale economies can be used to subsidise emergency cases where there is a need for contingency reserves because forward planning is not feasible. Thus the existence of local monopoly in

hospitals services offers the possibility of pooling resources and cross subsidisation (assuming this is legally permissible). It may also be questioned whether monopoly in purchasing does make it easier to identify community needs. It may be argued that large centralised organisations suffer managerial diseconomies including poor communication and control, which limits the responsiveness of the organisation.

In addition, there are a number of issues regarding property rights. In a quasi-market in health care there is no clear division of property rights. In reality there is a mix of state, municipal and NHS Trust ownership of provision of health care, which is further complicated by the lack of a “bottom line” in terms of the performance of the organisation. So even if it were clear who owns the rights to share in the rewards from health care provision it would not be clear what form the rewards will take. The analysis is complicated further still by the existence of positive externalities in the consumption of better health, given that the individual, their employer, family and society at large may all benefit but it is not clear who owns such benefits (Mooney, 1994).

Even if there was a perfectly competitive market in health care provision it would still be infeasible to fully delineate property rights (Barzel, 1989). This is because the transaction costs involved in defining property rights are perceived to increase as rights become more delineated. The transaction costs themselves arise because of the individuals direct efforts to protect their property rights; the potential for opportunistic behaviour by other agents, who recognise the possibility for capture of incompletely delineated rights; and finally, the consequent costs arising from the resulting need for market governance by regulating authorities.

As Chapter 5 will demonstrate, the difficulties of delineating property rights is greatly enhanced where contracting is not based solely on cost and volume measurement. Empirical evidence generated by the current research programme indicates the development of relational based contracting resulted in deployment of specialised governance procedures.

Le Grand and Bartlett (1993) stressed the significance of market structure, beginning their analysis from the orthodox position of the perfectly competitive market. Whilst they accepted the improbability that perfect competition would develop within a quasi –

market in health care, they identified a range of advantages from imposing a quasi-market if it was at least contestable. This approach is defensible on the grounds that,

“the properties of the contestable market are the best that may be achieved according to the yardsticks of neoclassical welfare economics”

(Forder et al 1996, p 204)

In particular, contestable markets ensure that the incumbent produces at minimum average cost, ensuring productive efficiency, and that the incumbent sets $P = MC$, ensuring allocative efficiency. The failure to do so results in costless market entry allowing entrants to marginally undercut the incumbent within the range of their relative cost advantage. Thus the market is open to so called hit and run entry. However, it is argued that further consideration of the problems associated with contestability in quasi - markets in health care is required.

In particular, more emphasis must be given to structural imperfections in health care markets. This is important because the model of contestability assumes there are no structural imperfections. Following Forder et al (1996), it is appropriate to divide potential structural imperfections into exogenous and endogenous barriers to entry and exit to and from the health care market. In respect of the former, resource supply constraints and sunk costs provide good examples. In some health markets, the incumbent, e.g. a Direct Managed Unit may have monopsony power in respect of consultant services, e.g. in a world - renowned centre of excellence. Consequently, structural imperfections are so significant as to prevent contestability.

Sunk costs should also not be underestimated. For example, CT body scanners represent a large proportion of total costs (such that they are not recoverable), a highly specific asset and furthermore represent a major commitment to pre-entry output levels. The latter point suggests that the incumbent is making a credible threat (Lyons, 1991). The incumbent will accordingly find that it is less costly to fight potential entrants by reducing prices than to attempt to reduce output, although this assumes potential entrants recognise this threat to lower prices if entrants attempt to contest the health market.

Moreover, Davies (1991) suggests that first mover advantages in some markets are potentially so great as to deter entry. Clearly, this in turn implies that some health care markets may not be contestable, i.e. in the context of second, third and a fourth wave NHS Trusts. For example, in terms of paediatric care, second movers must invest heavily in technology and human capital to avoid being relatively cost disadvantaged to the extent that market exit is threatened. Indeed, in Chapter 5, first-mover advantage will be identified as a key determinant of NHS Trusts relationship marketing strategies.

Meanwhile, Forder et al (1996) stressed the importance of user vulnerability in welfare markets as limiting contestability. He identified the difficulties of moving patients between treatment centres, sometimes over large geographic distances, with consequences for patients health status. Potential entrants must cover direct resource costs and costs arising from a detrimental change in the patients well being. Forder et al (ibid) argued that patient welfare was an important element within the utility function of potential care providers and therefore, negative changes in this variable were perceived to be a key entry barrier to potential markets.

2.2.2 Transaction Costs

Williamson (1985) identified the firm as a governance structure resulting from market failure, but emphasised that it is not simply a means of co-ordinating inputs and outputs as Alfred Marshall (1920) had argued. Following Coase (1937), he argued that the high cost of using the market leads to internalisation, or hierarchies in an attempt to minimise costs. These costs can be divided into ex ante and ex post costs, the former including the cost of drafting, negotiating, and safeguarding contractual agreements. Ex post costs include maladaptation costs when transaction costs are out of alignment, the subsequent costs of re-specification of contracts and governance systems, and finally the costs of building long term relationships. It should be stressed, however, that empirical evidence provided by the current research programme identifies a significant increase in transaction costs as a consequence of relational based contracting. The focus here is not solely upon cost or volume negotiation but also augmentation and customisation of contracts reflecting non-price competitive behaviour. Clearly these costs are extremely relevant to the provider/purchaser relationship in quasi-markets in health care in the NHS where the

price signalling mechanism or administrative bureaucracy alternatives are replaced by negotiated contracts.

The existence of such transaction costs, regardless of their source, are the consequence of the co-existence of the following: bounded rationality; opportunism; and asset specificity.

Bounded rationality (Simon, 1962) implies that individuals have a limited ability to process available information, and suffer from informational uncertainty, the latter being stressed by Williamson (1985). This encourages individuals to find solutions to unforeseen problems but implies that the usefulness of forward planning is limited, with the subsequent predominance of sequential problem solving. Of note for the current research, this identifies an enhanced opportunity for NHS Trusts to develop relationship marketing strategies.

Meanwhile, asset specificity is concentrated in durable human and physical capital often leading to the existence of bilateral monopoly. Many examples can be imagined in health care, for example the specialised health team skills of providers, and specific capital machinery owned by the purchaser.

Finally, opportunism is defined as the existence of “self seeking with guile”. (Williamson, 1985, p 47). This may arise because of asymmetric information; the costs of delineating property rights (as discussed above); differences in cultural values between purchasers and providers, e.g. the acceptability of capture behaviour; and the regularity of contractual negotiations. With respect to the latter, the potential for opportunism may be limited where contracts are negotiated continuously because of the existence of specialised governance structures, whereas for idiosyncratic contracts governance costs may be exorbitant and require the intervention of an independent third party. The latter is common in the US where the expert medical auditors are used to resolve disagreement between purchasers and providers regarding the costs of treatment.

There are a number of limitations of Williamson’s (1985) approach to explaining the existence of the firm in the context of quasi - markets in health care. In a system based entirely upon bureaucratic planning, the non-existence of the market would imply that there was an absence of transaction costs. However, it is apparent that there would still be

bounded rationality in the context of a bureaucratic planning system, and the potential for opportunistic behaviour by utility maximising bureaucrats.

Furthermore, if we accept the existence of transaction costs in quasi-markets in health care, we should question the centrality of the role of opportunistic behaviour by providers or purchasers. It is likely that the continued emphasis upon social objectives recognised by health care managers (Bartlett & Le Grand, 1993) or the predominance of relational based contracting (as evidenced by the current research's findings) will lessen or remove the possibility for opportunistic behaviour.

Moreover, Hirsch (1976, p 142) has argued that increasingly trust is becoming an essential characteristic of market economies per se,

“Truth, trust, restraint, and obligation are among social virtues grounded in religious belief which are now seen to play a central role in the functioning of the individualistic, contractual economy”.

Indeed, the current research emphasises the centrality of trust in the development of NHS Trusts relationship marketing strategies. Additionally, cultural bias in some countries, i.e. in respect of peer pressure to conform to high standards of honesty, will similarly remove or reduce the significance of opportunistic behaviour.

The researcher faces the additional problem that opportunism and bounded rationality may be confused. Providers of health care services may be perceived to pursue self interest with guile, whereas in reality their behaviour may be explained in terms of their limited ability to accurately process relevant information, or alternatively, may be the consequence of poor quality or missing information. There is evidence that the quality and range of performance data for health care systems in the UK is limited (Birchall et al, 1995; Gray & Ghosh, 2000b). The former emphasised that the majority of data generated is limited in scope, with NHS Trust managers focusing upon the gathering and analysis of data required of them by the Department of Health. These are principally rate of return on assets employed, the extent to which external finance limits are met, and also the income expenditure balance.

Meanwhile, the issue of uncertainty is also important to the evaluation of transaction costs, Best (1993) arguing it is given limited coverage by Williamson (1985). Best (1993) claims that breach of contract may arise because of different perceptions regarding costs between providers and purchasers even when the latter is attempting to behave altruistically.

Le Grand and Bartlett (1993) argued that long - term contracts will be incomplete in the face of associated uncertainty and bounded rationality. They claim further that such uncertainty will be compounded by the inability of purchasers and providers to fully employ a sequential response. However, this perspective stands in stark contrast to Milgrom and Roberts (1982) view who contend that in the face of low governance costs short -term contracting can be efficient in response to non-contracted contingencies.

Additionally, supporting Williamson (1985, p 61), Le Grand & Bartlett (1993) claim that the firm's objective is to minimise transaction costs and production costs. There is an inherent contradiction here because the former is based in part upon the existence of bounded rationality, whilst the latter is concerned with the neo-classical interpretation of production functions which is based on the existence of perfect knowledge.

Moreover, it is argued that Le Grand & Bartlett's (ibid) view on the role of the market in the purchaser – provider relationship may be perceived as naive in the context of the changing nature of business organisations. Empirical evidence provided by Child (1987, p 67) suggested that,

“Markets are increasingly seen as chains of enduring relationships involving a variety of forms of exchange”

He highlighted six main organisational types ranging from the fully integrated firm to the quasi-firm based on co-ordinated contracting. The latter is based on the existence of a prime contractor co-ordinating other sub-contractors. It is argued that this perspective is more appropriate for analysing transaction costs in the context of quasi - markets than that of Williamson (1985) which Le Grand & Bartlett (1993) have adopted.

Finally, it may be argued that Le Grand and Bartlett's (1993) approach is not a systematic comparative governance theory because transaction costs are considered in isolation from other factors in identifying the former as a condition for success or failure in quasi-markets. Their logic is that high transaction costs result in failing quasi-markets whilst low transaction costs reflect successful quasi-markets. However, unanswered is the important question of whether identified transaction costs are a cause or a symptom of market failure? Moreover, a simplistic distinction between ex ante and ex post costs is of limited help in identifying whether one, or the other will be higher or lower in particular quasi-markets.

2.2.3 Information & Contracting

Le Grand & Bartlett (1993) argued that both providers and purchasers required accurate, cost-effective information for quasi markets to operate efficiently. In particular there was an emphasis on the need for costing of activities, which we have already seen to be problematic in the context of public services given the associated technical difficulties, and the moral aversion to such costing. Due to the asymmetry of information between purchasers and providers it is essential that the optimal form of contract be established. This is to avoid or lessen the impact of two factors. Firstly, moral hazard, where the provider puts in insufficient resource to meet their contractual obligations and secondly the problem of adverse selection where the purchaser has characteristics which affect service provision but internalises these characteristics. Moreover, there is an important link between the asymmetry of information and quality of treatment (Walsh, 1995)

“Really it is the provider that does most of the measuring and monitoring of quality at the detailed level, with the purchaser doing very little” (p 7)

The primary problem here in the design of contracts is that of co-ordination failure which raises market transaction costs. Examples in game theory abound (Sutton, 1986; Lyons and Varoufakis, 1989) where in two person bargaining games players can fail to identify efficient solutions, or alternatively waste resources in fighting for a better bargaining position. However, it may be argued that such co-ordination failures will decline where, for example, the purchaser can choose between a number of bargaining partners. Indeed,

it is clear that the most extensive problems of co-ordination failure will arise in situations of bilateral monopoly based on the exchange of highly specific assets.

It is argued that the problem of information asymmetry in the context of purchaser-provider contracting can be resolved in a number of ways. Firstly, a monitoring system can be imposed with an emphasis on quality. Propper (1992) argues that quality is a vital performance criteria, with increasing pressure for its measurement reflected in the demand for waiting list data, and other health care league tables by the Department of Health. However, accurate monitoring of service quality requires a number of pre-conditions including clear output measures; an emphasis on the establishment of long term relationships between providers and purchasers which will enhance trust; and a disincentive mechanism for providers, for example, the existence of the credible threat of management take-over if performance criteria are not met.

Secondly, Propper (ibid) suggests the need for detailed contract bid submissions. This would reduce the impact of adverse selection, and by raising the costs of submission would deter smaller inefficient bidders who cannot spread the risks of not being awarded the contract. This could be further enhanced by insisting on an increase in the required number of bid submissions before purchasers could legally award a contract. The argument is that increasing the number of bidders would reduce the costs of contracts.

Despite the theoretical potential for reducing the negative effects of asymmetric information, the reality of the competitive tendering process for NHS health care contracts is very different. Propper (1992) cites US evidence including:

- a. the establishment of “sweetheart” relationships, whereby purchasers favour specific suppliers, often those previously operating within the former bureaucratic health care structures
- b. enhanced competition where health care services are new. Meanwhile, with reference to current service contracts, they were typically allocated to existing providers.

- c. contract allocation being subject to cream-skimming. Providers categorised patients in terms of costs and health risk, and behaved risk aversely. However, this may be addressed in terms of contract design by focusing on block contracts and excluding cost per case contracts, the latter increasing the possibility for opportunistic, risk averse behaviour by providers.

Furthermore, it is important to consider the consequences of poor contract design or failure to comply with agreements. According to Walsh (1995), only 19% of NHS contracts specify termination of contract for failure to comply with agreed performance criteria, with 50% of NHS contractors having no default measures built in at all. Clearly this has important implications, suggesting the potential significance of Williamson's (1985) ex-post transactions costs. Moreover, Walsh's (1995) evidence is at odds with the evidence provided by the current research presented in Chapter 5.

2.2.4 Motivation

The last pre-requisite for the existence of quasi-markets in health care cited by Le Grand and Bartlett (1993) is the existence of appropriate motivation or incentive mechanisms for purchasers and providers. Ultimately it may be argued that there is little logic in introducing the market if there is no profit motive.

In respect of purchasers there is effectively no economic incentive mechanism. Firstly, DHAs have a geographical monopoly on patient care so that the principal is constrained by a single agent; patients may be ignorant of their rights within the Patients Charter; and additionally, DHAs may benefit from risk pooling given that they are funded by the state. With respect to the latter point, it may be argued that there are limitations to their ability to pool risk with respect to specific medical treatment for specific individuals. This is because failure to provide access to appropriate medical services results in political scandal, e.g. the "Jennifer X" case during the 1992 UK general election.

The Le Grand and Bartlett approach (1993) identified franchising of DHAs rights to purchase health care on the behalf of end users as a mechanism for encouraging competitive bidding. What this ignores, however, is that monitoring of performance would still be an essential incentive mechanism. Indeed, the empirical evidence cited by

Whynes (1992) suggests that performance monitoring of DHAs undertaken as a consequence of the 1989 White Paper reforms has resulted in an increase in outputs which the Department of Health requires to be measured. Implicitly this suggests that non-measured outputs have declined and suggests a change in input mix. In turn this does not necessarily imply an increase in the utility of end users, because agents are not operating in a competitive environment. Furthermore, the principal agent relationship still remains.

Meanwhile, the main incentive for providers has been the establishment of NHS Trust status hospitals. The key features of these are as follows:

- a. powers to set pay and conditions locally
- b. rights to borrow from central government to finance new assets and cover the cost of maintaining existing capital assets
- c. direct funding from the Department of Health

However, in the context of incentive mechanisms there a whole series of constraints placed upon NHS Trust hospitals. Firstly, they are unable to cross subsidise services, effectively constraining their pricing strategy to a P – average total cost approach. The average total cost calculation must include depreciation and a 6% return on net assets. Thus as mentioned earlier they are unable to use surpluses from planned elective surgery budgets to cross subsidise an increase in unforeseen costs due to a sudden increase in demand for acute emergency services. Additionally, the NHS Trusts operate a “not for profit” model based on an efficiency index with the emphasis being on breaking even, with any financial surplus (residual) going to the State.

Consequently, NHS Trusts target performance is tied to past performance. According to Handy (1987) such incentive mechanisms induce lower efforts because good performance in a specific time period makes the achievement of future target performance more demanding. Moreover, this reduces the likelihood of entrepreneurial behaviour (Propper, 1995). This is principally because there is no risk and uncertainty element in the contracting process. This is especially important because the existence of uncertainty

allows some individuals to interpret the world more accurately than others and capture the generated residual income (Knight, 1927).

This has wider theoretical implications because it implies there is no role for the Schumpeterian firm where innovation is central to the dynamic process of market development. Innovation was seen by Schumpeter (1950) to enforce reductions in costs and encourage cut-throat competitive behaviour. Rather than consumers choosing pre-existing goods (setting $P = MU$) or entrepreneurs buying and producing at the margin (Coase 1937) driving capitalism's development, innovation was seen as the key driving factor.

New products, processes, and organisational forms would emerge as part of the process of "creative destruction". It may be argued that the non-existence of the entrepreneurial firm in quasi-markets for health care is of recognised concern to the Department of Health. This is reflected in the 1988 Parliamentary Committee on Science and Technology report "Priorities in Medical Research", and the creation of a new senior post, Director of Research and Development in the Department of Health from January 1st 1991.

A further limitation of Le Grand & Bartlett's (1993) Theory of quasi - markets, and a weakness of traditional economic theory in general, is that the social environment surrounding transaction costs is under-emphasised. More particularly, Granovetter (1985) has argued that social relations in markets are more significant, and that those in hierarchies are less important than economic theory suggests (see also Perrow, 1990). Similar conclusions are reached by Putterman (1986) who claimed that efforts should not be focused solely upon where the boundary point lies between the market and the hierarchy, but to view the market and hierarchy as being "woven into the cloth of the wider economy" (p 23). In essence these authors argued that individuals are driven by social norms and values, whether we are considering private or public provision of goods.

What is of primacy is the positive correlation they cite between the importance of such norms and values, and the degree of risk associated with any transaction. For instance, where transactions are complex and the associated risk high, the more influential social norms and values will be in determining the response of contracting parties.

Suppose an NHS Trust hospital is closely associated with a given purchaser and regularly augments basic service contracts, for example to include more respite care than a Diagnosis Related Group (DRG) assessment would suggest necessary. Suppose further that the NHS Trust introduces more complex monitoring of health outcomes to support such contract augmentation. Lastly, suppose this relationship building arises in the context of social pressures to raise the quality of patient care. In this situation, quoting Miller (1992, p206), the consequence of “deviation from the norm” may be large, uncertain and negative. Furthermore, in terms of Le Grand & Bartlett’s (1993) perspective, such behaviour would not appear instrumentally rational.

An additional related theoretical criticism, is Le Grand & Bartlett’s (1993) limited recognition of the importance of reputation (Krepps, 1990a; 1990b; 1996) in motivating agents in quasi-markets to behave opportunistically. Central to the selection of governance procedures in quasi-markets will be the weighing up of the costs of additional contractual measures to deal with contingencies, and the risks of being exploited.

Krepps (1990a; 1990b; 1996) analyses situations where contracting parties may defer governance tasks, e.g. collection, collation, and monitoring of performance data, to another party. In the context of health markets, a District Health Authority may reduce efforts at quality measurement if they perceive a given NHS Trust hospital is not believed to be opportunistic. The principal explanation offered for such behaviour is that opportunism is not deployed by the providing NHS Trust hospital because of the desire to safeguard their reputation, with reputation being the incentive or “glue” which enables transactions to arise which without the reputation effect would be too costly.

A formal treatment (Krepps 1990b; 1996) is beyond the scope of this chapter. However, in essence formal modelling based upon the “folk theorem” (Fudenberg & Tirole, 1992) predicts that long term modest rewards from abstemious behaviour where there are repeat transactions (as in the NHS Internal Market) can exceed those rewards arising from short-run exploitation.

However, it is recognised that such modelling is not without its weaknesses. Short – run exploitation may arise where there are substantial time lags between “purchase” and identification of outcomes: this mirrors the lag between diagnosis by a GP and the

effectiveness of the recommended clinical intervention being assessed. Secondly, finding a unique or limited number of equilibria becomes more problematic as the range of possible “quality” levels increases. Again, in the context of health care this is especially problematic, because for instance different health populations will respond differently to the same sets of health interventions (Gray, Harrison & Barlow, 1998). More specifically in terms of focal points Krepps (1990a) argued,

“The current state of formal theory allows for a possibility of a wide range of focal points. But we certainly don’t have many good formal criteria for picking out any particular one” (p.513)

Lastly, problems arise with so called noisy observables. Suppose a given NHS Trust hospital cannot control quality: when it aims at “low” quality there is a .9 probability of getting low quality and a .1 probability of still getting a high quality outcome. Moreover, when targeting high quality, suppose the probability is .8 of achieving high quality, and .2 of achieving low quality. Suppose further, the NHS Trust hospital contracts with 4 GP fundholders, two receiving high quality and two low quality outcomes for their patients. In this instance, if the GP fundholders do not punish the provider, *ceteris paribus*, they will always get low quality. But, even if the NHS Trust hospital always targets high quality, it can still have what Krepps calls “unlucky days”.

However, Krepp’s (ibid) approach does provide an appropriate case for considering in detail a further set of literature explaining why individuals voluntarily cede control of transactions governance to other parties. This work is evaluated in detail in Sections 2.3 and 2.4 below, but at this point it is sufficient to quote Sako (1992) who argued, “firms may form links or bonds of a long term ‘relational’ nature, through which they become interdependent for business” (p23).

Moreover, as Sako (ibid) and similar writers (e.g. Dore, 1983) contend, trust is seen as vital to the contracting process. Supporting this view, Forder (1999) has argued,

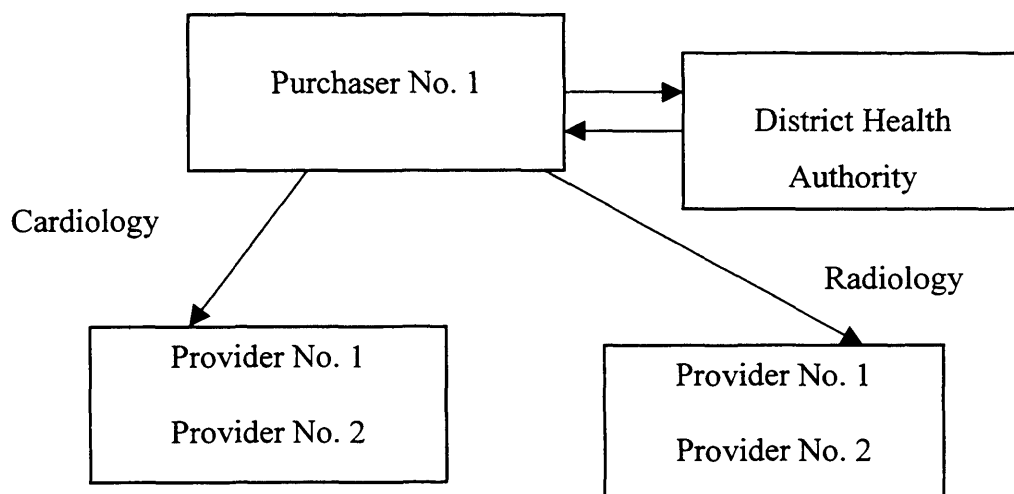
“This pattern of governance can be interpreted as an exchange or re-assignment of control rights and ‘trust’ can be interpreted instrumentally as reputation”, (p 17).

2.2.5 Game Theory & The Purchaser – Provider Relationship

The previous section used the work of Krepps (1990a; 1990b; 1996) to critically evaluate Le Grand & Bartlett's (1993) evaluation of motivational elements necessary for the efficient operation of the NHS Internal Market. However, it is argued that further exploration of a game – theoretic approach to modelling the purchaser – provider relationship is justifiable. It may be argued that the purchaser – provider relationship readily lends itself to a game theoretic approach. There are essentially two players: firstly, there are purchasers with money (i.e. per capita funding), but limited technical (i.e. clinical) knowledge, and secondly, providers with technical (i.e. clinical) knowledge, but bounded rationality in respect of how to maximise organisational revenue.

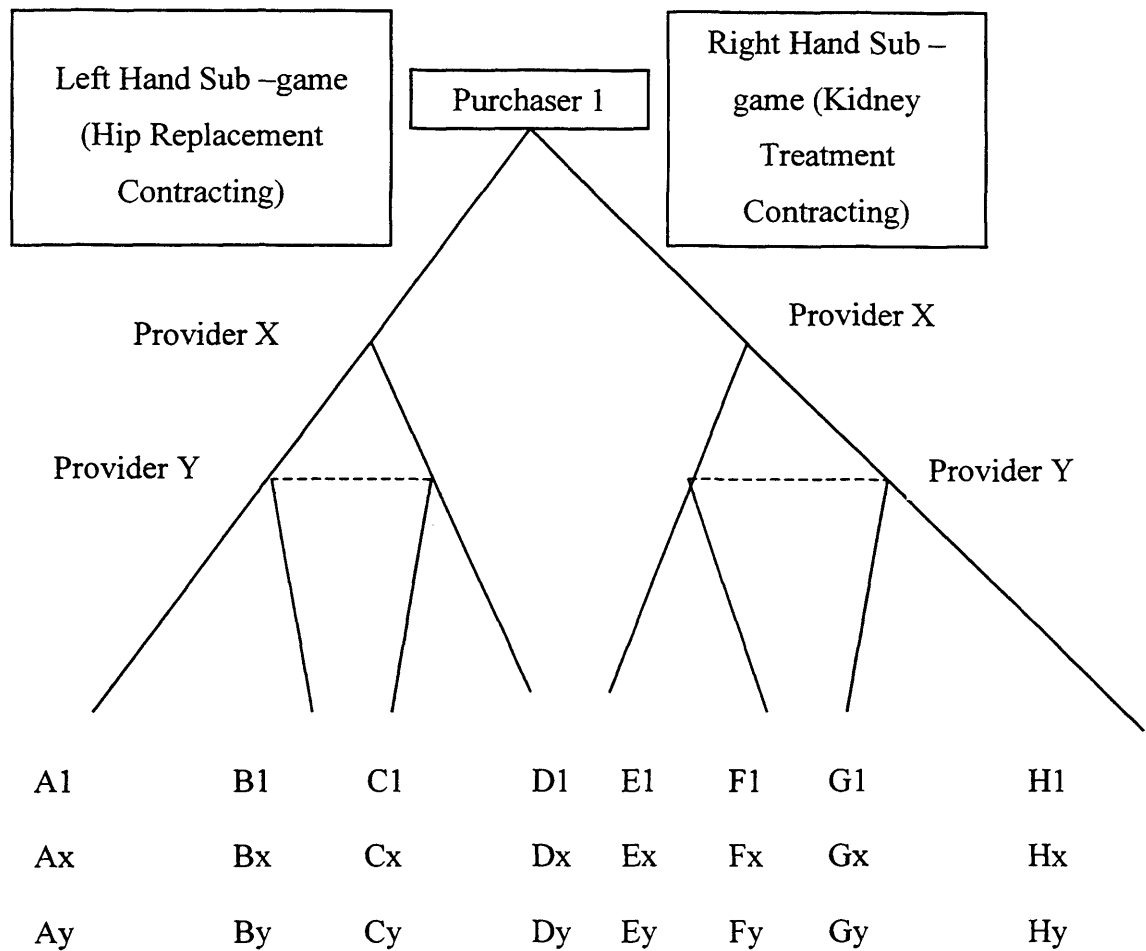
In particular, the NHS Internal Market provides an example of what Tsebelis (1990) calls a “nested game”, i.e. a game played out in multiple arenas. The following figure provides an example of these multiple arena:

Figure 2.1: A Diagrammatic Illustration of Relationships between Purchasers and Providers



Consider an example of a nested game in health care provision in more detail. Suppose we are considering the relationship between a specific purchaser, a number of potential providers and a number of health conditions. A typical game is depicted by the following decision tree:

**Figure 2.2: Decision Tree for a Nested Game in a Quasi – market
(adapted from Tsebelis, 1993)**



We have assumed the purchaser moves first and that the providers move simultaneously. Previous choices are shown higher up within the decision tree, and it is assumed that previous choices are known to subsequent players. Simultaneous moves within the game are indicated by the dotted lines in the figures.

Here, the purchaser determines whether we are observing the left or right hand side of the game, i.e. the purchaser identifies the relevant sub-game, and it is assumed that the players are all rational, i.e. select their optimal strategies. We have also assumed that provider X and Y follow mutually optimal strategies corresponding to the purchaser's choice with reference to the relevant sub-game. Finally, it is assumed that the purchaser knows its own pay-offs, and those of the providers, and behaves rationally by selecting that strategy which maximises its pay-offs given providers X&Y are following their own maximising strategies.

Suppose however, the purchasing authority is compromised of many “agencies” with regards to different aspects of patient care, and different treatments. These agencies will all interact to determine the different strategies the purchaser may follow, and ultimately will interact to determine which one is selected. In other words, these different agencies interact to determine which sub-game is played. Moreover, the purchaser must interact with other purchasing authorities, voluntary care agencies, the Department of Health and so on.

The implication of this so called “nested” game is that the nature of the pay-off matrix will depend upon situations in all the different arenas. The observer cannot therefore know all the pay-off. The only possibility is to isolate out the so - called “principal arena” (Tsebelis, *ibid*), assume a specific strategy has been selected and subsequently identify the pay-off to players. It is notable that this would only represent a partial equilibrium approach.

In addition, there remain a whole series of problems associated with modelling the purchaser-provider relationship within a game theoretic framework, which subsequently provides further support for modelling the purchaser-provider relationship using an alternative paradigm, i.e. Relationship Marketing. Consequently, consideration of the caveats associated with a game theoretic approach is readily justified.

The overriding problem is the complexity of real world problems, “even if a representation of all aspects of such a game were possible, such complicated games are usually intractable”, (Tsebelis, 1990, p.57)

More specifically, if we could isolate sub-games the final pay-offs would be affected by the possibility of communication between players, e.g. collusion between purchasers. Moreover, the observer's life is made more difficult because many of the sub-games will be repeated over long periods of time, i.e. the sub-games will not be “one off” games. It is not possible for the observer to draw accurate conclusions, therefore from simply one or a limited number of observations, especially given that any specific sub-game is merely part of a much larger nested game which, itself, cannot be observed.

Furthermore, a game theoretic approach to modelling quasi-markets in health would assume we could identify the utility function for players, and more significantly that the

observer can identify an interval scale of utility. This involves identifying a range of values of utility relating to players preferences based on a set of probabilistic outcomes, and thus game theory assumes a stronger set of assumptions than ordinal preference theory. There is the related problem of identifying whom to ask questions of regarding preferences and associated utilities, which is further heightened within a nested game where there are multiple players.

Additionally, Hamburger, (1979) stresses that the whole approach of game theory is in conflict with various behavioural theories, including of pertinence to our discussion the Theory of Cognitive Dissonance (Hamburger, *ibid*). This suggests individuals with incompatible values and objectives will reduce mental conflict and the associated stresses by rethinking these values. For example, a hospital manager facing the undesirable consequences of a ward closure may look for positive aspects of the event to justify the decision taken, and thereby raise her utility. Overall, cognitive dissonance implies that the individual's utility is not constant throughout the moves along a decision tree, which further limits the applicability of game theory in the evaluation of relational behaviour in quasi - markets in health care.

Finally, and supporting the principal argument of the evolutionary Economists (Hodgson, 1995), whilst game theory can identify the optimal solution to conflict between purchasers and providers (by identifying the maximum pay-off possible), it does not identify the processes and routines which result in specific pay-off.

2.3 Relational Based Theories: an Alternative Approach?

2.3.1 Introduction

The beginnings of the theory of relational contracting are attributed to Macaulay (1963), and later Macneil (1974; 1978; 1980; 1983) who focused upon a distinction between legal and relational contracts. The former were perceived to be discrete; voluntarily entered into, and involving autonomous exchange partners whereas, by comparison, relational contracts were based upon recurrent relationships, developed around dependency, coercion, and shaped by social norms. In this sense, these closely mirror social network theories referred to earlier by the likes of Granovetter (1985) and Wellman (1983).

Meanwhile Dore (1983) defined relational contracts as, “the sentiments of friendship and the sense of diffuse personal obligation which accrue between individuals engaged in recurring contractual economic exchange” (p460).

This section begins the detailed critical consideration of relational based theories, beginning with relational contracting. The previous section (2.2) provided a detailed critique of the predominant theoretical framework employed by economists to evaluate the NHS Internal Market. Furthermore its weaknesses as an appropriate framework for analysing the relational strategies of NHS Trust was thoroughly evaluated.

2.3.2 Dore’s (1983) analysis was based upon evidence relating to the Japanese brand cloth industry in which evidence suggested that production was not co-ordinated by Williamson’s (1985) hierarchical vertical integration or via market exchange in the pursuit of profit maximising contracts. Instead, co-ordination was via “kinship” groups in which overall efficiency was sacrificed in favour of risk spreading and greater equality of profits growth among kinship members. Dore (1983) argued that in the context of Japan, relational contracting was seen as a duty over and above the terms of a written contract which, “gives the assurance of the pay-off which makes relational contracting viable”, (p470).

Supporting Durkheim’s (1964; 1983) view, Dore (1983) emphasised that obligations are placed upon partners to resolve conflict in relational contracts, given that even in the context of relational behaviour, contracting remains conflictual rather than integrative. Indeed, Dore (ibid) sites Durkheim (1964; 1983) in identifying such obligations as, “universalistic social institutions- an engine cooling system to take away the heat”, (p471).

In the context of health care in the UK, these are reflected in the following. Firstly the culture of co-operation ingrained in the NHS; secondly, the sense of civic duty amongst clinicians and professional managers; and thirdly, the alien nature of management reforms required by the 1989 White Paper.

According to Dore (ibid) the incentive for such relational behaviour was threefold. Firstly, as mentioned there is the sense of duty imposed via social norms and values. Secondly, there are efficiency related issues: in essence, relational exchanges keep inefficient firms in production, which is at odds with Neoclassical thinking in the long term model, but has resonance with Hirschman's (1970) view. He contended that "rescue" of failing firms via voice mechanisms was preferential to market exit being imposed upon failing firms. Such countervailing efficiencies reflect Liebenstein's (1966) concept of X – efficiencies, which are sufficiently large in the relational case to outweigh allocative inefficiencies within the observed kinship group. The causes of such X – efficiencies are in turn perceived to be threefold.

Firstly, the possibility exists to reduce uncertainty. The relative, subsequent security has the positive impact of encouraging investment in supplying companies, which reduces the extent of Williamson's (1985) "hold-up" problem (see also Grossman & Hart, 1986).

Secondly, relational behaviour encourages trust and mutual dependence, one impact of which is an increase in the volume and quality of shared information within the kinship group. The importance of the latter is illustrated by reference to models of monopoly regulation, such as the work of Vickers (1996). He demonstrates that regardless of the distribution of bargaining power, the existence of two-sided asymmetric information "results in inevitable inefficiency in trade" (p15). In such circumstances the information rents arising from efficient trade would be greater than the gains from trade. Accordingly, both purchasers and providers would have to be given all the gains from trade in order "to induce efficient decisions – which obviously cannot happen without external subsidy" (ibid, p16). Indeed, the current research presents evidence in Chapter 5 demonstrating that District Health Authorities and NHS Trusts typically shared sensitive competitive data.

Meanwhile, in the Japanese case, Dore (1983) argued that adversarial bargaining inevitably reflects low trust relationships because "information is hoarded for bargaining advantage and each tries to manipulate the responses of the other in his own interest". (p472)

The final reason X – efficiencies arise through relational contracting (Dore, 1983) is due to the associated greater emphasis on quality. This effect is magnified where there is heightened sensitivity to quality issues, as is the case within the delivery of health care within the NHS. The 1997 White Paper emphasised the need for greater clinical governance and the need for commissioning agents to recognise the importance of monitoring outcomes as well as costs.

Sako (1991; 1992) reaches similar conclusions from his analysis of buyer - supplier relations. He distinguishes between firms whose contracts are based upon Arms Length Contractual Relations (ACR), and Obligational Contractual Relations (OCR). In respect of the former, contractual relations are based upon “exit” (Hirschman, 1970) at the close of the contract, with subsequent potential for large ex post costs arising from contingencies. Furthermore, relations with trading partners are based on non-disclosure of information; hard commercial bargaining based upon prices, and discrete “one-off” contracts. In terms of the latter, contracting decisions are unaffected by other companies behaviour or the firms individual past contracting decisions. Meanwhile, OCR is associated with long term relationship building between trading partners, with considerable importance being assigned to the role of trust within this relationship.

Focusing upon trust, Sako (1992) defines this as, “A state of mind, an expectation held by one trading partner about another that the other behaves or responds in a predictable and mutually acceptable manner”, (p 37).

The emphasis placed upon trust within OCR, and the latter’s close similarity with relationship marketing behaviour warrants a more thorough evaluation of trust at this juncture.

Sako distinguishes between three typologies of “trust”, these being contractual, goodwill and competence trust. Contractual trust reflects adherence to partners written or oral agreement with the consequences that complete contracts are exchanged. Assuming the latter, there would be no room for opportunistic behaviour (Forder, 1999). Within OCR’s contractual trust is characterised by suppliers beginning production runs on the basis of oral communications prior to written orders being received, which contrasts sharply with the ACR scenario in which production never begins until written orders are received.

Meanwhile, in respect of goodwill trust, Sako (1992) defines this as “the mutual expectation of open communications to each other. Commitment may be defined as the willingness to do more than is formally expected” (p.39), and as such this definition has close resemblance to Akerlof’s (1982) view that trust represents a partial gift exchange deemed essential to supporting and maintaining relationships. For OCR firms, this involves the sole sourcing by the buyer combined with the suppliers transactional dependence. Again this contrasts sharply with ACR firms where there is multiple sourcing by the buyer, linked with suppliers’ low transactional dependence. Moreover, there are important implications for the likelihood of opportunism under OCR rather than ACR relationships. As Sako (1992) states, “someone who is worthy of goodwill trust is dependable and can be endowed with high discretion, as he can be trusted to take initiatives, while refraining from unfair advantage”, (p.39).

Lastly, competence trust in OCR firms involves minimal inspection of quality on delivery, and furthermore, the potential for buying firms to determine the quality assurance process of their suppliers. By comparison, for ACR firms, competence trust is dependent on thorough inspection of goods and services at the point of delivery, within a culture of *caveat emptor*, i.e. buyer beware. Competence trust is defined in terms of the expectation that exchange partners are technically and managerially competent. This is vital in health care where the risks associated with incompetence are high, i.e. detrimental changes in patients health, reductions in intrinsic motivation (Frey, 1998) and potential embarrassment.

It is noted, however, that trust has been variously defined in economics. In essence, it has been defined as a relation specific asset analogous to an intangible capital asset (Casson, 1991). From this perspective trust is only gradually acquired but rapidly destroyed.

An alternative view is that trust results from performance over and above the minimum level, i.e. x-efficiency (Liebenstein, 1966; Dore, 1983), which compensates for potential allocative inefficiency. Yet further perspectives define trust as a renewable resource: trust is perceived to increase with use, require ‘fuelling’ to grow and is associated with long-term relationship building (Morgan & Hunt, 1994).

Meanwhile Krepps (1990a; 1990b; 1996) defined trust, as noted above, in the context of a game theoretic setting. Within the NHS Internal Market, his perspective would be that the verification of whether a NHS Trust was worthy of a purchaser's trust would depend upon two factors. Firstly, the NHS Trust's reputation before entering into a new purchaser – provider relationship, and secondly, comparison of the purchaser's original expectations and actual experience of the NHS Trust as an exchange partner.

Lastly in this section it is important to recognise that Sako's (1991; 1992) analysis was not confined to consideration of the type and impact of differences in trust between ACR and OCR trading. In addition, he considered training and technology transfer; the nature of communication channels, and the role of risk sharing. The major differences have been summarised in the following table:

Table 2.1: Differences between ACR and OCR firms in respect of technology transfer, training, communication and risk sharing

Factor	ACR firms	OCR firms
Technology transfer; training	Transfer of human capital skills or technology only occurs if the net benefits are costed, and reimbursement for production related costs can be claimed in the short term	These elements are not fully costed within written contracts. Partners perceive benefits from such transfer as intangible benefits which should be discounted
Communication channels	Narrow communication channels based on a few key negotiators and a minimum, sufficient number of negotiations	Multiple, open channels for regular communication.
Risk sharing	Risk sharing minimised. If included in contracts relevant contingency plans are formalised and made explicit at the beginning of contract negotiations	Risk sharing made explicit. Nature of cost-sharing negotiated on a case by case basis applying the principle of "fairness"

(adapted from Sako, 1992)

The importance and implications of a number of these are taken up in proceeding chapters. The empirical analysis of risk reduction strategies by NHS Trusts is taken up in Chapter 5 through consideration of default contracting, cost - sharing, and loyalty discounting. Moreover, in the same Chapter, consideration is given to the nature of direct communications within NHS Trusts relationship marketing strategies. The issue of technology or human capital transference was not a primary research question: however, the analysis of contract augmentation and customisation did reveal interesting findings, primarily through the Case Study analysis. For instance, in the Warwick Case, relationship marketing strategies resulted in the upgrading of the local clinical skills base. The implications of this is considered in detail in Chapter 7.

2.4.1 Relationship Marketing: a Hybrid Paradigm

Relationship Market (RM) has been variously defined depending upon the business environment under consideration. Berry (1983, p. 25) perceives RM to involve, “attracting, maintaining, and in multi - service organisations, enhancing customer relationships”. Meanwhile Jackson (1985 p2) defined RM as, “marketing oriented towards strong lasting relationships with individual accounts”, which has resonance with respect to the contracting process between purchasers and providers of secondary care within the NHS Internal Market.

Moreover, it should be noted that relationship marketing is a hybrid paradigm including elements of relational contracting (MacNeil, 1980, 1983; Dore, 1983; Sako, 1991; 1992), strategic alliances (Day, 1990), working partnerships (Anderson and Narus, 1990), and networks (Thorelli, 1986; Achrol, 1991; Ferlie and Pettigrew, 1996).

From the traditional economist’s perspective, there is an important paradox within the relationship marketing paradigm. Morgan and Hunt (1994) identified that, “to be an effective competitor requires one to be a trusted co – operator in some network” (p.20). This view is reinforced by Morgan and Hunt (ibid), citing McKinsey & Company, who argued, “the days of flat – out, predatory competition are over...companies are learning that they must collaborate to compete”, (Morgan and Hunt, ibid, p. 21).

Despite this paradox, there appears to be a lack of detailed studies defining RM in the context of health care, with some exceptions, i.e. Paul (1988), Hatton & Mathews (1996), and Willcox & Conway (1998).

For the purpose of this research, following Morgan & Hunt (1994 p 22), RM is defined as

“marketing activities directed towards establishing, developing, and maintaining successful relationship exchanges”.

Our focus, as justified in detail in Chapter 4, is the use of such strategies to support the contracting process by NHS Trust hospitals in England.

2.4.2 Relationship Marketing and Quasi-markets in Health Care

This section identifies a range of factors in the provision of secondary health care in the NHS Internal Market which are likely to result in the development of relationship marketing (RM) strategies.

Firstly, it is clear that improvements to individuals health status as a consequence of health interventions represents value added to the individual, family and society, although the nature and extent of any value added is difficult to quantify (Drummond and Maynard, 1993; Gray, Harrison and Barlow, 1998). Moreover, despite the importance of agency relationships between the patient, purchasers and providers, the pursuit of improvements to health status will be explicit elements of the objectives functions of purchasers and providers (Mooney, 1994). Meanwhile, the literature on RM (Stone & Woodcock, 1995) stresses the importance of value added in determining the likelihood of RM developing, arguing that where there is high valued added there is a high likelihood of RM strategies developing. This is primarily because of the opportunity of capture of additional revenues and profits. Clearly in secondary health care, interventions result in high value added (given the caveats mentioned above), and thus RM strategies are likely to emerge.

Moreover, following Frey (1997; 1998) it is argued that the predominant motivational factors in the provision and purchase of health care will be intrinsic rather than extrinsic.

The former are not based upon outside forces such as monetary reward, but reflect self-oriented goals including contribution to others well-being, contribution to team performance, and pleasure (Frey, *ibid*). Furthermore, the relative importance of intrinsic elements are likely to be high for both purchasers and providers. This will tend to reinforce the desire to build close working relationships between purchasers and providers in an attempt to improve the likelihood of NHS contracting managers maximising their utility.

Thirdly, it may be argued that continual development of innovations in medical technologies mirrors the proliferation of product brands in consumer markets. It has been argued that (Stone & Woodcock, 1995) brand proliferation results in greater competition: in the context of NHS Trusts hospitals, continual innovations imply that competing Trusts will be able to offer differentiated health interventions. Of importance, the concentration of new health technologies will differ between potential providing units, with the consequence that the ability to differentiate services will vary between different providers: for example, being greater in a large urban general and acute hospital than a small community hospital. One important implication is that suppliers with a relative competitive disadvantage (Porter, 1987) in new interventions will attempt to counter increased competition through a RM strategy. One way an RM strategy may achieve this is through the development of a stronger customer (i.e. purchaser) orientation, with providers differentiating their health interventions through additional service benefits being used to ‘top-up’ basic service agreements. In this instance, additional benefits will not focus upon elements central to clinical interventions, but upon elements peripheral to core clinical aspects of contracts, e.g. supporting management information systems, or forms of “aftercare” such as additional patient transport services. This augmentation of contracts will enable competitively disadvantaged Trusts to compete more effectively.

An additional macro level factor increasing the probability that RM strategies will emerge in the NHS Internal Market relates to the nature of specific health care interventions. Of most relevance here is the homogeneity or heterogeneity of health care interventions. In respect of the RM literature, it is argued (Doyle et al, 1996) that the greater is product homogeneity the more likely it is that providers will attempt to differentiate each intervention package from that of its rivals. It is likely, for example that for particular types of cardio-vascular interventions there will be a well recognised set of necessary

elements within the episode of care, indeed this is the whole basis of DRG analysis used to contain costs of interventions in the USA. Thus individual providers may recognise the opportunity to differentiate their cardiovascular “standard” procedure from that of competing providers. This may be achieved by augmenting or customising contracts for specific purchasers. Moreover, this may be achieved without breaching guidelines laid down by clinical governance agencies, e.g. the Department of Health or the British Medical Association.

The centrality of information flows, and its quality was emphasised by Propper (1992; 1995). In respect of contracting, information is vital to contract specification in terms of volume of treatments, time horizons, the monitoring and auditing of contracts, and responses to non-fulfilment of contracts. The need for this depth of information, and its primacy in quasi-markets (Propper, *ibid*) provides the opportunity for providers to identify the needs of purchasers. RM strategies, with their emphasis on direct communications strategies will enable providers to more accurately “map” local health needs, and thereby strengthen relationships with purchasers.

Meanwhile, Le Grand and Bartlett (1993) have stressed the importance of market structure in determining the likelihood of quasi-markets achieving their objectives, i.e. of increased efficiency, greater access and choice, and increased responsiveness. The nature of market structure is also considered important in determining the likelihood of RM strategies developing. Doyle (1995, p.5) has argued that where markets are highly concentrated

“relationship marketing strategies become both viable and also essential (although not always forthcoming”)

As case evidence suggests (Le Grand & Bartlett, 1993; Appleby et al, 1994; Wistow et al, 1996) the extent of competition with the Internal Market in health was more perceived than real, with the purchaser – provider split resulting in bilateral monopoly vis-à-vis localised health care provision. In the absence of substantial cross-boundary flows of patients via ECRs, a single Health Authority would typically represent the dominant purchaser and often faced a limited number of NHS Trust providers. Moreover, evidence suggests that local purchasers and providers often developed “sweetheart” relationships

(Propper, 1995), with DHAs having preferred providers often determined by personal relationships formed between senior managers who previously worked within the bureaucratically planned NHS. Thus in respect of RM theory, (Doyle, 1994) it could be predicted that there is a strong likelihood of RM developing.

Doyle (1994) has further argued that RM strategies are likely to be more significant where there are frequent purchases of products. Frequent purchasing clearly arises within a quasi-market in health care, e.g. with reference to contracting for hip replacement operations. Moreover, this frequency of purchasing was compounded by the enforced, DoH annual round of contracting operating under the former NHS Internal Market. From an accounting point of view frequent purchasing reduces the marginal costs of specialised management systems used as an integral element of RM strategies (e.g. systems used for monitoring progression of contracts) and increases asset utilisation rates. In addition, following Doyle (*ibid.*) p. 6.

“Such frequency may also generate communication economies through familiarity, lower involvement, and development of habitual or routinised purchase”.

The theoretical literature on RM also suggests that there is an inverse relationship between RM and transaction costs (Doyle, 1996). Where augmentation and customisation of contracts does arise, this will actually reduce potential information economies from uniform transaction management. This will offset the information economies arising through repeat purchasing, and in turn may provide an incentive for managers to more closely consider means of containing cost.

Continuing, with the evaluation of transaction costs, it is important to consider how RM strategies will affect more generally the extent of transaction costs in the contracting process. Following Williamson (1985), it is recognised that transaction costs will tend to be enhanced within the purchaser-provider relationship by opportunistic behaviour, difficulties caused by asset specificity, and the existence of bounded rationality (Simon, 1962). Recent empirical evidence on residential care for the elderly (Forder, 1997) identifies the existence of opportunistic behaviour, although there is a paucity of evidence for secondary care in the UK. It may be argued that attempts by providers to build closer,

regular contractual relationships with purchasers will reduce the possibility of such opportunism.

As an integral part of RM strategies, providers will jointly gather information on the needs of local health populations, and also augment and customise services to meet specific purchaser needs. By fine tuning contracts, the nature of output and outcomes will become better defined and failure to achieve appropriate outputs and outcome levels will become more visible. Furthermore, one consequence of customisation of contracts is the development of a contract monitoring system unique to a specific GP funholder or District Health Authority. This will again reduce the potential for opportunistic behaviour.

In respect of asset specificity, there are clear examples in secondary health care where RM strategies can reduce consequent transaction costs. In terms of elective surgery, the need for operating theatre and staff ties buyers and sellers of health care into the contract, and makes it costly for either party to exit the contractual relationships. However, as Le Grand and Bartlett (1993) argued, it is the provider who is most vulnerable to contract prices being negotiated downwards, or contract switching behaviour by purchasers. In essence, the operating theatre represents a sunk cost and in the face of falling prices/contract switching there may be a disincentive to further investment. Despite this, RM strategies may enable mutual cost savings to contracting parties, and in particular enables more intensive use of highly specific assets. In this dual incentive situation, transaction costs may be reduced as occurred in the Warwick General NHS Trust case evaluated in Chapter 5.

Moreover, RM strategies may reduce the extent of bounded rationality, by providing improved information on the needs of local purchasers and by developing a closer working relationship, which subsequently reduces uncertainty. As argued above, customisation and augmentation of patient services may involve the development of unique monitoring systems to consider the progress of contracts, thus reducing ex post costs. Moreover, the additional transaction costs arising through non-standardised contracts may provide an incentive for providers to reduce ex ante costs associated with the drafting, negotiating and safeguarding of contracts. It is recognised, however, from a

theoretical perspective that it is not possible to eradicate bounded rationality through RM (Forder, 1999), given planning for all contingencies remains impossible.

Finally, the Trust-Commitment (Morgan & Hunt, 1994) hypothesis argues that successful RM strategies depend upon the presence of both trust and commitment. Morgan and Hunt (ibid) consider in detail definitions of commitment and trust in the marketing literature, choosing an eclectic definition. Trust occurs when one contracting party has confidence in an exchange partners reliability and integrity, whilst commitment occurs when an exchange partner believes an ongoing relationship with another is important as to warrant maximum efforts at maintaining the relationship.

Recognising (as outlined in Section 2.3.2 above) that there are many conflicting definitions of trust in the literature, from the perspective of the Trust – commitment hypotheses it is clear that trust is of primacy in health care markets.

Clearly, product failure will be unacceptable in the context of the consequences on individual's health states, and also the political implications. Moreover, Morgan & Hunt (1994) emphasises that the existence of trust reduces transaction costs during the contracting process, e.g. because competent performance may lessen the need for tight monitoring of contracts progress.

Furthermore, it may be argued that the continued importance of social objectives in health care, and the cultural bias within public services towards honesty and truth should encourage trust among purchasers and providers. Moreover, even if opportunism were present, with subsequent reductions in levels of relational trust, then following Best (1993), it may be argued that such opportunism is simply the consequence of uncertainty. For instance purchasers and providers may express different perceptions about unit costs simply because of bounded rationality even when they may both be behaving altruistically.

In respect of commitment, the nature of market concentration may enforce committed behaviour between purchasers and providers. A localised quasi-market in health care may not be contestable let alone perfectly competitive. Furthermore, the possibilities for exit,

or effective voice (Hirschman, 1970) by purchasers in the face of concerns over service quality by providers may be limited or non-existent.

Iteratively then, if commitment and trust are both pre-requisites for successful RM strategies, then their predominance in health care markets is likely to encourage the development of RM strategies by NHS Trusts.

Lastly in this section, it should be noted that the potential for the introduction of relationship marketing strategies by NHS Trusts is affected by the perceived importance managers place on each element of the strategy, e.g. loyalty discounting. Furthermore, Hatton and Mathews (1996) argue that the greater the belief in the importance of each element, the easier is the shift towards a systematic RM strategy. Following Hatton & Mathews (*ibid*), and important to the evaluation of how significant RM was in the NHS Internal Market, they stressed that,

“The lack of support for individual elements of relationship marketing does not invalidate the strategy as a whole, instead it means more effort will be required in the implementation phase of such a strategy”, (p. 46).

Furthermore, there is growing acceptance that marketing behaviour is not solely applicable to provision of private goods and services. As Willcox and Conway (1998) argued marketing is primarily “exchanging mutually satisfactory values, and these mutually satisfying exchanges are not solely relevant to profit seeking organisations”, (p. 124).

Moreover, further supporting the relevance of the above case for applying the RM paradigm to the NHS Internal Market, Willcox and Conway (*ibid*) argued, “Today there would seem to be general acceptance that marketing can, and should be applied to the health care sector” (p. 124).

2.4.3.1 Applying Relationship Marketing Principles to the NHS Internal Market: Some Caveats

Whilst section 2.4.2 made a strong case for the relevance of RM strategies to the NHS Internal Market, a number of caveats should be added. Firstly, it is clear that the NHS serves multiple publics, i.e. an NHS Trust provides services for purchasing agents, and end service users. In this setting NHS Trusts, are unlike ‘for profit’ organisations because the latter have marketing functions which simultaneously attract and allocate resources. Meanwhile, for NHS Trusts, the attraction of and allocation of resources often “involves different constituents with differing needs”, (Willcox & Conway, 1998, p. 125).

In addition, there is the relevance of non – financial objectives. In the NHS Internal Market the success or failure of marketing strategies might be measured by success in attracting contracts (and the associated revenues). However, this may not be an effective measure of how far purchasers were satisfied with the providers services. Indeed, an integral element of relationship building strategies is greater efforts to gauge purchaser satisfaction through satisfaction surveys of both patients and DHAs. Moreover, given the emphasis within RM on building long term relationships, a short - term analysis of revenue flows would be inappropriate.

Additionally, Walsh, (1994) considers non – market pressures to limit the extent to which marketing can be applied to health care. As considered in more detail in the subsequent chapter, Walsh (ibid) argued, *de facto*, public services *raison detre* constrains marketing’s role to promotion, awareness, and customer relations. In his view, the central resource allocation decisions should necessarily be taken through the democratic process and not as a consequence of the development of RM strategies by NHS Trusts.

Finally, it may be argued that the commercially oriented concepts associated with an RM strategy outlined above make limited sense in the context of NHS basic service agreements. This is primarily because such agreements were often poorly defined in respect of standard contract elements, e.g. volume (Paton, 1998), let alone more intangible aspects such as contract augmentation. However, the wider evidence on which the statistical evidence presented in this thesis is based (see Chapter 5), suggests that contract augmentation and contract customisation were typically accompanied by the inclusion of

additional governance procedures. For example, these included various default clauses to cover contingencies arising. Thus elements of service agreements relating to the commercially oriented concepts of augmentation, and customisation may be regarded as tangible aspects of NHS Trust contracts.

2.4.3.2 Identifying Relationship Marketing Strategies in Health Care

Given the strong case for the existence of RM strategies within the NHS Internal Market, it is necessary to specify those factors central to any RM strategy in the sector. Assessing the prevalence of these necessary factors will provide direct evidence of the extent of RM behaviour in the quasi-market for secondary health care. It should be stressed, however, as indicated in the introduction that there is no singular definitive answer to the question “what is relationship marketing, and what are the key components of any such RM strategy?” Thus it is necessary to identify a set of generic factors integral to the development of RM strategies.

Following Stone & Woodcock (1995) it is intended to focus upon the so-called cornerstones of relationship marketing. These are identified as Service Augmentation; Customisation of Services; Market Segmentation; Direct Communications Strategies; and finally the development of Specialised Distribution Systems. It must be emphasised that contract augmentation and customisation represent examples of non-price competitive strategies.

Service augmentation was measured in terms of whether NHS Trusts offered additional services and benefits over and above that necessary for fulfilment of basic service agreements. In essence, such augmentation was in terms of “top-ups” to basic service agreements, which were typically provided to all purchasers, and, moreover were not usually related to core clinical services. (See Chapter 5).

Meanwhile, customisation of services was defined in respect of the “fine-tuning” of generic patient services to meet the needs of a specific, individual purchaser. Thus the focus here was more heavily upon elements central to core clinical treatment.

In addition, the study considered whether such customisation was extended to governance procedures, with NHS Trusts asked to specify whether they had a standard monitoring

procedure across all types of purchasers. Moreover, the customisation of contracts is not to be confused with the concept of cost-per case contracting. The focus is, however, demand led changes in basic service agreements, required of NHS Trusts by DHAs and GP fundholders. Contract customisation did not involve compiling, and then costing a care package for a single patient.

In terms of market segmentation the analysis considers both price and non-price discrimination by providing NHS Trusts. This establishes whether providers have different contractual relationships with different purchasers, and as argued above indirectly reflects the need to differentiate health products in the face of potential competition from alternative providers, and as a response to the proliferation of medical technologies. Consideration was given to the extent of volume discounts, loyalty discounts and other alternative forms of pricing discounts. Furthermore, NHS Trusts were asked to identify their perceptions regarding the segmentation of the market by lead purchasers, i.e. District Health Authorities in terms of the existence of preferred providers, and differentiation of governance procedures between competing providers.

In terms of direct communications strategies, pertinent questions included the extent of regular feedback on the satisfaction of purchasing units, the emphasis given to personal relationship building, and the extent of information exercises undertaken jointly to assess purchaser needs.

In the context of health care, specialised distribution may involve development of new services which remove the need for intermediaries, innovations to the layout of medical facilities, or the development of advanced support systems for purchasers. As Doyle et al, (1996) argued, specialised distribution has a number of advantages. These include increased user satisfaction (e.g. achieved through the reduction in transaction costs to purchasers), an increase in profits (which in the NHS would be reflected in higher revenues for providers), and finally, reductions in “long channels” of communications with further subsequent reductions in transaction costs. However, it is recognised that it is often difficult to delineate key elements of the relationship marketing strategies of NHS Trusts. Indeed, the empirical evidence presented in Chapter 5 identifies that NHS Trusts often developed corporate wide RM strategies, deploying a wide portfolio of individual strategies, making such delineation more problematic. Thus the evaluation of specialised

distribution systems is considered alongside the analysis of contract augmentation and customisation.

2.5 General Conclusions

This chapter has demonstrated a whole range of epistemological problems. These relate to defining key evaluative aspects of the NHS Internal Market including efficiency, equity, access and consumer choice, and also key structural elements, i.e. competition, information, transactions cost, uncertainty, and motivation.

In addition, there are conceptual difficulties in defining what is meant by relational behaviour, i.e. in the context of the differing perspectives associated with competing theories, including Reputation theory, Contract theory, Relational contract theory and relationship marketing. Moreover, there are also significant problems associated with defining loyalty, trust, and opportunism in the context of a quasi – market in health care, which is important because these are fundamental elements of relational oriented strategies. These problems are compounded further because “health” is an intangible, unique and complex product (Mooney, 1993).

The foundation of a theory of quasi – markets in health care was provided by Le Grand and Bartlett (1993). However, this chapter identified a range of conceptual and technical weaknesses associated with their work from the perspective of evaluating the relationship building strategies of NHS Trusts. Despite this, it is important in concluding this chapter to provide some defence of Le Grand and Bartlett’s (1993) theory.

Foremost, it is essential that researchers identify the empirical consequences of the quasi-market reforms. Despite the associated problems, Le Grand and Bartlett (ibid) stressed,

“To do this requires the development of the theory of quasi-markets”. (p 13)

Moreover, as well as recognising their work only represented a starting point, they also recognised that the pre-conditions identified for a quasi – markets success are not static,

“If it is impossible to meet one, this does not necessarily imply that the second best position is for the others to be met. It is better for another condition to be violated so as to compensate for the failure to meet the first condition”, (Le Grand & Bartlett, 1993, p 14).

Thus they recognised that the relative necessity and significance of the individual pre-conditions will vary over time, and also in different quasi-markets and sub-markets. However, Propper (1993), commenting on Le Grand and Bartlett’s (1993) work stated, “This view is no single blueprint for all quasi-markets”, (p 67).

Meanwhile, the most important conclusion drawn from the critical review of Contract theory, Reputation theory, Relational Contracting and Relationship Marketing is that relational strategies impact upon competition, information, transactions cost, uncertainty, and motivation. Subsequently, there are a series of implications for whether quasi – markets will achieve their anticipated benefits of increased efficiency, responsiveness and access and choice. These implications are explored further in Chapters 5, 6 and 7.

Undeniably, given the importance of social norms and values in driving the behaviour of health service managers and clinicians within the contracting process, it is appropriate to evaluate the contracting process from a relational perspective. Indeed the theoretical literature suggests that this is true for private goods markets as well as for public services (Lunt et al, 1996).

As argued, the most robust and feasible method for systematically evaluating the contracting process from a relational perspective is incorporation of the relationship marketing (RM) paradigm. It is important to note, however, that the relationship marketing paradigm is a hybrid, comprised of elements of relational contract theory, networking theory, and strategic alliances (Morgan & Hunt, 1994). Subsequently, some caution should be expressed in applying this paradigm to the evaluation of NHS Trusts relational behaviour, given there are dangers in being too eclectic. In particular, the latter can bring disciplines together without full consideration of their compatibility.

CHAPTER 3

Literature Review: Applied Studies

3.1 Introduction and Overview

This chapter critically considers the applied research on quasi-markets in health care, and is intended to complement the theoretical consideration of quasi-markets presented in the previous chapter.

The previous chapter identified the predominance of the Theory of quasi – markets in the evaluation of the NHS Internal Market. Consequently, a large proportion of applied studies evaluated in this chapter, *de facto*, have their basis in Le Grand and Bartlett's (1993) theory, although as far as possible, the critique of these studies is from a relational perspective.

It is contended there is a relative dearth of economics studies specifically applying the relationship marketing (RM) paradigm to the NHS Internal Market, especially in such a comprehensive way as the current research. Indeed, where the theory on relationship marketing has been applied, it is primarily in the field of manufacturing rather than the public services. This is despite the robust arguments provided in the previous chapter, identifying relational marketing behaviour as an integral element of the operation of the NHS Internal Market.

However, the review of applied literature did reveal a number of economic studies with a limited, non- systematic evaluation of relational behaviour. These are drawn from the transformational literature; literature on the social embeddedness of governance processes, and the study of social care markets.

A key comparative study for the current research is also introduced and evaluated in this chapter, i.e. Paton's (1998) study, "Competition and Planning in the NHS". This is dealt with in the section providing a critique of studies applying marketing principles to quasi –

markets in health, i.e. Walsh (1994), Hatton and Mathews (1996), and Wilcox and Conway (1998).

For structural reasons, the review of applied studies is sub-divided into five categories. Although this is justifiable, there remains some overlap between categories, and any distinction might therefore be viewed as arbitrary.

The principal categories are as follow:

- (a) Partial evaluation studies. These studies are founded in orthodox neoclassical economics, and focus primarily upon one of Le Grand and Bartlett's (1993) necessary conditions for quasi-markets success. It should be emphasised that these studies are not partial in the sense of the meaning used in Welfare Economics.
- (b) General evaluation studies. These are not general equilibrium studies in the sense of the Walrasian auctioneer (Walras, 1954), but "general" in respect of a comprehensive coverage of all (or the majority) of Le Grand and Bartlett's (1993) necessary conditions for quasi – markets successful operation.
- (c) Studies from the transformational literature. A limited number of studies were selected which emphasised the relative strength of analysing the impact of health market reforms in terms of changes in organisational processes rather than organisational structures. These studies, which are not founded in orthodox economic theory, claimed it was only when specific changes had occurred, e.g. in respect of management culture, that the necessary and sufficient conditions for the efficient operation of quasi – markets could occur. Two key issues emerge here; firstly the significance of networking within the NHS Internal Market, and secondly the process of social rather than simply legal contracting. It has already been demonstrated that both these elements are central elements of relationship marketing strategies.
- (d) A number of studies are considered dealing with Social Care markets. Further justification is offered below, but in brief these studies indicate the strong similarities between quasi-markets in secondary health care and social care, a

number offering comprehensive evaluation from the perspective of a whole range of paradigms, i.e. the Austrian School, New Institutional economics, and “New” Industrial sociology. The latter provides support for the view that an eclectic approach to the evaluation of relational behaviour is preferable.

- (e) The final section provides a critique of those studies dealing specifically with “marketing” in the context of the quasi – market in health care. Moreover, two such studies provided an explicit evaluation of the relationship marketing paradigm in the NHS Internal Market.

3.2.1 Partial Evaluation Studies

Propper (1995) considered the impact of competition on prices in order to establish the impact of competition on efficiency. More specifically, she considered three aspects of this:

- (a) the relationship between spot-market prices and competition
- (b) spot-market prices and relative market power
- (c) hospital specific factors influencing efficiency

The context for her analysis was conflictual evidence from the US (Propper, *ibid*) which suggested that more competition was associated with higher prices on the one hand, and on the other that competition lowers prices at least in respect of the prices charged by providers to major purchasers.

Her analysis was based upon a sample of all acute hospitals in England from 8 pre-1994/95 Health Regions (representing 118 units). Within these units the focus was upon four specialties, i.e. general surgery, Ear, Nose and Throat (ENT), gynecology, and orthopaedics for the years 1991/92 to 1993/94. Price data was in the form of Extra Contractual Referrals (ECRs), i.e. ECRs relating to unforeseen and small volumes of episodes of care (thus mimicking a spot market).

The price equation was of the form

$$P_{its} = B_1 + B_2C_{its} + B_3M_{is} + B_4X_{is} + B_5B_{its} + B_6Z_{is} + E_{its}$$

where

P_{its} = average specialty ECR price

C_{its} = unit cost

M_{is} = measure of market size

X_{is} = vector of other characteristics

B_{its} = relative bargaining power

Z_{is} = a vector of hospital features allowing it to raise prices (e.g. reputation effects)

E_{its} = white noise error

The key findings were as follows:

- a. ECR prices are influenced by market forces
- b. ECR prices are not solely determined by costs
- c. ECR prices vary by hospital type, e.g. urban versus rural, teaching versus non-teaching
- d. There was an inverse relationship between prices and the size of the local health market, e.g. in respect of ENT and gynecology
- e. Of equal importance it appeared that the relative bargaining strength of hospitals made little difference to prices in respect of orthopaedics and ENT.

This last point is interesting from the perspective of analysing NHS trusts relationship marketing strategies. If, despite relative bargaining strengths, NHS Trusts with a perceived comparative advantage in costs are unable to compete on contract pricing, then *ceteris paribus*, they will compete using none – price competition. The latter is synonymous with relationship marketing strategies.

A number of criticisms can be made of the research. Firstly, it was assumed that the medical services provided were homogeneous in respect of the quality of the treatment received and its effectiveness. This is unlikely given the difference in production

functions employed by different types of hospital, i.e. teaching, general etc, and in particular the heterogeneous nature of one of the key inputs, i.e. the patient themselves. Moreover, it is reasonable to assume that patients would include quality in their consumption function for health care services, and that hospitals may be able to use perceived quality as a form of non-price competition.

Secondly, there is no analysis of the prices set for annual “block” contracts between DHAs and the NHS or between acute hospitals and GP fundholders. Statistically these represent by far the most important form of contracts in respect of volume (Paton, 1998) and value as discussed in Chapter 2. Furthermore, there is insufficient evidence whether ECRs can be used as a surrogate measure for block contract prices.

Thirdly, Propper (1995) uses average specialty cost as a surrogate measure for marginal cost. It could be argued that the research should have used marginal cost given that price is a function of marginal cost. However, on balance Propper’s (ibid) approach reflects the lack of readily available data on marginal costs associated with treatments. Finally, Propper measures bargaining power in respect of the share of a hospital’s income accounted for by a DHA purchaser. The higher the share, the more bargaining power the hospital has (and less the DHA has) because this income can be taken for granted. Whilst this may be justified for modelling purposes, it is clearly naïve. Potentially, NHS Trust hospitals are empowered to award contracts for hospitals outside their immediate administrative boundaries, and this power may be more likely to be exercised for extra contractual referrals than for block contracting. Furthermore, the pattern of income sourcing for a given hospital may reflect the nature and extent of relational contracting, or historic referral patterns (Paton, 1998) rather than the extent of market concentration, as considered in detail below.

Meanwhile, Shanley et al (1993) considered the relationship between price and competition in the context of the development of “payer driven” managed competition in the US. The latter is associated with well informed, price sensitive insurers and employers and constitutes 40% of the total US health care market. Payers maintain databases on thousands of patients and are argued to be less idiosyncratic in their negotiations of contract prices because of the wide portfolio of patients. This volume of patient throughput enables them to negotiate block contract prices rather than simply

reimburse providers for a specific episode of care in terms of the associated accounting costs. Moreover, purchasing power is concentrated among a few large buyers, e.g. the Blue Cross Patient Buyer Plan (with 740,000 members in California in 1993). This system is replacing the older “patient driven” system associated with “price insensitive patients and physicians with limited knowledge” (Shanley et al, p 180). Under this system pricing is set purely with the patient in mind with little incentive for the payer to influence the providers behaviour, e.g. via selective contracting, co-payment premiums, or relational based marketing strategies.

The central hypothesis was that payer driven competition would result in a reduced price/cost margins. To test this, Shanley et al’s (1993) study focused upon Californian hospitals in respect of the private insurance market for the financial years 1983/84 to 1988/99. They selected a surrogate measure for price not based upon published hospital list prices but the prices paid by insurers for a basket of health services. The functional form of the model was as follows:

$$Mit = Bt + BzZit + BxXit + BhHit + Ei$$

where

Mit = the hospital mark-up. This represents the mark-up on average costs

Zit = a set of characteristics enabling an increase in the mark-up, e.g. the extent of hi-tec practices.

Xit = another set of influences on the ability to raise mark-ups including geographic position, service mix, and access to guaranteed state funding via the Medicaid programme.

Eit = white noise

The key findings and conclusions were as follows:

- a) it is not possible to generalise on the impact of competition upon prices. It depends upon the nature of managed competition.
- b) for payer driven markets, however, a lower level of concentration (measured by a Herfindahl index) is associated with a lower mark-up.
- c) the extent of monopsony buyer power in California was limited by hospitals altering the basket of medical services offered. Hospitals were seen to lower the provision of low mark-up services, and increase the volume of high mark-up services.

There are, however, a number of weaknesses with the research from the perspective of evaluating relational behaviour. Firstly, as Shanley et al (1993, p 200) recognised, there are pitfalls in interpreting the price/cost/concentration/competition relationship. It is feasible that hospitals may have a large market share, low costs, and a high mark-up regardless of the levels of market concentration. This may be the consequence of superior managerial skills, technology, or pro – active relational marketing strategies which tie purchasers to providers, e.g. achieved through loyalty discounting. In addition, Shanley et al (ibid) did not allow for co-operation between hospitals. More specifically, it is argued that a rational response of hospitals attempting to countervail monopsony buying power would be to form strategic alliances.

In the context of the UK NHS, evidence presented in Chapter 5 emphasises the importance given to joint ventures between NHS Trusts. These joint ventures, established in respect of both existing and innovative clinical services, represented one key form of strategic alliance.

Of most importance given the hypothesis tested, it is argued that Shanley et al failed to recognise that the prices paid by “players” may vary because of a whole series of non-concentration related factors, especially relational contracting elements. The latter were seen to be significant in Chapter 2, where evidence relating to “preferred supplier” behavior by purchasers was cited for the US. Lastly, and again of importance because of Shanley et al’s (1993) focus on concentration levels, a number of issues arise regarding the definition of a hospital’s market. The research used census data, defining urban population groups of 5000 + and with at least 1 large general hospital as constituting the

market boundary. However, this may not reflect patients and physicians perceptions of the boundary of the market. Propper (1995) suggested that the boundary of the market, in geographical terms should be defined in terms of travel distances, more specifically in terms of travel times in non-rush hour traffic. Propper (ibid) sites evidence that patients and physicians perceive that a 30 minute travel time from the patients home to the hospital unit marks the maximum feasible distance, and as such defines the boundary point of the market. Furthermore, defining the boundary of the market using census data does not account for differences in the product mix of different hospitals, suggesting that the definition of the market's boundary should take into account the 'bundle' of the medical services being offered by particular units. Lastly, on this point, hospitals may jointly provide services, for instance to improve opportunities for contesting new markets, which will again influence the boundary of the market as perceived by patient, physician, and other purchasing and supplying agents.

The last "partial equilibrium" study to be considered is that of Fotaki (1996). Her research was aimed at analysing the changes in quality of care resulting from the development of the quasi-market, focusing upon cataract surgery in 4 case studies. The latter involved an inner city teaching hospital; a "new" department in a well established hospital; a "thriving" unit; and a "struggling" hospital unit. The key objectives were to study the following:

- a. The levels of patient choice
- b. The type and volume of data available to providers and purchasers
- c. Waiting times for special appointments
- d. Waiting times for operations
- e. Adherence to appointment times
- f. Changes in attitudes of providers to users

The methodology involved semi-structured and open ended in-depth interviews, further supported by published data. The findings most pertinent to the current research programme relate to competition and market structure.

In respect of evidence relating to enhanced competition, 70% of the patients surveyed perceived they had no choice in terms of their treatment, and that choice was principally constrained by standard medical practices in the field. Thus patient demands did not appear to influence resource allocation, lending support to the view expressed in Chapter 2 concerning the predominance of the bioengineering approach to resource allocation. Of those surveyed, only 17% of patients stated that choice had actually increased following the health reforms of the 1989 White Paper. The latter is significant in light of evidence presented in Chapter 6 that NHS Trusts relational marketing strategies with GPFHs raised patient's expectations regarding additional service benefits appropriated to their GP, and also resulted in reduced waiting list times.

Of note, Fotaki (ibid) did not identify the extent of the importance of relational strategies, especially that of contract augmentation and customisation, upon patient's choice of, and access to clinical services. The current research evidence will demonstrate the high degree to which inequality in service levels arose through pursuit of relational marketing strategies by NHS Trusts.

However, in defense of Fotaki's (ibid) study, limited evidence did identify that the majority of responding GPFHs believed referral choices had fallen following the market reforms introduction. Of responding GPFHs, 75% stated this was because they had established an exclusive relationship with just one provider based upon superior relative cost performance and relatively higher quality of service. Importantly though, it should be stressed that her arguments over emphasise the role of price competition in driving this preferred provider relationship. Fotaki's (1996) study did not systematically evaluate all the possible causes of this behaviour which is important in light of the evidence provided in Chapter 6, which demonstrates the significance of GPFHs "risk income" in motivating providing NHS Trusts to offer GPFHs additional service benefits.

Further, in defense of Fotaki's (1996) analysis, there was clear evidence of the emergence of relational contracting between non-GP fundholders and providers based upon patterns of relationships developed prior to the quasi-markets inception, which agrees with Paton's (1998) later findings.

3.2.2 General Evaluation Studies

Le Grand and Bartlett (1993) studied the Bristol and Western District Health Authorities (DHAs). Their selection of DHAs to be studied was partly based upon the early application for Trust status made by general hospitals in 1990 in the relevant DHAs. In addition, in 1990 and within the case study areas there had been the early establishment of a cross boundary flow model similar to that discussed in the theoretical context of Chapter 1.

Their analysis was based upon interviews with Purchasing Committees, teams developing NHS Trust hospitals, and a heterogeneous group comprising the District Health Authorities, employee groups, and City Health Council members. These interviews were conducted between April 1989 and March 1990.

Le Grand and Bartlett (*ibid*) directly considered the question of whether the prerequisites for the efficient operation of quasi-markets were in place in the Bristol and Western Health Authorities focusing upon market structure, information, motivation, and transaction costs.

In respect of market structure, the relevant DHAs were bilateral monopolies, with the stimulation of competition being given a low priority, and, moreover with the local health markets being subject to constrained levels of bidding from potential providers of health care services. Imperfect competition in the Authorities was exacerbated by the mergers in Avon of 3 purchasing committees with the consequence that, “little consideration if any was given to the possibility that a single purchaser might distort the market and create inefficiencies”. (Le Grand & Bartlett, 1993, p 82) In addition Le Grand and Bartlett (*ibid*) identified that 60% of local health services were purchased from one dominant local provider.

Meanwhile, their brief consideration of the cost structure of the DHAs suggested high levels of fixed costs to be an important constraint, exacerbated by the existence of teaching facilities. Overall, the implication was that entry by new competitors was unlikely in general hospital care and acute services, leaving only community care services as a potentially contestable market.

Furthermore, empirical evidence suggested significant difficulties regarding the establishment of appropriate information flows, the central concern among purchasers being the poor quality of information flows making it difficult to avoid the following:

- a. Choosing a poor quality service
- b. Buying less input from the provider than was contracted for within basic service agreements

Whilst purchasers clearly recognised the importance of good quality contract design within the quasi-market, they implied that mechanisms to ensure this were in their very early stages of development.

The next necessary condition analysed by Le Grand and Bartlett (1993) was transaction costs in the local quasi-market. Research identified that in 1991/92 95% of the Health Authorities cash limit was spent on block contracts with 6 local NHS Trusts in the Avon area. Empirical evidence presented indicated three key aspects of transaction costs in the Avon area. Firstly, there was considerable variation in the ability of providers to design appropriate contracts. Secondly, a wide difference in the availability of technical data to purchasers on cost-based prices, activity rates, and general service data, and finally, a large number of inconsistencies in the specification of block contracts across providers

Le Grand and Bartlett's (1993) study gave only marginal consideration to motivational factors. As justification for this, they state that, "economic theory provides little guidance as to the way in which the variety of agents motivations (monetary reward; empire building; pursuit of excellence etc) can be expected to impinge upon the efficiency of service delivery", (ibid, p 85).

However, they did present evidence giving a vague indication of motivating factors among purchasers and providers studied. For instance, one purchaser stated the main motivation was "utilising available resources to optimises the health status of the local population" (p 86) whilst one provider stated it was "continuing excellence of teaching and research in Bristol" (p 86). Often, according to Le Grand and Bartlett (ibid)

purchasers and providers identified multiple motivational factors but were unable to identify weightings for specific motivational elements. Of particular importance, respondents were not explicit regarding the priority given to efficiency, responsiveness, choice, equity and quality, i.e. the principal benefits often cited as flowing from the development of the quasi-market in health care.

It is argued that Le Grand and Bartlett missed the opportunity to more fully examine the aims and objectives of the contracting process. Le Grand and Bartlett (1993) provided tantalizing reference to empire building, and the pursuit of managerial excellence which themselves reflect the growth of managerial professionalism in the NHS Internal Market. The latter will be seen, through Case Study evidence presented in Chapter 6, to be perceived as a key causal factor behind NHS Trusts developing relational marketing strategies.

Meanwhile, a more recent study attempting to apply Le Grand's and Bartlett's (1993) framework was that of Appleby et al (1994). A research consortium comprising NAHAT, West Midlands RHA, the King's Fund Institute, and the University of Northumbria undertook the first and only systematic analysis of whether the necessary and sufficient conditions for the efficient operation of quasi-markets in health are in place.

The "Monitoring Managed Competition Project" ran from January 1990 to January 1993 involving in depth interviews with 86 Chairmen, Hospital Managers, Clinical staff, GP's, CHC members, and FHSA representatives. This was supported in a second phase with 77 interviews based upon 1 medical specialty per Health District surveyed, and, moreover focused upon hospital staff from ward sister level through to hospital directors. The geographic focus was the West Midlands covering 18DHA's and 33 acute service providers. The research was further supported by a national survey of purchasers covering all DHAs in England and Wales, achieving an average response rate for the two phases of the national survey of 69%.

Whilst the researchers focus was principally upon the nature of change during the transition towards a quasi-market, i.e. how the changes had been managed; and also the perceptions of why observed changes were happening, the research did provide useful findings on the nature of structural change during this transitional phase. The latter

enabled the consideration of market structure, transaction costs, motivation, information and uncertainty elements.

In respect of market structure one key finding was that there was no single identifiable form to the various quasi-markets studied. District by district the scale of competition, extent of cross boundary flows (i.e. ECRs), choices available to purchasers and the implications of per capita funding varied significantly. Moreover, the research indicates that the heterogeneity of actual quasi-markets reflects in part the discretion given to “local” managers within the NHS. This was deemed by the research team to represent a serious criticism of Le Grand and Bartlett’s theory (1993). In their opinion it was unlikely that in such a dynamic market environment, and given the varied number of quasi-markets as existed, that there would be one unique set of prerequisites, even accepting Le Grand and Bartlett’s (ibid) claim that their relative weightings would vary between quasi-markets

In respect of the interview findings it was clear however, that there was consensus in terms of the perceptions of the benefits of more competition in improving efficiency. Appleby et al (1994) provide the following observations from interviewees:

- a. “Competition at the margin tweaks the unit’s tail”
- b. “You have preferred providers locally but you have to create some kind of tension”
- c. “A win situation with incentives both ways, but where there is a constructive tension keeping people on their toes”

(ibid, p 36), which were cited as ‘typical’ responses.

Appleby et al (1994) and later Renade (1995) also considered the extent to which these diverse quasi-markets were contestable. In respect of supply, they provide evidence that some hospital units were engaging in joint production to contest new markets, and that by 1993 purchasers’ perceptions of the extent of choice had increased because of the ability to purchase services from beyond previously constrained geographic boundaries.

Meanwhile, in terms of demand for 3 of 18 DHAs studied there was a pure monopoly in purchasing, whilst 85% of interviewed DHA personnel stated that a high ranking was

given to GP preferences in placing patients. As with Fotaki's (1996) research, Appleby et al (1994) and Renade (1995) found limited evidence of relational contracting, although again it was only defined primarily in terms of preferred - provider behaviour. There was no systematic attempt to identify the causal factors behind this "relational" pattern of behaviour, although this is partly a consequence of the focus of their research agendas.

In terms of information, the above research sites major difficulties with the quality, accuracy, and also the opportunity costs in respect of time input in the contracting process. Purchasers knowledge was identified as poor in respect of:

- a. The health needs of the local community
- b. The quality of providers services
- c. The comparative cost-based prices of different potential providers

Purchasers particularly focused upon it being more difficult in the quasi-market to verify and access relevant data,

"in some cases providers were claiming increased costs and hence prices which the purchasers found difficult to verify in the absence of yardstick pricing"
(Renade, 1995, p 253)

However, there were perceived to be some improvements to the volume, range and quality of information emerging from the development of the quasi-market. The latter took the form of improvements to the billing procedures of hospitals, and some incentives for providers to provide accurate data on cost based prices and activity rates.

The emerging evidence on the nature of transaction costs supported the earlier findings of Le Grand and Bartlett (1993). It was discovered there was a predominance of block contracting, and a recognition amongst purchasers and providers that these have higher ex- post costs but lower ex-ante transaction costs than per case contracts. Of more significance for the current research, Appleby et al (1994) found that improvements were being made to contracts to reduce the extent of uncertainty. This was achieved through the development of communications channels for the speedy resolution of conflict over

the performance of failing contracts, cost-sharing agreements, and contract negotiations on behalf of all purchasers being controlled by so called “lead purchasers”.

Appleby’s et al’s (ibid) work did suggest that managers were marginally aware that competition was an anathema in that they were effectively still shielded from the rigors of fierce competition. However, of note, the evidence does support an increased cultural awareness among purchasers and providers of the theoretical outcomes associated with perfectly competitive markets. More specifically, agents behaviour was perceived to have been changed as much by this increased awareness as the actual operation of the NHS Internal Market.

In respect of Williamson’s (1985) analysis of transaction costs, but pertinent to motivation, research evidence suggests that the distinction between purchasers and providers had enabled “self interest seeking with guile”. Appleby et al’s study (1994) indicated the emergence of increased opportunism, for example, in terms of both the raising and settling of old political scores, and the chance to raise the profile of long standing debates regarding the role of acute and emergency services (ibid, p 260). In addition, Renade (1995) suggested that, “some districts have never made the purchaser-provider split, they are still far too soft on their own units” (p 255).

Despite the significance of findings relating to Appleby et al (1994), and Renade’s (1995) research, it is pertinent to comment upon the methodology employed, and raise a number of concerns. Firstly, the boundary of the “market” was defined in terms of a Herfindahl Index. This was constructed for 39 West Midlands acute hospitals using patient flow data for 1 specialty, i.e. general surgery. This enabled a value to be calculated for the number of competitors per market area and their relative market shares, with a value of 0 reflecting perfect competition and 10000 reflecting pure monopoly.

There are a number of problems with this approach. It requires detailed local knowledge of the change in the local health care market to explain changes in the Herfindahl index over time. Moreover, the smaller the level of analysis, i.e. Trust, then sub-unit, the greater the concentration level, de facto, and the higher the index value. A similar problem emerges with the focus re the illness category being considered: broad categories produce high index values. Lastly, in respect of the contestability of health

care markets it is vital to recognise that it is not the actual level of concentration which the incumbent considers, but the potential concentration level which the researchers ignored.

The second key problem, accepted by Appleby et al (1994), relates to the problems of analysing the nature of change within the health care market. Ideally the analysis of social change would involve predicting change and comparing this with actual change, or alternatively, a retrospective analysis of the current situation with on the one at some baseline point in time. As Appleby et al state (ibid p 30),“ the picture we observe of the NHS at any one time reflects a multitude if interacting factors. Isolating the impact of any one of these such as the introduction of managed competition is riddled with interpretive pitfalls”.

Lastly, in evaluating the NHS market reforms, both Appleby et al (1994) and Renade (1995) provided only minimal insight into the causal factors behind the relational strategies they mention. Why, for instance, did the cost – sharing and default contracting both studies report actually arise?

Meanwhile, Prevezer (1996) considered two parallel developments in the UK’s Maternity Services. Firstly, the establishment of the quasi-market, and secondly a change in policy focus away from perinatal/infant mortality towards “uncomplicated pregnancy and birth” (ibid p8).

Prevezer (1996) then utilised the Le Grand and Bartlett (1993) Theory of quasi - markets, considering market structure, information, and the nature of transaction costs although motivational elements were not considered. In respect of market structure there was an identifiable shift towards decentralisation of services and increasing consumer orientation. However, the extent of this shift had been limited by the relatively weak voice of the consumer, who had had little influence over the purchasing decisions of either GP fundholders or district health authorities. The process of decentralisation of services could in principle encourage market entry through the re-establishment of smaller maternity units and increasing home care. Despite this opportunity, it would have required pump-priming investment in these health services at a time when, “the Department of Health’s view, is that what is required is the redeployment of existing resources”, (Prevezer, 1996, p15).

The most pertinent point made by Prevezer (1996) was the emergence of conflict within the internal market for maternity services. In particular, she identified the development of a competitive culture and the development of network forms of social organisations. The former is perceived to be the consequence of increasing patient choice through competition, whilst the latter arose through attempts to encourage greater flexibility in response to the health needs of the local community. This in turn results in greater pressure for providers and purchasers to build on existing trust and develop closer links. Despite this perception, no attempt was made to formally model, or provide *a priori* explanation of what caused these “greater pressures” (ibid, p 16) to develop.

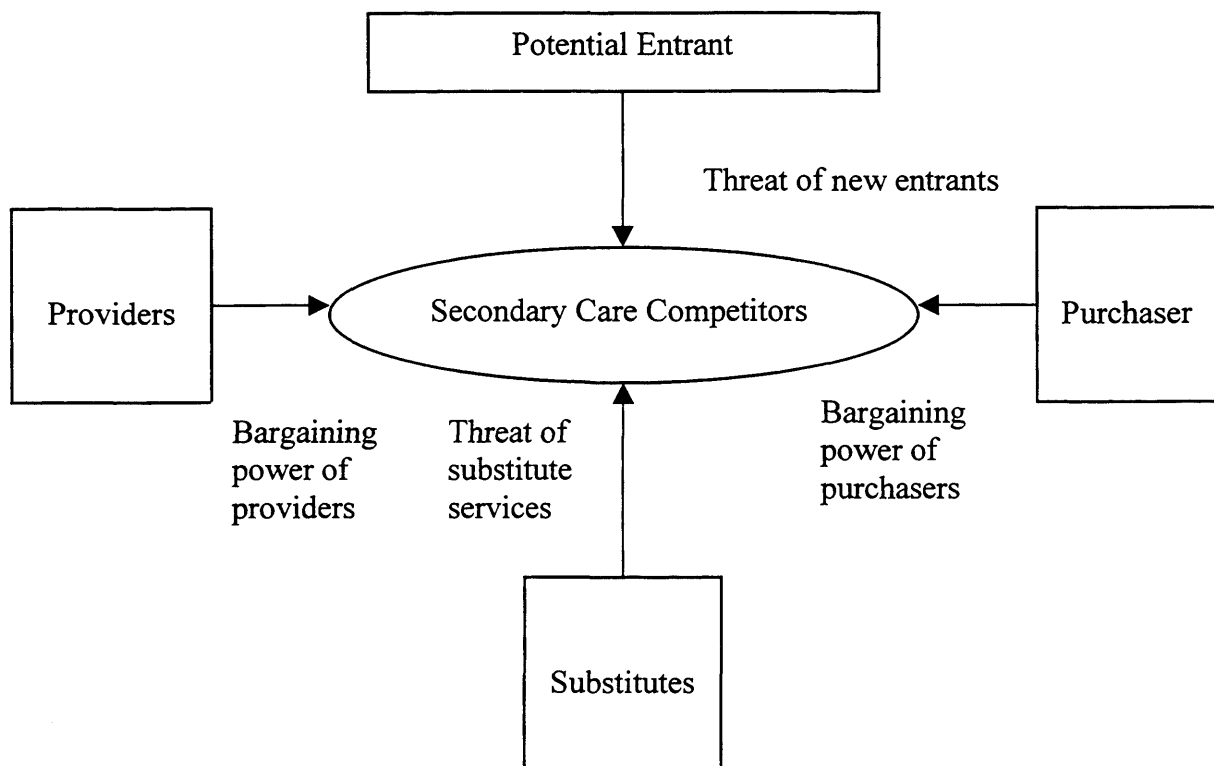
Prevezer (1996) perceived that in terms of information, its quality and availability actually declined following the development of the NHS Internal Market. This view was, however, further qualified: data collection and collation at the local level by trusts, DMUs and GPs had increased whilst publicly available data on the NHS’s spending patterns, treatment costs etc had declined. One issue here is that the increasing gathering and dissemination of data at the “micro” level resulted in an accompanying increase in the internalisation of data, primarily because in a quasi - market such data would be perceived to be competitive. However, this opinion is at odds with that of the current research: in Chapter 5 it will be demonstrated that DHAs often made potentially competitive data, e.g. monitoring requirements made of specific providers, or their costings for contracts, freely available to all providers.

Finally, Prevezer’s (1996)) research presented very little evidence regarding transaction costs, only reporting anecdotal evidence suggesting an increase in the administrative cost element of contractual negotiations between GP fundholders and providers. Of particular relevance, Prevezer (ibid) failed to recognise the impact additional pressures for closer contractual relationships with providers would have upon ex-ante or ex-post transaction costs.

Lastly in respect of general evaluation studies, Scrivens and Henneh (1984) emphasised that markets do not operate efficiently automatically, but require an appropriate organisational structure and a regulatory mechanism to correct for market failure. In particular, they point out that the appropriate organisational structure relates to the nature

of the organisations external economic environment. Consequently, they adapted Porter's 5 Forces model (1983) to identify the pre-requisites for an efficient quasi-market. The following figure provides a representation of Porter's model applied to the NHS Internal Market.

Figure 3.1: An Adaptation of Porter's Model for a Quasi-market in Health Care



Scrivens and Henneh (1984) then identified five sets of questions to ask:

- a) **What is the threat of entry to the incumbent?** In particular what is the nature of barriers to entry to the local health market? Are they exogenously or endogenously determined? Are sunk costs significant regarding human capital or capital equipment?
- b) **Are new products or substitute products becoming available?** This is significant in the context of innovations in clinical practices. Scrivens and Henneh (ibid), assumed that purchasers would "shop around" for the most

competitive contract prices, volume of treatments, and highest quality of interventions.

- c) **What is the extent of the rivalry?** According to Porter's model, the degree of competition is principally affected by the tradition of competition in the market; the number of providers; the level of industry growth; and whether similar products are available.

d & e) What is the relative bargaining power of purchasers relative to providers?

The optimal scenario was perceived to be a highly concentrated market in purchasing relative to a diffuse group of providers.

Scrivens and Henneh (1989) then applied the model to different health market scenarios, one example being a comparative analysis of a rural and suburban district General hospital. They assumed that the latter was a non-teaching institution providing core services and elective surgery, arguing subsequently that there was little competition among providers, but that GP fundholders could refer patients to different units. The extent of GP fundholding is a vital influence on market power of providers. In essence, the more purchasers the better, e.g. 200 GP fundholders facing a single DHA. Some competition may occur regarding non-core activities if patients can be transferred across health authority boundaries., although evidence suggests (Propper, 1995b; Paton, 1998) that Extra Contractual Referrals represented a minority share of all contracts for NHS Trusts. In addition, there is room for entry regarding minor day surgery, which could be done by single or colluding GP fundholders. From Scrivens and Henneh's (1989) analysis it is possible to contend that:

- The relative importance of the various 5 forces within a specific quasi-market in health care will vary over time, and will be different for different quasi-markets.
- Given a specific local quasi-market in health there will be a set of unique necessary pre-conditions. In some respects this is a criticism of the approach. Potentially, there are an infinite number of pre-conditions depending upon the specific economic external environment faced. This makes the model, of limited use for policy decision makers, and ironically attacks one of the supposed methodological strengths of Porter's model which

is its generality (Foss, 1996).

- Utilising Porter's model allows us to identify organisations competitive strategies in the context of its external economic environment. Moreover, of importance to economists there is clear recognition of the importance of industrial structure in determining both the potential strategies open to health organisations and also the competitive rules of the "game". It is possible therefore to identify which strategy will be adopted in the face of specific environmental conditions. For example, a snapshot could have been taken prior to the imposition of the recommendations of the 1989 White Paper, and one taken in 1997. These could then be compared to see the change in organisational strategies adopted.

However, following Foss (1996), it would not identify how specific health units behave in the face of changing external environments, or why they may change their behaviour. The latter is a significant criticism in the context of evaluating the determinants of relational behaviour. Moreover, the level of predictions possible from this approach are low. It is simply a case of "given this external environment, this is the optimal, strategy, and given an alternative external economic environment this is the optimal strategy". One important policy implication of this is that "worst practice" providers could not learn by observation of the "best practice" provider.

3.2.3 Transformational Literature

Ferlie and Pettigrew (1996) base their analysis of quasi-markets in health care upon the theory of networking developed by Best (1993) and Nohria (1992). This theory seeks to explain the transition from Fordist systems of production towards networking, the principal features of the latter being:

- i) The growth of hi - tech companies with separate legal identities but operating closely, e.g. through cost - sharing in Research and Development, and labour training facilities.
- ii) The emergence of the entrepreneurial firm

- iii) The breakdown of large geographic concentrations of industry into smaller ones, e.g. as occurred throughout the 1980's in textiles in Emilia Romagna, Italy
- iv) The centrality of inter and intra-organisational social relations.
Organisations are deemed to evolve over time, reflecting changes in social relations as well as changes in market structure
- v) Of particular note given the aims of the current research, there is an emphasis upon trust, reputation, and reciprocal behaviour between economic agents
- vi) The development of joint ventures, strategic alliances and outsourcing

One key methodological question is whether the NHS has the elements of networking as defined by Best (ibid) and Nohria (ibid). Ferlie and Pettigrew (1996) state that the emerging quasi-market in health care in the UK closely related to the theory of networking (ibid p 82).

Firstly, NHS contracts are not discrete “one offs”, but are often repeat contracts based upon a continuous process of negotiation between purchasers and providers. Moreover, these contracts are complex, with demand from purchasers not simply being driven by prices but reflecting quality of outcomes, the anticipated speed of response when contracts fail, and re-admission rates associated with a particular provider.

In addition, it was argued that the ever complex and technically progressive nature of health care identified potential net benefits to providers through networking. The latter enabled exchange and co-interpretation of knowledge amongst providers and is vital given the high sunk cost element of obtaining medical knowledge, and also the bounded rationality of physicians assimilating ever specialised knowledge. Networking within the NHS appears to support the Penrose (1959) view of the “learning firm” considered earlier in Chapter 2.

Furthermore, the nature of health as a consumption good induces networking, especially in respect of joint ventures in episodes of care. A notable example is the treatment of Rheumatoid Arthritis which involves co-operation between a multitude of agents

including the NHS, the informal care sector, and the voluntary sector, e.g. Arthritis Care (Gray, Harrison & Barlow, 1998).

Finally, the development of the NHS Internal Market led to a change in managerial culture. This has been away from general management based on the hierarchical planning model towards team working, and the emergence of what Ferlie and Pettigrew (1996) described as the “corporate diplomat”. NHS managers are argued to require skills in corporate diplomacy because they deal with inter and intra-organisational agents, and notably, these skills are central to the development of relational marketing strategies (Stone and Woodcock, 1995). This in turn, they argue supports the emergence of the ‘entrepreneurial organisation’, which Enthoven (1985a; 1985b) specified as central to the successful operation of a quasi – market in health care. Having considered the relevance of networking to the emerging health care quasi-market, it is appropriate to investigate the findings of Ferlie and Pettigrew’s (1996) applied research.

They consulted 9 purchasing Authorities across Great Britain which met the Department of Health's criteria for being at the “leading edge” of networking within the NHS. Within these purchasers, “a spread of respondents from different functions and agencies were accessed, amounting to seventy in all”, (ibid, p 587).

One key finding was that, “as relations within the NHS trusts matured reliance on the market was seen as marginal, and even as declining with network based forms of management rising in importance” (Ferlie & Pettigrew, ibid, p 587)

Moreover, there was clear evidence that managerial cultures were evolving away from hierarchical, general management models based on uni-functional or profession oriented roles. The revealed shift was towards team based, multi-disciplinary models taking matrix forms (Handy, 1987). Individuals within specific teams and matrices were expected to be “matrix hoppers” (Ferlie & Pettigrew, 1996, p 588). This transition was supported by a move away from meetings based communication and co-ordination towards the use of new technologies, especially Electronic Mail.

Co-working among GP fundholders and non-fundholding GPs was found to be of limited significance, the majority of GPs still being micro oriented in terms of focusing on their own practice. However, the researchers did provide evidence of, “new intermediate or

broker roles such as GP locality advisers, GP multi-fundholders, and GP Reference Groups” (ibid, p589)

However, as Ferlie and Pettigrew (1996) identified it was not clear what the motivation for this trend was, again indicating that there is little evidence to date regarding the incentive for deployment of relationship building strategies. As they stated, development of these new roles indicated that agents were strategically aware of the net benefits of networking, or alternatively in Williamson’s (1985) language that they were simply “interest seeking with guile”.

Such strategic alliances were also identified between the NHS and Social Services, and it was recognised that there was a range of barriers to their development. These were primarily the consequence of the disparate nature of market oriented reforms in each sector. Firstly, there was an increased burden placed upon Social Services through the re-organisation of long term care in the UK, i.e. through the Care in the Community Program, which was perceived to have soured inter-sector relations. Furthermore, it was argued that the potential for networking had been limited due to the different pace of development of quasi-markets in health and social care. Ferlie and Pettigrew (1996) perceived that Social Care markets lagged behind Health markets such that structural differences had hampered the growth of joint ventures and other strategic alliances. Lastly, and related to the latter point, the different pace of change towards the quasi-market in each welfare sector had resulted in different management cultures making co-ordination and communication difficult. In the Social Care sector, Ferlie and Pettigrew (ibid) argued that management had remained professionally and uni-functionally oriented, based upon a management hierarchy which hampered communication with the team oriented, multi-disciplinary health care sector. Moreover, where strategic alliances had been formed they had been sensitive to turnover of key personnel in Social Services. The latter point is of importance in the context of the theory of relationship marketing (Stone & Woodcock, 1995; Doyle, 1994), which suggests that successful RM strategies are developed “corporate wide”, and as such are not sensitive to the exit of specific individuals involved in contract negotiations. Subsequently, it is argued that the extent of relationship marketing in social care was likely to have been limited.

A number of qualifications to Ferlie and Pettigrew's (1996) work should be considered. Firstly, the time period under consideration is vital for this type of research. The danger is that changes in management cultures, the development of strategic alliances, sharing of gathering/dissemination of information, and the emergence of a new entrepreneurial class based on corporate diplomacy may be,

"No more than cynical rebelling exercises so that ingrained behaviour re-emerges once the heat is off", (ibid, p 589).

Moreover, the survey sample was compromised of "leading edge" networkers as perceived by the NHS itself. Thus it may be argued that the interview data is biased and unrepresentative of the total population of purchasers, and that the general applicability of the studies findings will become more spurious the further away from this leading edge the purchasers under investigation becomes.

Additionally, it is not unreasonable to assume from the work of Best (1993), Nohria (1992) and Ferlie and Pettigrew (1996) that networking would involve both purchasers and also providers, e.g. via joint ventures to identify local health needs. Despite this, Ferlie and Pettigrew (ibid) only focused upon one half of the market, basing their conclusions upon the corresponding evidence. It is argued that a more thorough analysis would consider networking within/amongst purchasers and providers, but also between the two groups. Networking, involves the deployment of relational based strategies, and the latter, by definition depends upon two way negotiations. Indeed, evidence from the current research presented in Chapters 6 and 7 identify important dual incentives driving the development of relationship marketing strategies.

Meanwhile, earlier work by Ferlie (1994) focused upon the relational contracting aspect of networking in the emerging health quasi-market, his analysis being based upon longitudinal data for the NHS from 1990 – 1993. Ferlie (ibid) stressed the difference between the orthodox economic perspective of the market compared to the actual nature of health markets as the starting point for his analysis.

Conventional markets are based (as evaluated in detail in Chapter 2) upon the existence of the "simple" firm pursuing profit maximisation; active producers operating in atomistic markets; and passive consumers. Ferlie (1994) argued that health market's principal

features were pro-active consumers, and limited numbers of large scale producers, the latter having complex objective functions.

These complex objective functions were perceived to include two key elements in respect of social production, i.e. in the areas of health, education, and social services. Specifically, they include elements of relational contracting and elements of institutional embeddedness. Relational contracting (Dore, 1983; Sako, 1991, 1992), as explained in Chapter 2, suggests that trade revolves not just around physical production and exchange, but also social exchange based upon trust, moral commitment, reduction of uncertainty and conflict, and the need for repeat purchasing. This emphasis builds upon the work of Granovetter (1985) who emphasised that the role of governance and hierarchy in determining and regulating transactions had been over estimated by Williamson (1985). It will be recalled that Granovetter's (1985) analysis is based on the evaluation of trust; the relational links between buyers and buyers, sellers and seller, and buyers and sellers; evaluation of how trust and relational links influence patterns of trade and pricing decisions in the market.

Meanwhile, institutional embeddedness reflects that, "organisations are driven to include the practices and procedures defined by prevailing rationalised concepts of legitimate work, eg hospitals should be more business-like", (Ferlie, 1994, p 108).

The rationalised concepts of legitimate work are in turn driven by politicians and professionals, Ferlie (ibid) suggesting that public sector institutions are subjected to fads and fashions in respect of organisational design and inter-relationships determined by these key players.

A number of pertinent conclusions can be drawn from this research. Firstly, Ferlie (1994) identified a relational spectrum with the orthodox market at one extreme based entirely upon transaction costs, and what historically may be defined as pre-market conditions based entirely upon relational contracting at the other extreme. This is important from a methodological perspective. Evidence suggesting the growth of relational contracting, *ceteris paribus*, would imply the transition within the NHS Internal Market away from the orthodox economic model in terms of this spectrum. Equally, evidence suggesting a decline in the importance of relational contracting would indicate a move towards the

orthodox model of markets, and explicitly the growing importance of transaction costs in determining patterns of trade and pricing. This latter pattern would, therefore, lend support to Williamson's (1985) perspective. Similar conclusions could be drawn from the parallel model of Obligated Contractual Relationships offered by Sako (1991; 1992), and evaluated in Chapter 2.

Secondly, in respect of institutional embeddedness, evidence of such a movement towards the predominance of transaction costs would necessitate changes in the regulation and control of health contracts in respect of the current descending hierarchy of DoH.... Regions..... DHAs..... individual units. These changes would include the development of new forms of regulation and governance, e.g. agencies to resolve contractual disputes between purchasers and providers, greater financial control for agencies; and more governance autonomy for individual providing units.

Lastly in this section, Ashburner et al (1993) focused upon the process of organisational transformation. The evaluation of the nature of transformational change was then used to gauge the extent of the move away from the traditional hierarchy model towards one of competition. One concern expressed by Ashburner et al (ibid) was the disparity between the intentions to reform the health sector and the extent of reforms actually achieved. Following Metcalfe and Richards (1990), Ashburner et al (1993) stated,

“The record of administrative reform in Britain has been poor, with its appeal being much greater than its administrative impact” (ibid, 1993, p3).

Previous research on the pace and extent of transformation within the welfare services falls into two principal camps. Firstly, that of Pollit et al (1991) and Harrison et al (1992) indicating that reforms had little impact on organisational form, and secondly, that of Kimberley (1989) and Davies (1987) suggesting the pace of change and its impact has been greater than originally perceived. More importantly, Ashburner et al (1993) cite Laughlin's (1991) evidence suggesting that whilst the “language” of the market and competition had been absorbed within the NHS, there had been no core cultural or organisational changes.

Ashburner et al's (1993) empirical research was based upon the period of 1990-1993. Interviews were conducted amongst 2 RHAs; 3 DHAs; 2 FHAs; and 4 acute NHS Trust hospitals. The latter was comprised of two "first wave" trusts (April 1991), one "second wave" trust (April 1992), and one "third wave" trust (April 1993). Key personnel were interviewed including Board Members, Authority Members, and a wide spectrum of other health related personnel including managers of community services and a variety of clinicians. These interviews were further supported by two national postal surveys of Authority Members and Trust Directors, obtaining a response rate of 66% and 62% respectively. There was no geographical bias in the responses.

The primary objectives of the research was the identification of changes in the following:

- a) Organisational forms
- b) Personnel rules
- c) Leadership groups
- d) Organisational cultures
- e) Multiple changes in all of the above
- f) An evaluation of how changes in these factors had affected purchaser - provider, provider - provider, and purchaser – purchaser relationships.

In brief Ashburner et al (1993) discovered three pertinent findings. Firstly, purchaser became more focused upon their role in shaping and developing the local quasi-market, and in setting up mechanisms for monitoring the performance of contracts. The latter included the development of systems to deal with the failure of providers to meet agreed contract specifications. In addition, they found significant evidence that supports Laughlin's (1991) view that the language of the market was being absorbed. This was reflected indirectly, it is argued, in the time devoted on average to discussions relating to finance in board meetings.

It was also observed that the nature of the financial information considered during these board meetings was significantly "upgraded" compared to typical financial data used in similar meetings prior to the imposition of the NHS Internal Market reforms. Moreover, in terms of informational change, they identified that traditional performance measures

and supporting data were becoming harder to obtain. This indicates that the new information requirements of the emerging quasi-market were becoming predominant,

“as the relationship between the two parties (purchasers and providers) became more negotiative and contractually oriented, so traditional sources of information began to dry up” (Ashburner et al, 1993, p 7).

Finally, similar evidence to Ferlie and Pettigrew (1996) was found of a movement away from traditional hierarchical management styles towards multi-disciplinary, team based management requiring multi rather than unifunctional skills from managers.

3.2.4 Social Care Markets

A number of studies focusing upon the emerging quasi-market in Social Care were also considered. This is justifiable on a number of grounds:

- a. There was a similar split of purchaser and provider to that in State health care
- b. Social care products are equally as complex as that of health care.

In the case of the latter, there is a similar agency relationship with social care professionals having superior quality technical information relative to service users. Additionally, there is a complexity in respect of outcomes, and associated difficulties in measuring performance. For example, outcome measures would include qualitative elements such as “quality of life” and degree of individual “dignity”, the relative importance of which would vary between individuals, and for one individual at different points in time. Moreover, provision of social care services are not discrete one-offs, but represent repeat episodes of care. Finally, there is a similar reliance on social norms and values influencing the nature of trust, and the degree of opportunism in the purchaser – provider relationship as in State health care.

Wistow et al (1996) focused upon structural changes in the market for social care. They employed an orthodox economic analysis of demand and supply side conditions to assess the extent to which reforms in the social care market resulted in increased competition,

wider consumer choice, greater sensitivity to local needs, and an increase in cost effectiveness.

Of most relevance to the current research programme, the evidence presented by Wistow et al (ibid) makes a number of important observations on the structure of quasi-markets and the importance of their analysis. Firstly, they identified the role of Government in shaping the market.

“this role can be described as one of strategic commissioning: that is, it could be seen as setting or helping to define the architectural brief and thereafter overseeing, but not undertaking the design, construction and running of the building”
(Wistow et al, ibid, p 18)

Moreover, Wistow et al (1996) argued, “market development does not prevent providers from developing markets where some providers are preferred to others”, (ibid, p 23). The latter is pertinent in the context of evidence presented earlier on the development of preferred – provider relationships.

Moreover, there was little evidence of networking amongst Authorities or other relevant agencies in order to develop direct communications strategies, e.g. based on shared collection, collation and analysis of needs related data. Thus little evidence was found regarding the extent to which purchasers and providers experienced relational oriented behaviour, “joint work is still relatively rare, although many Authorities have begun to discuss such a strategy”, (Wistow et al, ibid, p 55).

The most significant problem was that whilst 20 of 25 responding Local Authorities placed importance on recording and monitoring unmet needs, only 2 had any intention to disclose such data for wider dissemination by fellow Local Authorities and other agencies in the social care sector. In particular, Wistow et al (1996) perceived that such data was seen as necessary for the generation of gains in efficiency among economic agents in a quasi-market. The best performing agents could, in principle, guide others in reducing unmet need, although this assumes they are willing to share information which provided them with a competitive advantage. Such information sharing would relate to:

- i) Organisational structure
- ii) Management culture
- iii) Information systems.

Also, agent's understanding of 'the market' was limited in respect of supply side conditions. Evidence presented suggested that only 2 of 25 responding Local Authorities attempted to map supply conditions locally by gathering data over and above the minimum required by law. For example, in residential/domiciliary care markets, responding Local Authorities had the following information:

Type of Data Providers	Percentage of Authorities Providers on which relevant data held
Range of Services	26
Audited accounts	0
Unit costs/prices	4
Levels of utilisation	13
Staffing levels	8
Pay rates	0

(Adapted from Wistow et al, 1996, p 48)

This is an important finding because one key aspect of direct communication strategies within the relationship marketing paradigm (Doyle et al, 1996) is the collection of data on the capacity of potential supplying firms.

However, indicating a limited, naive perception of market forces and pressures, purchasers did identify (Wistow et al, 1996) that financial data on local providers was difficult to obtain primarily because of providers' concerns that such data would be deemed competitive. Moreover, purchasing agents were aware that providers had only limited faith in their guarantee of confidentiality, such that the level of Sako's (1991; 1992) competence and contractual trust was low.

Finally, in respect of market understanding, Wistow et al (ibid) identify naivete among purchasers regarding providers' motivations, and the degree to which they were open to opportunistic provider behaviour. The purchasers were only able to broadly distinguish between the voluntary and private provider sectors, the former being perceived to be driven by "philanthropic goals" whilst the latter were perceived to be driven by the profit motive.

Meanwhile, the work of Lunt et al (1996) on social care markets is also of interest given the aims of the current research. Lunte et al (ibid) considered the potential contribution to be made to the analysis of prerequisites for quasi-markets offered by the "New" Industrial Sociology. The latter is based upon three principles, sited by Lunt et al (1996) as:

- economic goals being accompanied by non-economic goals, including status, sociability, and peer group approval
- that economic institutions are defined and organised as a result of social and economic external circumstances
- economic activity cannot be explained by isolated individual actions and motives, but are embedded in social network relations

The emphasis within this context is then upon social networking and also non-price competition (Granovetter & Swedberg, 1992), both of these elements having considerable relevance to the evaluation of relational marketing behaviour in the NHS.

The importance of social networking within the emerging quasi-market in health care has already been noted as significant in the applied work of Ferlie et al (1996), Ferlie (1994) and Ashburner et al (1996). Meanwhile, Lunt et al (1996) emphasised that in health care ex post pricing is the norm within the quasi-market, with "prices" being determined by the nature of trust, status, and reputation within the purchaser – provider relationship. Indeed, they sited evidence that even in financial securities markets in the City, "complex and enduring social networks influence the pattern of trade and the price of commodities", (Lunt et al, ibid p 379).

Lunt et al (1996) presented important arguments relating specifically to the role of trust in developing social networks and shaping social care markets. Following Sako (1991; 1992), they defined trust as:

“an intangible capital asset which economises on the costs of bargaining, monitoring, insurance, and dispute settlement”

(Lunt et al *ibid*, p 388)

and subsequently considered Sako’s (1991; 1992) three main categories of trust:

- competence trust indicating the likelihood of competent performance
- contractual trust identifying adherence to written and oral agreement
- goodwill trust indicating standards of compliance over and above that necessary in terms of volume, quality, and completion times.

The significance of trust for relational based contracting was considered in detail in Chapter 2, but it is vital here to reiterate that higher levels of trust reduce transaction costs, the latter being central to the operation of the quasi-market (Le Grand & Bartlett, 1993). Secondly, higher levels of trust reduce the likelihood of product failure which is morally, and politically unacceptable with respect to complex health care products.

The second contribution of Lunt et al’s (1996) work was their call for eclectic research when evaluating contractual relationships within quasi-markets. They argued that searching for a “meta-theory” was fruitless, and to support their argument, compared the key evaluative criteria of four competing paradigms. These were given as follows:

	Neoclassical	Trans Cost	Austrian	New Industrial Sociology
Allocative Efficiency	##		##	
Managerial Efficiency	##	##		
Choice	#		##	
Transaction Costs		##		##
Innovation			##	
Continuity of Care		##		##
Equity				##

Their overriding conclusion was that,

“because it is possible to engage with the market in a number of ways, different approaches to thinking about the market can yield different, or contradictory results”
(Lunt et al, *ibid*, p 373)

More specifically, they emphasised that focusing upon one specific paradigm will result in overlooking key prerequisites for quasi-markets in social care, and subsequently results in spurious evaluation of a quasi – market’s performance. This provides indirect support for the evaluation of relational based contracting using the relationship marketing paradigm, given the latter is, as argued in Chapter 2, a hybrid paradigm.

Lastly in respect of social care markets, Forder (1999), presented a scenario based upon high physical asset specificity and poor exchange information to consider what would be the “appropriate” governance mechanism from the perspective of Quasi – market theory; New Institutional economics; Contract theory; and finally Reputation theory.

In respect of the former, his perception was that Quasi – market theory typically predicts market failure, such that, “hierarchy may be far better” (Forder, *ibid* p29). A similar conclusion was drawn from New Institutional economics, whereby the combination of incomplete contracts arising from poor exchange information, and high governance costs associated with highly specific assets suggest, “hierarchies are likely to be the best choice”, (Forder, *ibid*, p29). Not surprisingly, given the theoretical discussions presented

in Chapter 2, these conclusions do not place importance on the role of relationship building in determining the relative superiority of governance mechanisms.

However, in terms of Reputation theory, with its resonance for relational oriented behavior, it was argued that poor information could be dealt with by a, “reputation based hierarchical solution”, (Forder, 1999, p30). Furthermore, it was stated that high asset specificity would suggest that a break – down in the exchange relationship would prove relatively costly, such that again a reputation based solution would prove superior to the market. Lastly, in terms of Contract theory, Forder (ibid) argued that providing co – ordination failures were avoided, high asset specificity did not necessarily imply that market governance costs would exceed that of hierarchies. Given Forder’s (1999) suggested scenario, measurement costs associated with information deficiencies would be anticipated to be high within both markets and hierarchies.

What is of note about this study is that in respect of his evaluation of Reputation theory and Contract theory, Forder (1999) made explicit reference to the centrality of reputation, reputation being synonymous with “trust” (Krepps, 1990a; 1990b). In respect of the latter, i.e. trust, he emphasised the need for “clear focal points to guide swift co – ordination”, (Forder, 1999, p30). Both of these elements, i.e. trust and ‘focal points’ are central elements of relational marketing strategies. In respect of the former, relationship marketing can achieve this through contract augmentation or customisation, or alternatively through loyalty discounting (see Chapters 5 and 6). Meanwhile, the latter can be achieved through bespoke monitoring procedures, and also the maintenance of direct communications links between purchasers and providers, founded on “personal” as opposed to simply “formal” relationships. Despite these insights, Forder (ibid) does not make explicit reference to the impact relational marketing strategies would have upon the selection of optimal governance procedures.

3.2.5 Studies of Marketing Behaviour in the NHS Internal Market

The first paper considered in this section is Walsh’s (1994). The context for Walsh’s (ibid) paper was his view that,

“Every service it seems, from health to waste management and from the courts to housing is being subjected to radical reorganisation, based upon the application of market principles” (p 63).

Moreover, in this context he further argued, “It is not surprising in this atmosphere, that marketing, as both concept and metaphor, has attracted increasing attention from the public sector managers and politicians”, (p. 63).

Walsh (ibid) stressed that marketing was, however, not new to the public services, having been present in the form of advertising and promotion of leisure services by local councils for decades. Despite this, he argued that the recent growth in interest, and heightened attempts to deploy marketing techniques in public services was the consequence of three factors.

Firstly, he cited the rise of consumerism associated with right wing ideology, with its inherent emphasis upon the inefficiency and unresponsiveness of the public sector. According to Walsh (ibid), consumerism was widespread within public services by the mid – 1990’s based upon the principles of:

- a. increasing decentralisation of services
- b. growing “customer consciousness”
- c. greater emphasis on “voice” for service users, i.e. the rise of consumer complaints systems
- d. widening of choice for service users

Secondly, he cited the rise of strategic marketing behavior in the public sector, arising as a consequence of two new processes of resource allocation: these were the growth of contracting out of public services and the development of a series of quasi – markets in health, education, and housing. In respect of the development of quasi – markets, Walsh (1994) stated,

“For many public providers there is now the danger that market failure can put them out of business. Strategy is necessary once monopoly positions are eroded, and they must act in light of what others do” (p. 64)

Lastly, he identified the increasing emphasis given to promotional activities by public services, citing the NHS reforms and the Citizens Charter. Moreover, he emphasised that even in public organisations where dedicated marketing units had not been established, there was a, “need to understand the nature of marketing given competition and consumerism have grown”, (Walsh, *ibid*, p 65).

The central thrust of Walsh’s paper is a critique of marketing in the context of public services. In his view, by the mid – 1990’s marketing behavior had had limited impact on quasi – markets primarily because it’s application was in an early phase of development, and secondly because it had not developed in a way, “specific to the context of government” (*ibid*, p65). The latter point is made in the context of the belief that marketing principles make coherent public debate more problematic, in particular removing individual agent’s responsibilities for each other.

Walsh (1994) stressed that any marketing orientation should be secondary in importance to political decisions on, “what is right and good for the community”, (*ibid*, p67). Thus in this context he argued, “Mission and strategy are matters for political decision, as is the case of what shall be produced and for whom”, (*ibid*, p 68).

A number of critical comments regarding Walsh’s (1994) paper are pertinent. Firstly, his view of “marketing” as a concept appears somewhat naïve in respect of the theory of relationship marketing (Doyle et al, 1996; Stone & Wodcock, 1995). His analysis was based on a perception of the predominance of “organisational” oriented marketing (Kotler, 1994), rather than a relational oriented approach (Berry 1987; Stone and Woodcock 1995). Indeed, it appears Walsh (1994) perceived the prime purpose of marketing still to be based upon the four P’s associated traditionally with the marketing mix, i.e. product price, product features, promotion, and place. Meanwhile, the current research will demonstrate in Chapters 5 and 6 NHS Trusts deployment of mature, relational based marketing strategies.

In addition, Walsh (1994) used contracting behavior as a means of demonstrating the inappropriateness of marketing in public services. He argued, from a normative perspective that,

“Contractarian theory can no more give us a criterion for our contemporary dilemmas of liberty and the efficient distribution than it can deliver universal prescriptive principles of political justice” (p. 69).

However, the current study demonstrates the relevance of “contractarian theory” as Walsh (ibid) calls it, to the operation of the NHS Internal Market, identified through the deployment of relationship marketing strategies by NHS Trusts. Furthermore, Walsh (1994) did not recognise that pro – active relationship building by NHS Trusts is intended to generate and develop loyalty and trust between contracting partners. Subsequently, an awareness of the “responsibilities” of each agent towards each other becomes an integral aspect of any such strategy. Moreover, as revealed through the review of Contract theory, and Relational Contracting in Chapter 2, social norms and values, especially in social welfare provision influence contractual exchanges. Thus the objective functions of purchasers and providers are not likely to be entirely conflictual, but are likely to contain a number of shared determinants, e.g. an emphasis upon professional responsibility. More importantly by way of a critique of Walsh’s (1994) view, it is likely that purchasers and providers objective functions will both include the desire to achieve “public responsibility”, which Walsh (ibid) assumed would be eroded by relationship marketing behavior.

Additionally, Walsh (1994) appears to confuse the concept of “markets” as used by economists, and “marketing” as used by marketers. He stated, “Marketing is a set of ideas based on the assumptions of exchange, competition, and profit”, (p 70). This further underlines he did not fully recognise marketing in the context of relational behavior, where, as argued previously, marketing strategies are a means of competing through co – operative behavior (Morgan & Hunt, 1994; Doyle et al, 1996).

Finally, Walsh (1994) argued that evaluating the role of marketing in quasi – markets was an anathema because,

“If marketing is to be developed for the public realm, then it needs to develop a language that is defined by the specific character of that realm, not negatively, by contrast, with the private sector” (p70).

Ironically, the current research evidence presented in Chapters 5, and 6, will demonstrate that NHS Trusts deployed a wide range of relational strategies with strongly similar characteristics to those deployed in the private sector, i.e. contract augmentation, contract customisation, default contracting, and cost – sharing agreements.

Meanwhile, Hatton and Mathews (1996) considered whether the NHS Internal Market lent itself to relational as opposed to simply discrete transactions. The former were identified, following an evaluation of transactions in a number of key private sector markets (e.g. the motor industry) to depend upon:

- a. long term relationship building
- b. a focal shift away from prices towards non – economic factors in exchange negotiations
- c. joint working towards shared goals

Within the context of healthcare, it was suggested that a shift towards relational transactions could be achieved by focusing upon the role of quality, given, “Relationship marketing aims to integrate marketing with quality, and customer service within a supplier organisation, in order to meet customer needs”, (p. 45).

They drew a number of pertinent conclusions. Firstly, they suggested that a predominant exchange characteristic during the 1990’s would be “inter - organisational relationships”, and that although the NHS was new to this, “It would be wasteful if the lessons from the private sector were not heeded as the Internal Market for health develops”, (p. 46).

Thus explicitly, they recognised that private sector relational marketing strategies were appropriate to the NHS, supporting the arguments made by the author previously in justifying the selection of the RM paradigm as the most appropriate for the evaluation of the purchaser – provider relationship.

Moreover, recommending that NHS Trusts deploy RM strategies, they site Kotler’s (1992) view that,

“To remain competitive, organisations must continuously amplify or enhance their value added package. This is the key to relationship marketing: organisations do not sell products alone. The bundle of benefits that the firm puts together is what keeps customers for life” (Hatton & Mathews, 1996, p 46).

Importantly, the current research evidence supports the “bundling” of benefits by NHS Trusts. Evidence presented in Chapter 5 will identify that far from “selling the product alone”, NHS Trusts deployed a whole range of relational strategies based upon segmenting markets, augmenting or customising services, establishing new supply processes, or developing direct communications strategies of various types.

Meanwhile, the most important conclusion drawn by Hatton and Mathews (*ibid*) is the inherent difficulties associated with evaluating the impact of relationship marketing in quasi —markets in health. This is perceived to be because of the importance of intangible costs and benefits associated with health care, for instance regarding customer care. As Hatton and Mathews (1996) argued, to fully evaluate the impact of relationship marketing would involve, for instance, assessing the impact on patients well-being of good practice by a GP or consultant’s receptionist. It is important to note, however, that economists would draw a similar conclusion, given their understanding of cost – benefit analysis.

An alternative analysis is that of Bennett and Ferlie (1996). They used qualitative data based upon HIV/ AIDS services to determine whether NHS contracts accurately mirrored different theoretical contract types. More specifically, they evaluated the dynamic, fluid process of contracting HIV/ AIDS services by applying four different discrete models. Firstly they applied the Classical model of contracting, with its basis in legal documentation, discrete one- off transactions, and recourse to litigation if disputes arise. Secondly they considered Regulated contracts, which in the NHS Internal Market reflected the imposition of formula funding for NHS Trusts, and the use of arbitration services when contracts outcomes could not be agreed by exchange partners. Thirdly, they applied Pseudo – contracting, with its basis in the transformational literature considered earlier in this chapter. This approach emphasises that market reforms in health are unlikely to achieve sustained changes in the way resources are allocated, primarily because managers across the purchaser – provider divide simply deploy the rhetoric of the market, playing “lip – service” to political pressure for organisational change. The

perception is that once such political pressure is removed, managers revert to pre – market approaches to allocating resources. As Bennet and Ferlie (ibid) argued, “In this model, competition might be more apparent than real, and purchasing viewed as no more than old style allocation re - labeled”, (p. 53).

Of most relevance to the current research, Bennet and Ferlie (1996) applied the model of Relational Contracting evaluated in detail in Chapter 1. It will be recalled, citing MacNeil (1974; 1978; 1980; 1983) that in essence relational contracts are the result of social norms and values influencing the complexity and duration of contracts. Such contracts are typically open – ended and deemed to be more effective when social norms and values are strongly relevant to exchange, as is the case in State secondary health care.

They discovered that in its infancy, the NHS Internal Market had witnessed the adoption of classical contract language, i.e. an emphasis upon competition and adversarial relationships. Despite this, Bennett and Ferlie (1996) identified a failure of pricing of contracts in HIV/ AIDS services to accurately reflect the cost of resources involved.

Moreover, they cited evidence for the importance of elements associated with relational contracting having increased as the NHS Internal Market developed. In particular they identified two forces behind this change. Firstly, the increasing desire for contracts to be based upon long term relationships, i.e. between three and five years compared to the enforced annual rounds of NHS contracting. Secondly, and of great importance to the current research, they presented evidence that contractual trust had initially diminished with the imposition of the NHS Internal Market. Given the lack of detailed contract information associated with Classical contracting, agreements were often entered into whereby, “trust may be obligatory rather than felt”, (p.51).

Bennet and Ferlie (1996) provided evidence of a high degree of mistrust, quoting one purchaser as stating, “the providers are just a bunch of crooks”. Whilst this may represent an atypical “outlying” opinion, the authors did cite evidence recorded in interviews with providers who admitted adjusting contracting information for opportunistic purposes. Of importance for the current research though, Bennet and Ferlie (ibid) argued,

“Recently, however, we have noticed signs that both purchasers and providers are becoming very aware that the lack of trust may put both parties at a considerable disadvantage”, (p. 54).

More importantly still, the authors stated there was a shift towards, “regular meetings with the explicit purpose of developing closer relationships”, (p. 54). This provides some evidence of the development of relationship marketing strategies in HIV/ AIDS services.

Bennett and Ferlie (1996) drew three very pertinent conclusions. Their analysis found the prevalence of each theoretical contract type, although their methodology did not enable them to identify which was the most significant. In addition, they perceived a major shift away from adversarial exchange towards co – operative exchange, and notably identified a number of disadvantages arising from this transition. The latter included a reduction in contract detail as levels of mistrust fell, one consequence being a greater likelihood of ex post disagreements occurring. Furthermore, they suggested that a greater emphasis on relational behavior would reduce efforts to invest in contract monitoring systems, primarily because levels of mistrust would fall as the relationship was strengthened. However, it is noteworthy that the evidence from the current research presented in Chapter 6 will show that a central characteristic of the emphasis on contract augmentation and customisation was the parallel development of additional, more complex monitoring systems. Innovative, bespoke monitoring systems were introduced relating to ‘performance’ of contracts in terms of the additional service benefits being offered by NHS Trusts.

Meanwhile, Willcox and Conway (1998) evaluated the role of clinical directors in the development of strategic marketing by NHS Trusts, based upon two NHS Trust case studies. Their contention was that during the evolution of the quasi – market in health the role of the clinical director had shifted towards strategic marketing, although the considerable emphasis they gave to this shift appears to be at odds with the evidence presented by Patton (1998). Willcox and Conway (1998) further argued that the shift towards strategic marketing was enhanced where specific clinical specialties were exposed to the contracting process, or alternatively where particular specialties had a history of managerial behaviour, in some cases pre – dating the 1989 White Paper’s reforms. It was their perception that in both case studies, the imposition of the NHS

Internal Market had re - focused the role of clinical directors, with particular emphasis subsequently being given to:

- initial contract negotiations with purchasers
- gauging purchaser satisfaction
- evaluating competitive threats, and ensuring quality was maintained or enhanced
- managing the performance of contracts against targets
- satisfying multiple stakeholders.

Subsequently, Willcox and Conway (1998) argued that clinical directors were typically associated with developing leadership skills; enhancing marketing and sales programs, and taking a strategic role within the NHS Trust. In respect of the former, clinical directors were expected to influence peer opinion, and involve all clinical staff in decision making. Meanwhile, in terms of marketing and sales, it was suggested clinical directors had three primary functions: firstly dealing with purchasers; secondly providing an “interface” between directorates within the NHS Trust and the Trusts purchasers, and lastly, directing efforts towards promoting and selling NHS Trust services to purchasing agents. In respect of their strategic role, clinical directors were seen within the case studies to be responsible for leading in the planning and development of clinical services, and expected to play a key role in developing corporate strategy at NHS Trust Board level.

In their investigations, Willcox and Conway (1998) adopted a research methodology based upon Kotler and Andreasons framework for estimating the extent of customer compared to organisation oriented marketing. The predominance of the former would be considered to demonstrate the existence of strategic marketing behavior. The key distinctions between customer and organisational oriented marketing is explained through the following text box:

Organisation Oriented Approach	Customer Oriented Approach
Belief that organisations “offerings” are inherently desirable (little awareness/responsiveness to customer needs)	Regular feedback sought regarding customer needs
Lack of incentive/ managerial ignorance a key barrier to success	Heavy emphasis on market research in general, e.g. evaluation of capacity of potential competitors
A view that “one good strategy will suffice”	Predictions made regarding market segmentation
Minor role for customer research	More mature perception of role of competition
Assumed to be no generic competition	Deployment of full marketing mix, including promotion, communication, services offered, the form of service delivery and so on.
Marketing’s role only promotional/ marketeers have “expert” knowledge about firms “offerings”	

Using this methodology, Willcox and Conway (1998) reach a number of general conclusions pertinent to the current research. Firstly, they argue that on balance the case studies suggest a partial shift away from an organisational orientation amongst the NHS Trusts towards a customer orientation. Of most significance, they suggested,

“Other ‘publics’ such as third parties, competitors, and other stakeholders such as suppliers may require other benefits from the organisation. It is therefore important to build and maintain strong relationships with various customers over time”, (p. 132).

Furthermore, Willcox and Conway (ibid) argued strongly for health professionals to further apply strategic marketing principles. Ironically, this last contention was made in the context of the 1997 White Paper’s prime objective of replacing competitive with co – operative delivery of NHS care. The evidence from the current research strongly

indicates that such strategic marketing behavior was already common within the former, competitive oriented NHS Internal Market.

The most recent applied study of relevance to the current research is that of Paton (1998). His findings were based upon two related studies. The first was carried out in early 1994, focusing upon the relationship between purchaser and provider and the nature of competition. The research surveyed all NHS Trusts and DHAs in England and Wales, with a supporting sub-sample of GP fundholders. This research was supported by a later survey in late 1995/ early 1996 with the same sectoral and geographic focus. This latter survey focused upon three key elements:

- a) The nature and extent of transaction costs
- b) Marketing strategies developed within the NHS Internal Market
- c) The contracting and monitoring process

The national postal survey was supported further by case studies of purchasers, providers, and Regional Health Authorities based on face to face interviews, and exploring the three categories above. A detailed survey of Paton's (1998) thorough findings is beyond the scope of this chapter, and moreover, various findings from his research are considered in detail alongside those of the current research in Chapter 5. However, it is pertinent here to evaluate a number of the central findings of Patton's (ibid) work, focusing upon the process of marketing and relationship building.

Of interest in respect of relationship building, Paton (1998) considered the extent of DHAs dependency on single or majority providers to explore whether dependency was symmetric. The analysis of DHA spending patterns provided the evidence of dependency: the findings do imply a higher degree of dependency. Typically, DHAs gave half their budgets to the main local provider, with 70% of DHA income typically spread between just three providing NHS Trusts. When extended to 80% of DHA income, the average number of providers remained relatively low at five NHS Trusts. This evidence suggests that markets were constrained in respect of contestability, and moreover, that efforts to strengthen purchaser – provider relations via relational strategies by NHS Trusts would have had a limited success in such highly concentrated markets.

Indeed, as briefly considered in Chapter 1, Paton (1998) identified a low priority given by NHS Trusts to the development of closer relationships with DHAs. Only 25% of NHS Trusts had a specified marketing function, and moreover, 23% stated they had no marketing department and no senior management responsible for marketing. Further implicit evidence of the limited importance the surveyed NHS Trusts gave to relational oriented strategies, was the fact that 55% of respondents had less than two full-time equivalent employees with marketing responsibilities. Where efforts were made by NHS Trusts to develop relationships with DHAs, Paton (ibid) claims this was principally because, “their managers are captivated by playing market games”, (p75), rather than because of managers introducing a systematic strategy aimed at strengthening purchaser – provider relationships.

Compounding this evidence, Paton (1998) found that in respect of choosing providing partners, relational strategies were not identified as important. Indeed, relevant factors deemed to be important in this selection were typically reported to include cost, quality, preferred - provider links, and spatial location, with only minor additional importance being attached to the potential service capacity of local NHS Trusts.

Lastly, in terms of the type of marketing activities, NHS Trusts identified the low importance given to clinician’s involvement in developing relational oriented strategies. In total 38% of responding NHS Trusts had centralised marketing units run by professional health managers, and only 17% of respondents claimed these units were mainly specialty based with greater subsequent involvement of clinicians.

Also of note in terms of relational aspects, Paton’s study (1998) did present evidence on risk avoidance behavior by NHS Trusts. His survey evidence identified an increasing preference of NHS Trusts for negotiating activity - based contracts. This pattern of preference was principally emerging for two reasons: firstly, it ensured that NHS Trusts income better reflected their activity, and secondly, reduced risk by guaranteeing income compared to the alternative simple block contracting. However, Paton (1998) did not present findings regarding the use of specific contracting elements to reduce risk, i.e. in the context of the current research, he did not consider in detail the extent to which contracts included relationship marketing elements such as:

- a. contract augmentation
- b. contract customisation
- c. loyalty discounting
- d. default contracting
- e. cost- sharing contracts

Further, implicit evidence on the extent of pro-active relationship building by NHS Trusts in the NHS Internal Market was, however, provided by Paton's (ibid) insights into who had led the purchaser – provider negotiations over contracts.

Of responding DHAs, some 37% stated they led the contracting process with only 11% stating their providing NHS Trusts led. This contrasts with the NHS Trust perspective: of Acute NHS Trusts 39% claimed they led contract negotiations, the equivalent figure being much lower for Community NHS Trusts at 15%. The latter is a reflection of their relatively weaker bargaining power in local health markets compared to Acute NHS Trusts. Meanwhile, the figure presented for Acute NHS Trusts provides implicit evidence of pro-active relationship building behaviour, although Paton's (1998) findings do not explore a fuller analysis of how the lead in negotiations was made feasible.

The overriding inference drawn from examining Paton's (ibid) detailed study is that it does not fully explore the nature of purchaser – provider relationship building in a systematic way, despite one of its primary research objectives being the desire to evaluate marketing strategies within the NHS Internal Market. It is argued, therefore, that Paton (1998) may have alternatively employed a systematic analytical framework such as the relationship marketing cornerstones of Stone and Woodcock (1995) which was introduced and critically considered in the previous chapter.

3.6 General Conclusions

Where the purchaser – provider relationship has been investigated it is principally in the context of the Theory of quasi – markets (Le Grand & Bartlett, 1993). Consequently, the evaluation of the exchange relationship between NHS Trusts and their purchasers has been limited to an analysis of competition; the role of information and uncertainty; the nature of transaction costs; and lastly, motivation.

Moreover, *de facto*, this approach assumes that the relationship between purchasers and providers will be adversarial in nature. Subsequently, the emphasis is upon Classical rather than relational based contracting. It is unsurprising then that researchers who have adopted the Le Grand & Bartlett Theory do not make any direct reference to the process of relationship building within the contracting process. Notably, however, evidence from some studies reviewed in this chapter (Bennet & Ferlie, 1996; Hatton & Mathews, 1996; Willcox & Conway, 1998), and also the weight of evidence provided by the current research evaluated in Chapters 5 and 6, strongly suggest that contracting for secondary care was typically based upon a relational model.

Meanwhile, studies drawn from the transformational literature made explicit reference to the importance of relationship building within the purchaser – provider relationship (Ashburner et al, 1993; Ferlie, 1994; Ferlie & Pettigrew, 1996). However, whilst these studies focused upon elements integral to relationship marketing, e.g. elements such as trust, reputation and loyalty, the relevance of their findings were seldom set in context of the wider relationship marketing literature. Furthermore, such studies were typically based upon the networking paradigm, rather than the closely related relationship marketing paradigm.

Additionally, a central theme of the literature review was the abundance of partial evaluation studies (Le Grand & Bartlett, 1993; Shanley, 1993; Propper, 1995) which have focused upon the centrality of price rather than non – price competition to exchange relationships within quasi – markets in health care. As noted in Chapter 2, it is none – price competitive behaviour, which is the primary focal point for relationship marketing strategies. Good examples of the latter, explored in detail in Chapters 5 and 6, are contract augmentation and customisation.

Furthermore, the preceding evaluation of the applied literature has confirmed the relative paucity of economic studies which have systematically evaluated how NHS Trust hospitals attempted to develop, maintain and enhance exchange relationships with purchasers. Indeed, even where studies have directly investigated strategic marketing behaviour within quasi - markets in health care (Willcox and Conway 1998), their focus has been limited to an evaluation of one element of such behaviour, e.g. “did NHS Trusts

deploy a customer orientation or not?” Moreover, where studies undertook a more broad investigation of the nature and extent of relational marketing strategies, i.e. Bennett and Ferlie (1996), the evidence presented was constrained to one treatment area (HIV/ AIDS). Thus it was possible to question the general validity of their findings in terms of all treatment areas in secondary health care.

Of particular importance for the current study, the work of Hatton and Mathews (1996), and Willcox and Conway (1998) both emphasised that more research was required looking specifically at relationship marketing strategies within the NHS Internal Market. It is with this in mind that the following chapter outlines the research methodology used to systematically evaluate the extent of, and determinants of relationship marketing strategies deployed by NHS Trusts within the NHS Internal Market.

CHAPTER 4

Research Methodology

4.1 Introduction

This chapter outlines and justifies the research methodology used in the current research. The chapter aims to justify:

- (i) The selection of a combined methodology based upon both postal survey and case study approaches.
- (ii) The development and design of the national postal survey. This includes an evaluation of the pilot survey; justification of the adoption of an anonymous survey questionnaire; the selection of the spatial focus; the case for, and caveats associated with the adoption of Likert scales, and discussion of the general caveats associated with postal survey methodology.
- (iii) The development and design of the supporting case studies. This includes a general evaluation of the relative merits of case study analysis; identification of the case selection criteria; consideration of the caveats associated with the cases selected, and lastly, identification of the case study agenda associated with the face to face interviews.
- (iv) The statistical methods adopted for the analysis of the national NHS Trust Survey. This section focuses on the general case for using discrete choice regression models rather than the OLS regression model; the justification for the actual discrete choice model selected, i.e. Logit model, and the caveats associated with this selected model.

4.2 The Combined Methodology

The current research is based upon a national postal survey enabling quantitative analysis with a series of additional case studies enabling a qualitative analysis. As such, the research amalgamates both grounded theory (Strauss & Corbin, 1990) with an inductive approach using case studies (Creswell, 1994).

The former approach builds theories on a sequential basis, incorporating a set of logical stages, and this closely mirrors the methodology behind the national postal surveys, i.e.

- Development of hypotheses, e.g. relationship marketing was a widespread phenomenon, which determined the nature of contracting in the NHS
- Multiple stages of data collection to investigate the validity of these hypotheses, e.g. including the use of pilot surveys and final postal surveys
- The analysis of interrelationships between categories of data, i.e. descriptive statistical analysis (e.g. interpretation of statistical means) and Logit modelling
- The sampling of different groups to maximise similarities and differences in data, e.g. the NHS Trust vs District Health Authority perspective.

A more detailed justification for the use of case studies is provided below. However, at this point a definition of a “case study” is appropriate. In essence, case studies involve “the exploration of an entity bounded by time and activity”, Creswell (1994, p 12), eg a social group, programme, or managerial process. Often, as in this research, case studies themselves represent an example of a joint research method, combining face to face interviews with questionnaire data.

Moreover, the current research combines both deductive and inductive methodologies. The context for this approach is the work of Denzin (1989a; 1989b) on triangulation in social science research, which argued that such joint methodologies:

- a. reduced data bias
- b. limited investigator bias
- c. reduced the inevitable bias associated with single methodology approaches.

The current research could be described, following McNeil (1985) as a “between methods” approach given the combination of quantitative and qualitative analysis. A number of strong arguments can be developed in support of such an approach. In summary these are:

- a. The attempt to seek convergence of results. For instance, in respect of the impact upon relational behaviour of local competition, the national survey and localised case studies will provide a double check on the validity of recorded responses.
- b. The so - called “peeling away of layers of an onion”. For instance, in terms of governance structures in contracting, the national survey may identify the imposition of unique local governance structures by the relevant DHA, and meanwhile, the case studies may identify the link between this type of governance, and the extent of observed opportunistic behaviour by local NHS Trusts.
- c. Developmental benefits. For example, the face to face pilot interviews used to aid design of the national survey questionnaire revealed the significance of pro-active relationship building strategies by NHS Trusts with local GP fundholders. Consequently, in designing the case studies, it was decided to survey all GP fundholders in the relevant District Health Authority areas.
- d. The exposure of contradictions in findings and the introduction of fresh perspectives. In terms of the current research, one interesting and challenging finding was the apparent importance of contract augmentation nationally, compared to the apparent paucity of such behaviour within one case study as perceived by the local District Health Authority.
- e. So called “expansion”. As one example, the combination of the national survey and the case study approaches adds both width and depth to the research. It is appropriate through survey questionnaires to investigate broad issues, eg the extent to which unique governance structures were imposed on NHS Trusts by District Health Authorities, i.e. through “yes, no” type responses. However, through a face to face case study interview, the extent to which in the case example this may have occurred because of the extent of trust between contracting partners can be explored in detail.

It is recognised, however, that a whole debate continues to rage regarding the “best” approach to combined methodologies. One important debate relates to whether researchers should combine methods with paradigms. This debate is considered with

clarity in Creswell (1994), but it is useful here to identify the key differences in opinion.

Firstly, there are the “purists” who believe that methods and paradigms should not be mixed. Secondly, there are the “situationalists” who believe the compatibility of methods and paradigms depends upon the particular study, and lastly there are the “pragmatists”, who focus on the integration of methods and paradigms within individual studies. In terms of the current research, the approach adopted is what Creswell (ibid) calls the “dominant-less dominant design”, with the national survey research investigating the principal research aims, and the case studies being used to explore the related research objectives.

4.3 The National Postal Surveys

4.3.1 Introduction

The principal source for gathering information relevant to the testing of the central hypothesis of the current research was a national postal questionnaire carried out between October and December 1998. In order to gain a balanced perspective on the nature and significance of relationship building strategies within the NHS Internal Market, it was decided to survey the principal purchasers and providers of secondary care in England. Contracts Managers in NHS Trusts were asked to reflect on relational strategies developed between the date their organisation was granted NHS Trust status, and the dissolution of the NHS Internal Market, i.e. effectively the publication date of the December 1997 White Paper. Meanwhile, their DHA counterparts, i.e. Commissioning Managers were asked to reflect on their organisations experience of relationship marketing behaviour by NHS Trusts between the introduction of and dissolution of the NHS Internal Market. It is noted, however, that Case Study evidence indicates that relational strategies continued to be implemented, and further developed well into 1999.

4.3.2 The Pilot Survey

The NHS Trust and District Health Authority survey questionnaires (see Appendices 1 & 2) were developed following a pilot exercise carried out between September and October 1998. The latter involved a series of in-depth face to face interviews with

contract managers from NHS Trusts and lead purchasing managers within District Health Authorities (DHAs). The interviewees were each sent a draft copy of the relevant questionnaire, and after a two week period were interviewed for a 2 hour period in each case to discuss caveats regarding its design and interpretation. In total, two DHAs and two NHS Trusts, the latter with a wide service base were interviewed. These sessions proved critical in determining necessary corrections to technical terminology, and issues of possible misinterpretation of questions. The participants in this exercise are identified in Appendix 7.

4.3.3 Anonymous Survey Questionnaires

It should be noted at this juncture that because of the commercial and political sensitivity of much of the data gathered, ie in the context of a quasi-market, the survey analysis was done anonymously. Whilst this had the effect of increasing the potential response rate, a number of important issues do emerge.

Firstly, this approach does prevent use of matched pairs analysis, using relevant local Trusts and associated contracting District Health Authorities (DHAs) and GP fundholders, although it can be argued that the case studies presented counter this criticism to some extent. Furthermore, there is the danger on a more practical level that any confusion regarding the interpretation of recorded responses cannot be further investigated by telephone follow up. However, there are two pertinent responses to this criticism. Firstly, such checking may cause bias in the response given that the contract manager will be responding in a different control environment than other respondents had, and in actuality, all the recorded questionnaire responses were clear and complete. Finally, it should be noted that anonymity of respondents was acceptable because of the intention to do a single shot survey. Pilot testing of the survey had proved particularly successful, and moreover it was recognised that given the timing of the survey a number of particular issues were paramount. Of particular importance was the physical timing of the mail shot, ie December 1998. It was recognised that it was vital to gain homogeneity of response from NHS Trusts and DHAs at a time of major change in managerial structure, and managerial objectives in secondary health care. The latter were the consequence of the imposition of the 1997 White Paper's reforms to be imposed from the 1st April 1999. Had the research carried out postal surveys in waves, in response to recorded response rates, e.g. December 1998, January 1999 etc, there is a danger that the managerial environment

was changing, but as important that the appropriate managers to be surveyed would have changed positions.

4.3.4 Spatial Focus of the National Surveys

The national survey questionnaire was sent to all NHS Trusts and all District Health Authorities (DHAs) in England. The spatial focus was deliberately constrained not to include the remaining regions of the UK, i.e. Wales, Scotland and Northern Ireland. This approach limits the potential impact of regional differences in culture, tradition, and emphasis among NHS Contracts Managers upon relationship marketing strategies. Furthermore, within England there was no attempt to codify data into specific sub-regional geographic health markets. This is for a number of reasons. Primarily, there was no *a priori* reasoning to suggest that the key determinant of the likelihood of relationship marketing behaviour was geographic location, i.e. in the sense of important differences being anticipated to emerge between DHAs and NHS Trusts north or south of Watford. It was considered, *a priori*, that a whole range of other independent variables would prove more significant, i.e. the number of competitors, when NHS Trust status had been awarded (i.e. which 'wave'), and whether NHS Trusts engaged in joint ventures with other local NHS Trusts. Moreover, the use of specific statistical techniques, i.e. Sectoral analysis enabled the likelihood of certain relationship building behaviour occurring in any specified local health market to be predicted (see Section 4.5.7 below and Chapter 5).

In addition, given the usual resource constraints faced by an individual researcher in respect of personal time and finance, focusing on English NHS Trusts alone was rational.

4.3.5 Coverage

All types of NHS Trust (with the exception of NHS Ambulance Trusts) were surveyed, i.e. Acute, Community, Mental Health etc. The exclusion of Ambulance Trusts is readily justified. The principal focus of the current research was relationship marketing within secondary health care. Whilst some NHS Ambulance Trusts provided specialised paramedic services, alongside patient transport, these were marginal in terms of overall volume, value and the range of patient services provided by other Trust types towards secondary care.

4.3.6 Questionnaire Design: The use of Likert Scales

The survey questionnaires sent to NHS Trusts and District Health Authorities were coded to enable consideration of a series of descriptive statistics, including statistical mean; standard deviation; correlation coefficients, and frequency distributions.

In order to gain relevant data, the survey questionnaire used basic agree/disagree (yes or no) form questions, and also a version of Likert (Oppenheim, 1970) scales to assess intensity of agreement with statements regarding the relationship building process. Likert scales were originally designed to deal with the problems of unidimensionality, ie ensuring all items measured the same thing, and also to make the respondents the “judges”, in other words by placing

“themselves on an attitude continuum for each statement – running from strongly agree....to strongly disagree. These five positions were given simple weights of 5,4,3,2, and 1”.

(Oppenheim, 1972).

Given the centrality of this scaling approach to the current research findings, some note should be made regarding the strengths and weaknesses of this method. Firstly, in support as Oppenheim (ibid, p 141) states

“Likert scales tend to perform very well when it comes to a reliable rough ordering of people with regard to a particular attitude”

Moreover, they are relatively easy to construct, and are typical of those used in research in health economics both in policy and clinical areas. In addition, they provide more accurate information regarding the respondents degree of agreement or disagreement, and are preferred by respondents themselves (Schuman & Presser, 1996). Lastly, again quoting Oppenheim (1972, p 141)

“it becomes possible to include items whose manifest content is not obviously related to the attitude in question, so that the subtler and deeper ramifications of an attitude can be explored”.

4.3.7 Caveats Regarding Likert Scales

Against these arguments, there are a number of caveats, however. It is often cited (Schuman & Presser, 1996; Oppenheim, 1972) that there remains a technical problem. In particular, the scales lack reproducibility: if for a given question, one summed the total score across all respondents, the same score could be achieved by different ways. Subsequently as with the current research, the focus should be upon the pattern of responses rather than the total scores per item. Furthermore, a number of criticisms have been made regarding Likert scale's interpretation of responses in the middle order range. Much debate remains whether scales should include a "uncertain", as well as "neutral" response option. It was decided here to use a five point scale as follows:

Strongly agree	5
Agree	4
No opinion	3
Disagree	2
Strongly disagree	1

The category "no opinion" or in some cases "neutral" was used in place of the more typical "uncertain" category within a five point scale, to reflect the criticisms laid at Likert scales using an uncertain category. If the uncertain category is used (in the absence of an additional 6th neutral category) it becomes impossible to gauge where responses change from mild agreement to mild disagreement, although this may be overcome with large samples through the calculation of percentile norms or standard deviation norms.

It is recognised that problems regarding mid-point responses remain even with a "neutral" category. In particular, the neutral point may itself not be the mid point on the scale for a number of reasons: firstly, a recorded neutral response may result from mixed intensity of feelings by the respondent at each extreme end of the spectrum, ie implying that the scale is not one dimensional. Moreover, it remains possible that mid-point responses on the scale are, following Oppenheim (1972, p 142), the result of

"lukewarm response, lack of knowledge, or lack of attitude"

suggesting that the neutral points is not necessarily the absolute mid-point.

4.3.8 General Caveats Relating to Postal Survey Analysis

A number of concluding comments to this section are pertinent. Firstly, given the development of a quasi-market in secondary health care in the UK, there could be no public observation of NHS Trusts behaviour: no national, normalised data base existed in the public domain detailing relational contracting behaviour at the micro level. Consequently, the survey questionnaire was the only way to elicit the research questions posed by this research. Secondly, it is recognised that as with any survey questionnaire research, several fundamental issues remain.

Primarily, there is the danger that respondent's answers suffer general bias associated with acquiescence or "yeasaying". A detailed discussion of the vast literature, principally in the field of psychology and sociology, is beyond the scope of this chapter although an excellent summary of the literature is provided in Schuman and Presser (1996). However, it should be noted here that a number of the most important sources of acquiescence identified by Schuman and Presser (*ibid*), i.e. social groupings, and educational background, are effectively controlled for in the current research because of the homogeneity of background of health service managers. However, a number of additional aspects of bias in response should be considered.

There is clearly the possibility that the respondent is not competent to answer the questions accurately, or that they have a vested interest (especially in the context of a quasi-business environment) in providing a biased answer, for instance relating to whether local District Health Authorities (DHAs) had preferred providers. These difficulties are minimised in the context of the current research. Particular emphasis was placed during the pilot questionnaire phase to identify which individuals in DHAs, NHS Trusts and GP fundholders could provide the relevant information. Moreover, it should be remembered that whilst contracts managers operated within a quasi-market, these organisations remained "not for profit", and equally importantly, the NHS continues to attract managers with a high level of commitment to social rather than business objectives (Patton, 1998; Le Grand & Bartlett, 1993).

It should be added, that given the timing of the postal survey, ie at a time when the “new” White Paper’s (DoH, 1997) reforms were being implemented, respondents had nothing to gain by providing inaccurate, biased responses.

The second fundamental difficulty with one shot postal surveys is that it is not known where the “snap-shot” taken lies in the evolution of the relationship building process. This is largely an irrelevant criticism: subsequent snap-shots could similarly be taken to establish the extent of change in the nature of the relationship building process.

Lastly, there is the possibility that through raising awareness amongst contract managers of the importance of the relationship marketing process, the research will actually interfere with managerial behaviour. Subsequently, the research may change behaviour rather than explain it! This appears to be a weak argument in the current context: it would be naïve and arrogant to assume that NHS professionals working within the quasi-market could be greatly influenced in terms of relationship building behaviour by the current research.

4.4.1 Case Studies: Overview

A case study element compliments and supports the national survey questionnaire. This is based upon two case studies, each with a number of sub-elements, whose identification and justification for selection are provided later in this section.

4.4.2 General Caveats Associated with Case Study Analysis

At this junction it is important to address some generic questions regarding the design and development of the case study analysis presented.

One key issue is the numbers of case studies which is optimal. An important ongoing debate continues on this matter (see for example, Martin & Powers, 1983; Eisenhardt ,1989; Dyer & Williams, 1991; Cresswell, 1994).

In particular Dyer and Williams (1991) argued that multiple case studies can result in researchers

“missing both the calibre and quality of theory we have seen result from classic story-telling through (‘singular’) case studies of the past” (p 618).

This is because this approach tends to generate thin, surface type data and often results in failure to understand the deep, dynamic of the case. However, here support is given to the views of Eisenhardt (1989). In essence he states that it is not really an issue of whether two is better than three or four case studies, but

“that the appropriate number of cases depends upon how much is known and how much new information is likely to be learned from incremental cases”
(p 622)

In addition to the physical numbers of cases examined, a key debate relates to the sampling procedure used for selection of cases. Here, it is sufficient to stress that it is not necessary to use statistical sampling methods to obtain accurate statistical evidence on the distribution of variables within the population, as is typical in the experimental hypothesis testing tradition. Typically, cases are selected on the basis of theoretical sampling, ie those cases chosen have a high probability of replicating or extending emergent theories. As Eisenhardt states (ibid)

“it makes sense to choose case studies such as extreme situations and polar types in which the process of interests is ‘transparently observable’” (p 537)

Having dealt with a number of key generic issues raised by case study analysis, we continue by justifying the specific choice of cases, and analytical approaches used in this research.

4.4.3 Case Methodology

Two main cases studies were undertaken, each with sub-elements. Each involved a singular District Health Authority, a set of lead providers within that District Health Authority area, and the relevant population of GP fundholders (GPFHs). Specifically, the cases selected were:

Case: 1

Warwickshire Health Authority
South Warwickshire General Hospitals NHS Trust

Walsgrave Hospital's NHS Trust (comprising 2 acute hospitals)
All GPFHs within the Warwickshire Health Authority area

Case: 2

Dudley Health Authority
Guest NHS Hospital
Hayley Green NHS Hospital
Russel Halls NHS Hospital
Worsely NHS Hospital
All GPFHs in the Dudley Health Authority area

The actual method of data collection varied, depending upon the sub-group. Both District Health Authorities, and the relevant NHS Trust hospitals were contacted by letter, including a copy of a discussion agenda (see Appendix 4). Thus a semi-structured interview approach was used in order to achieve a balance between the dual challenge of:

- a. avoiding tight constraint of discussion around existing theoretical ideas given that

“pre - ordained theoretical perspectives or propositions may bias and limit the findings” (Eisenhardt, 1989, p 536)
- b. maintaining a sufficiently broad research agenda but recognising the need to avoid being overwhelmed by data
- c. identifying some *a priori* reasoning such that if these emerge a important, for instance during face to face interviews, they can be further explored.

The face to face interviews were conducted during the Spring of 1999 for approximately 1 to 1.5 hours in each example, with written notes taken, and a tape recording of the conversations. This is justified because it ensures (a) that subtle points, and new ideas are not missed, and (b) that there is flexibility when combined with a semi-structured agenda. The discussions can change direction via what Eisenhardt (1989) has called “controlled opportunism”. It should be remembered that

the overall purpose is to explore emerging theory, and not to produce summary statistics about a set of observable relationships.

Meanwhile, GPFHs in each case District Health Authority area were contacted by written letter in January 1999, and their Fund Managers asked to complete a postal survey questionnaire (See Appendix 3). This had been pilot tested using 8 different Fund Managers from the Luton and Bedford Health Authority area in December 1998.

Thus, as for the research overall, a combined methodology was used for the case studies.

Selection of Interviewees for the Case Studies: Justification and Caveats

Interviewee Selection

In respect of NHS Trusts, the decision was taken to interview Contract Managers, whilst in respect of District Health Authorities (DHA) the decision was taken to interview Commissioning Managers.

In respect of evidence from the pilot survey interviews and the academic literature (e.g. Paton, 1998), it is apparent that NHS Trust Contract Managers and DHA Commissioning Managers played a pivotal role in developing contracting within the NHS Internal Market.

Moreover, it was perceived following the pilot survey interviews that both interviewee groups would have a sufficient breadth of knowledge of the contracting process to help investigate the nature of relationship marketing (RM) strategies deployed within the NHS Internal Market and the impact of such deployment on different stakeholders. Furthermore, it was perceived that these interviewee groups would have a detailed insight into the nature of trust and opportunism prevailing within contracting during the operation of the NHS Internal Market.

It is argued that the selection of these groups, i.e. NHS Trust Contract Managers and DHA Commissioning Managers is vindicated by the large, representative and completed sample of questionnaires returned through the national postal survey of English NHS Trusts and DHAs. It could be argued, that the successful response rate achieved by both the NHS Trust and DHA national postal surveys indicates, implicitly, that the appropriate interviewees were selected.

Moreover, it should be recalled that to ensure comparability of responses by purchasers and providers across the national postal survey and case study analysis, the same groups of interviewees were chosen for each respective methodological approach. Thus for the national postal survey and case analysis the contacts were Contracts Managers within NHS Trusts and Commissioning Managers within District Health Authorities.

Meanwhile, in respect of surveying GP fundholders within the selected geographic case areas, it was decided to contact the GP Fund Manager. Again, pilot survey interviews had identified the central role played by this professional group within the contracting process. Moreover, it would have been difficult to identify whether particular GP partners within a given GP fundholder practice were central to the negotiation of contracts with providers and the development of relational oriented exchanges. There is a clear caveat here, however, because evidence from the Warwickshire case study suggests that within specific GP fundholders there were GPs who behaved opportunistically, enjoyed playing the "market game" and were leaders in negotiating customised contracts with NHS Trusts. Indeed, as argued in Chapter 7, one important issue in terms of the future development of relational strategies within the "new" NHS arrangements is the possibility that Primary Care Groups will be lead by such proactive GPs. These GPs who became accustomed to contract customisation and augmentation within the NHS Internal Market may continue to expect such relationship marketing strategies to continue under the "new" NHS arrangements.

Caveats Regarding Interviewee Selection

Clearly there is the potential for response bias, given that for NHS Trusts and District Health Authorities the decision was taken to only interview a single group of health professionals involved in the contracting process within each respective institution. A similar argument could be made regarding the decision to target Fund Managers within GP fundholders.

The principal reasons for this relatively narrow focus was provided in the previous section. It should be emphasised here, however, that within a research programme of the current type there are physical constraints (e.g. time and finance) on the numbers of interviewees who can feasibly be interviewed within a face to face, one on one semi-structured interview format.

It is recognised, however, that in practice contracting decisions between NHS Trusts, District Health Authorities and GP fundholders typically involved a range of individuals (Le Grand and Bartlett, 1994; Ferlie and Pettigrew, 1996; Paton, 1998). For instance within one pilot interview, the interviewee identified for their NHS Trust the importance of the Contract Manager, the NHS Trust General Manager, the Clinical Director, Finance Manager and NHS Trust Chief Executive.

More specifically, within NHS Trusts previous research has identified the importance of Clinical Directors in the contracting process and the development of relational marketing strategies (Wilcox and Conway, 1998). Furthermore, in Chapter 2 it was emphasised that in respect of relational marketing theory (Berry, 1983; Stone and Woodcock, 1995) institutions with mature relationship marketing strategies are those who involve all employees in developing and enhancing closer relationships with purchasing agencies. Indeed, the case evidence for Warwick General Hospital NHS Trust evaluated in Chapter 6 demonstrates the relative complexity and maturity of The NHS Trusts relationship marketing strategy, which The NHS Trust's Contract Manager described as "very much a corporate wide strategy".

It is recognised that one solution to interviewee bias, and the argument that the individuals targeted within NHS Trusts, District Health Authorities and GP fundholders were 'generalists', would be the inclusion of focus groups within the case study analysis. The advantages of this methodology are well discussed in the context of the health economics literature (Gray, Harrison and Barlow, 1998). However, whilst this was considered, the practical difficulties involved in organising and running such focus groups proved insurmountable in the context of the current research.

4.4.4 Case Selection

The identity of the selected cases was given above. The following arguments are offered to justify their selection:

- Choosing two main cases, with a series of sub-elements enables comparisons and contrasts to be drawn within, and across each case study. Moreover, selecting only two cases provided the opportunity to do an in - depth analysis

of the nature of trust and opportunism within the localised quasi - markets in health care from the perspective of three different stakeholders, i.e. GPs, DHAs and NHS Trusts. Given resource constraints, selection of a wider number of cases would have implied interviewing fewer stakeholders.

- There were a number of practical considerations. In particular, the author had indirect contacts within each case organisation through Coventry Business School colleagues. This meant the co-operation was more likely, especially given that District Health Authorities, NHS Trusts, and GP fundholders were undergoing a period of rapid change during the study period. Secondly, it should be remembered that unlike related studies (e.g. Paton, 1998), the author did not have the benefit of a supporting research team. Lastly, it should be noted that the prime focus of the combined methodology was the national postal survey, itself requiring significant monitoring and management.
- Both cases fall within the same Regional Health Authority. This ensures that the impact of managerial culture, particularly regarding relationship building, is consistent.
- Lastly, there were some factors which potentially could have affected the process of relationship building within the case areas. Of prime importance was the difference in take up rates of GP Fundholder status between the Dudley and Warwickshire Health Authorities. The former District Health Authority, had a significantly lower take up rate of GP Fundholding (as considered in detail in Chapter 6), providing implicit evidence of differences in attitudes towards the desirability of quasi-markets between the case study areas. This is important in light of evidence which emerged from the pilot testing of the national postal surveys, which indicated that the greatest efforts towards pro-active relationship building by NHS Trusts was aimed at GP fundholders, rather than District Health Authorities. Again, this is explored in greater detail in Chapter 6. Secondly, of interest, the case areas (Dudley and Warwick) had different health population needs. The latter in particular had an acute problem in respect of a rapidly ageing population with the associated health problems. Further differences are found in socio-economic terms.

Having considered some generic issues regarding the problems of designing case studies, outlined the methodology adopted here, and justified in detail why the specific cases were selected, it remains to add a number of caveats.

4.4.5 Case Specific Caveats

Primarily, there is the danger that conclusions drawn from case studies are based upon limited data. Of specific relevance to the current research, such conclusions are often based upon “elite” interviews, i.e. only the lead player (of a wider team) in the contract negotiation process, and only for a handful of organisations. Following Pettigrew (1988) it is argued that this criticism is partly overcome through the use of pairs of cases, i.e. Dudley and Warwickshire Health Authorities, each with a number of sub-elements, i.e. different purchasers and providers.

An additional criticism is that inevitably the case studies lack sufficient quantitative focus to identify which variables are the significant drivers. Researchers have argued (Mintzberg, 1979; Yin, 1984) that this can result in over complex theories, trying to incorporate all variables and constructs. Without the statistical testing of the traditional hypothesis building approach, researchers can lose a sense of proportion. To some extent, this criticism can be countered in the current research because the national postal survey allowed cross-referencing of some key research questions, eg regarding the determinants of relationship marketing strategies.

A final general criticism of note is that a “bottom up” approach looking for theoretical explanations for a wider population from a handful of cases can develop idiosyncratic theories. These will fail to identify the necessary and sufficient conditions for generalised theories. However, in part this can be avoided, following Eisenhardt (1989) by comparing emerging theories or hypotheses with the extant literature asking:

- What are the findings similar to?
- What do the findings contradict?
- Why is there any contradiction?

Such questioning will enable an evaluation of the validity of the case evidence, and therefore the extent to which the findings can be generalised to all cases.

4.4.6 Case Study Discussion Agenda

The face to face interviews explored four specific issues, these being highlighted in the semi-structured interview agenda (attached as appendix 4). The key issues were as follows:

- a. The nature of trust and opportunism within the contracting process for secondary health care.
- b. An exploration of why NHS Trusts augmented or customised contracts.
- c. An analysis of the drawbacks of relationship marketing strategies deployed by NHS Trusts.
- d. The likelihood of relationship marketing becoming more or less significant as a form of NHS Trust strategic behaviour under the 'new' NHS arrangements (i.e., post 1997 DoH White Paper).

These four issues are explored in more detail below:

- The nature of trust and opportunism within the contracting process between NHS Trusts and DHAs. The principal questions posed were subsequently:
 - a. How trust affected the negotiations process in general;
 - b. Whether the nature of trust affected efforts to cover contingencies when defining contracts, i.e. an exploration of “contractual trust”.
 - c. Whether trust affected the monitoring of contract performance, i.e. competence trust.
 - d. Whether pre-market culture affected the extent of contractual and competence trust in the contracting process.
 - e. How the NHS Internal Market’s competitive culture affected contractual and competence trust.
- An exploration of why providing NHS Trusts augmented and customised contracts as an exploration of “goodwill” trust. This was to provide supporting and contrasting evidence to the empirical analysis of driving factors behind

relationship marketing strategies. To encourage open discussion, some prompts were provided, i.e.

- a. How important was the opportunity to meet latent demand?
 - b. How important was it as a source of new funding?
 - c. How important was managerial professionalism?
- What were the drawbacks of relational marketing strategies? The empirical evidence (see Chapter 5) identifies the causes of such behaviour, and consideration will be given in Chapters 6 and 7 to the likely economic consequences of such strategies. However, it is important to gain a balanced perspective on the impact of relational marketing strategies. Ideally, the analysis would identify the counterfactual model, ie what would have happened in the absence of relational strategies. Less ideal, but equally systematic, a cost-benefit analysis could identify the discounted net benefits (Brown and Jackson, 1988) of relational marketing strategies. However, the conceptual and technical difficulties associated with such a method abound (Brown and Jackson, *ibid*: Price, 1977; Musgrave and Musgrave, 1989), so that inclusion of a cost-benefit analysis was not feasible. Subsequently, a qualitative assessment of the likely costs of relational strategies was included within the case study analysis. Again, some initial prompts were provided for interviewees, i.e.
 - a. were there changes to management? (systems or structures)
 - b. were there additional transactional costs? (eg information; time; policing etc).
 - What will be the effects of the “new” NHS arrangements on the future of relational strategies within the NHS?

This provided evidence to be contrasted with the findings from:

- a. Iterative inferences drawn from the theoretical perspective
- b. Predictions made from the Logit modelling of relational marketing strategies (see Chapter 5).

As argued in Chapter 2, the analysis of trust is central to the exploration of relational strategies within the NHS Internal Market. The actual questions posed through the case studies were identified above, but it is pertinent here to reiterate why the evaluation of trust is so important to explaining relational marketing behaviour. Following Sako (1991; 1992) it is argued that trust economises on transaction costs, monitoring costs and insurance costs.

Moreover, as Sako (1992) argued,

“For economists, but for the existence of imperfect competition, bounded rationality, risk and uncertainty, trust would have no function to fulfil” (p 37).

Clearly, however, in the context of the theoretical discussion in Chapter 2, the NHS Internal Market was subjected to bounded rationality, imperfect information, and risk and uncertainty! Subsequently, the analysis of trust is critical, given that its extent and nature will compensate, at least in part for all these factors detrimental to the efficient workings of a quasi-market. However, Sako’s (1991; 1992) definition of trust was adapted to make it operationally feasible within the face to face interview setting, so the following working definition was employed, i.e. “Trust is having confidence in an exchange partners reliability and integrity”.

4.5 Empirical Evaluation of the NHS Trust Survey

4.5.1 Introduction

In the following chapter, the results from the national postal surveys of DHAs and NHS Trusts in England are presented. In both cases, a series of descriptive statistics are provided identifying mean scores, standard deviations, and frequency distributions for the questions posed. Whilst the primary focus of this research was not the application of econometric techniques, the nature of the survey questionnaire, and the large, representative sample gained through the national level NHS Trust survey enabled some more detailed statistical investigation to be carried out. The techniques adopted in respect of the latter are evaluated in detail in the proceeding sections.

4.5.2 NHS Trust Data: Logit Modelling

In order to answer one central question of the research, i.e. what were the driving factors behind key elements of relationship marketing behaviour?, a series of binomial qualitative response (QR) models were developed. For such models, the dependent variable is a discrete outcome, such as a “yes” or “no” decision. For instance, NHS Trusts were asked whether they included default measures within their contracts, and whether they augmented basic service agreements or not. In such cases, following Gujarati (1988), Maddala (1992) and Greene (1997) it is argued that:

“Conventional regression methods are inappropriate” (Greene, *ibid*, p 871).

Technical proofs of the greater applicability of these models to the current investigation over and above that of the ordinary least squares (OLS) approach are beyond the scope of this chapter. However, such a proof can be found in McFadden (1984) and Maddala (1983).

4.5.3 Selection of QR Model

The initial difficulty then arises of which QR model to adopt, although a series of alternative are automatically ruled out. The national postal survey had set a constraint to manager’s responses, i.e. yes (1) or no (0), rather than a wider range of responses, i.e. 1,2,3,4,5¹. Consequently, the need for conditional or multinomial models was ruled out.

The principal choice is then between linear probability models (LPM), Logit and Probit models. The LPM model is linked with earlier applications of QR models (Gujarati, 1988), the associated problems with its application being as follows. Firstly, the generally lower values obtained for R^2 (compared to OLS); secondly, the possibility of the observed dependent variable’s response lying outside of the 0-1 range; thirdly, heteroskedasticity, and lastly non-normality (Gujarati, *ibid* p 480).

Whilst econometricians have overcome these problems to some extent, e.g. by using large samples to overcome non-normality, there remains a fundamental weakness with LPM.

¹ It is possible to model data responses of this type using multinomial Logit techniques (Greene, 1997)

The LPM approach assumes that the incremental or marginal effect of X remains constant, i.e. $P_i = E(Y = 1/X)$. Consider the following functional form:

$$Y_i = a + bX_i$$

Here, Y_i is the decision to offer augmented basic service agreements, a is some constant, and b the coefficient on X_i , i.e. the numbers of competitors in a local health market.

Within the LPM approach, as the numbers of competitors increases by a single unit, the probability of providing NHS Trusts augmenting basic service agreements would increase by a constant amount (for a numerical example of this problem see Gujarati, 1988, p 480). Moreover, this would be so whether the initial base number of competitors was 2 or 22, which appears unrealistic. It could be argued for example, that the probability of contract augmentation will be very low under monopoly conditions in the local health market, whereas a sufficiently high level of local competition, chosen for illustrative purposes only at 10, NHS Trusts will most likely augment contracts. Any increase in competition beyond this critical number of competitors (i.e. 10 as selected) will have little impact on the likelihood of NHS Trusts augmenting their contracts. Subsequently, at the polar extremes of competition, the probability of augmenting basic service agreements will be hardly affected by a small increase or decrease in the number of competitors.

Thus the LPM is rejected for the purpose of the analysis of this research. There remains, however, the issue of choosing between Logit and Probit techniques. As Gujarati (ibid p 496) states:

“the logistic and probit formulations are quite comparable, the chief difference being that the logistic has a slightly flatter tail, that is, the normal curve approaches the axes more quickly than the logistic curve”.

And continues (1988, p 496) by stating:

“....the choice between the two is one of (mathematical) convenience and ready availability of computer programmes. On this score, the Logit model is generally used in preference to the probit model”

4.5.4 The Logit Model

Thus the Logit model was selected as the means of estimating the likelihood of specific relationship marketing strategies being employed. It is noted, however, that there are a number of important caveats regarding the Logit model.

Thus the Logit model is appropriate for cases of multiple regression where the dependent variable is qualitative (i.e. “yes” [1], or “no” [0]), for instance, regarding whether NHS Trusts offered loyalty discounted contracts to Health authorities and GP fundholders. Formally, the regression is estimated for an equation like

$$\ln (P_i/1 - P_i) = b_0 + b_1X_1 + \dots u_i,$$

Where P_i is the probability of loyalty discounting occurring, and $1 - P_i$ is the probability of loyalty discounting not occurring. From the estimates of b_0 and b_1 , and given the values of the relevant independent variables, we can work out $\ln (P_i/1 - P_i)$, and hence the probability (P_i) of certain events.

A further technical point should be made at this juncture. The Logit analysis was used to consider the marginal effects (Maddala, 1983; Gujarati 1988; Greene, 1997): these demonstrate the impact on the dependent variable, eg loyalty discounting, of a one unit increase in an independent variable. In Chapter 5, note will be taken that the marginal effects are not the reported coefficients as they would be for an Ordinary Least Squares Regression, and they are also not constant for all values of the independent variables presented.

4.5.5 Marginal Effects

The marginal effects are derived, following Bailey & Mallier (1997) by differentiating the functional form with respect to the models' independent variables (ie the x's) and then estimating for suitable values of independent variables such as the mean values of the independent variables. Thus for illustration, the functional form

$$y = \frac{e^{\beta'x}}{1 + e^{\beta'x}}$$

Is differentiated with respect to x to give

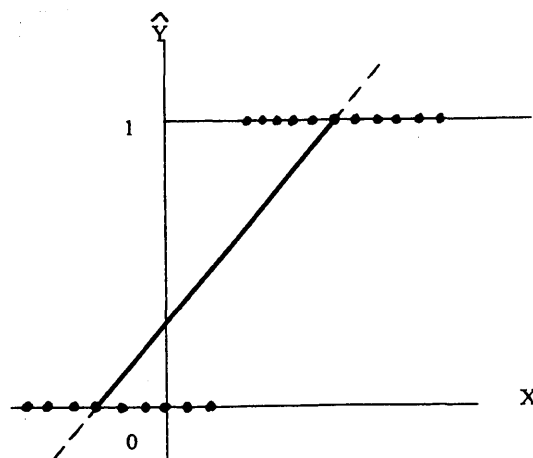
$$\frac{\partial y}{\partial x} = \beta \times \frac{e^{\beta'x}}{1 + e^{\beta'x}} \times \frac{1}{1 + e^{\beta'x}}$$

which is then estimated at the mean values of the independent variables for each coefficient². All calculations, and reported marginal effects in Chapter 5 are based upon outputs from Greene (1997, Limdep Software Version 7.0 for Windows).

4.5.6 Caveats relating to the Selected Logit Model

One principal problem relates to interpreting the “goodness of fit” of Logit models. An immediate problem is the questionable value of the standard R^2 test when used to explain discrete choice models rather than standard OLS models. Following Gujarati (1988), the primary reason why computed R^2 is of limited use in discrete choice models can be readily explained with reference to the following figure:

Figure 4.1: The Linear Probability Model



² A mathematical proof for marginal effects is provided as Appendix 6.

Above, corresponding to a given X, Y can either be 0 or 1. Consequently, all values for Y will either lie along the X axis or along the line corresponding to 1. Subsequently, no Logit model is expected to fit such a scatter well.

Gujarati (1988, p 472) concludes, therefore, by citing Aldrich and Nelson's view that,

“use of the coefficient of determination as a summary statistic should be avoided in models with qualitative dependent variables”.

Consequently, authors have suggested a whole series of “pseudo” R^2 measures to reflect this difficulty, see for example, Cragg and Uhler (1970); McFadden (1974); Maddala (1992), although again, there is some disagreement regarding which is most appropriate in different circumstances (Greene 1997; Maddala, 1992).

However, there is an additional complication here in that applied researchers do not consistently present the same set of summary statistics on the overall robustness of Logit models. For instance, a number present Chi-squared results, including for example, Greene (1996, Limdep 7 for Windows) and Blanchflower and Oswald (1999). Meanwhile, others do not report Chi-squared values, choosing to focus instead upon various pseudo R^2 measures (Maddala, 1983). For ease of calculation, and interpretation, and to reflect the recent trend in applied economics publications incorporating Logit analysis (see, for instance, Bailey & Mallier, 1996; Blanchflower & Oswald, 1999), a range of summary statistics are presented and interpreted in the following chapter. These are Chi-square values; the proportion of correct predictions, and lastly, McFadden Pseudo R^2 .

A second generic problem associated with Logit models is consideration of disproportionate sampling. Clearly, in many instances the number of observations in one group may be considerably smaller than in another group, an example from the current research being the number of NHS Trusts employing default contracts versus those who did not. Some writers have suggested the subsequent need to use a weighted Logit model to compensate. However, as Maddala (1983) stated,

“This is not the correct procedure. The usual Logit model can be used without any change even with unequal sampling rates”.

Furthermore, there is common agreement that disproportionate sampling is less problematic with relatively large data sets, as in the current research, where the analysis is based upon 173 complete responses from NHS Trust providers in England (representing 47% of the potential population).

Finally, in this section, some comment is necessary on the difficulty associated with heteroskedasticity. Whilst Gujarati (1992, p 427), notes that Logit regressions, “suffer from the problem of heteroskedasticity”, he further notes that this is confined to models based upon grouped data, an example being where data on hospital income were sub-divided into different income bandings. For the Logit regressions carried out here, the data is *micro* or *individual* data, i.e. NHS Trust observation number 1,2, 3...n.

4.5.7 Sectoral Analysis

In addition to the analysis of the Logit regressions discussed above, the national survey results were used to carry out a sectoral analysis (Pogue & Soldofsky, 1969; Gujarati, 1978). For each of the five models developed to test specific hypotheses on relationship marketing behaviour introduced in Chapter 1, and detailed in Chapter 4, the consequences of one of three different scenarios was considered. These scenarios were described as “Best case”, “Worst case”, and “Average case”.

The results from this analysis are presented and discussed in Chapter 5. However, it is helpful at this juncture to further illustrate the logic of the sectoral analysis. We consider the case of the probability of contract augmentation by NHS Trusts, including a constant term in our calculations and supposing (without justification at this point) that the relevant independent variables are X1 (numbers of competitors); X2 (long-term relationship building); X3 (preferred providers); X4 (competitive culture).

Suppose further that for the “Best case” scenario, i.e. that most likely to result in contract augmentation that

Numbers of competitors	=	10
Long-term relationship building	=	Yes (1)
Preferred local providers	=	Yes (1)
Competitive culture	=	5 (strongly agree)

(Again, at this point, no *a priori* explanation for the selection of these magnitudes for the independent variables is provided).

Thus for our Logit regression

$$\text{Ln} (P_i/1-P_i) = a + b_1 (10) + b_2 (1) + b_3 (1) + b_4 (5)$$

Suppose for instance that the results were such that

$$\text{Ln} (P_i/1-P_i) = M$$

Therefore

$$(P_i/1-P_i) = \text{antilog} (M) = k$$

Subsequently, the following formula can be derived³, i.e.

$$P_i = k / (1 + k)$$

The last equation can be used to calculate P_i of event Y for any value of k . This exercise is then repeated for each of the three scenarios and for each of the five Logit models developed in detail in Chapter 5.

The principal advantages of this approach is as follows:

- it enables estimation of the probabilities of a given relationship marketing strategy occurring under a very wide range of local health market conditions. The analysis need not be constrained to three scenarios, i.e. best, worst and average, but may also be extended to cover a range of intermediate cases.
- The approach can be used to predict the probability of a given form of relationship marketing occurring for a specific local health market. Assuming statistical significance for the Logit model for a given type of relational marketing behaviour, e.g. loyalty discounting, then actual values for real world

³ Given $(P_i / 1 - P_i) = k$, $\therefore P_i = k (1 - P_i)$, $\therefore P_i = k - kP_i$, $\therefore P_i + kP_i = k$, $\therefore P_i + kP_i / P_i = k/P_i$, and $1 + k = k / P_i$. Subsequently, $P_i (1 + k) = k$, $\therefore P_i = k / (1 + k)$.

health markets can be input. The outputs can then be compared to reality as a test of the emergent theory.

- However, an important caveat is recognised. If, as argued in Chapter 5, a particular relationship marketing strategy was found to be influenced by a large number of independent variables, then estimating the probability of a given scenario occurring in a specific local health market would imply exhaustive information requirements.

4.6 Summary

This chapter critically considered the adopted research methodology. A clear explanation was provided for the selection of a joint methodology based upon the analysis of national postal survey questionnaires and case studies. Throughout, recognition was given to a series of caveats associated with the chosen methodology, and in addition, an explanation for the rejection of alternative methodologies was provided.

The consequences of selecting a joint methodology are considered in both Chapters 5 and 6, the former presenting and evaluating the evidence from the national postal surveys of English NHS Trust hospitals and District Health Authorities, whilst the latter chapter presents and evaluates the evidence from the case study analysis.

CHAPTER 5

The National Postal Surveys: the Evidence for English NHS Trusts & District Health Authorities

5.1.0 Introduction and Overview

This chapter has a number of key objectives. Initially, consideration is given to the comparability of the NHS Trust survey's response rate with that of similar research, and the representativeness of the NHS Trust sample. The Chapter then continues with an evaluation of general perceptions of the NHS Internal Market perceived by NHS Trust managers.

In particular, evidence is considered regarding the following:

- a) The extent to which local health markets were contestable
- b) The importance of competitive culture in determining the nature of contracting
- c) The extent and nature of the purchaser-provider split
- d) The customer orientation of providing NHS Trusts
- e) The identification of NHS Trust manager's perceptions regarding the benefits of the NHS Internal Market.

The remaining NHS Trust data is then presented, the evaluation broken down into sections on the basis of four of Stone and Woodcock's (1995) cornerstones of relationship marketing, i. e. contract augmentation, contract customisation, market segmentation and direct communications.

Following this, the District Health Authority data is analysed, using again Stone and Woodcock's (ibid) cornerstones of relationship marketing to categorise the findings. This enables a comparative evaluation of NHS Trust and DHA perspectives.

This section is then followed by the presentation and evaluation of the 5 Logit models investigating contract augmentation, contact customisation, loyalty discounting, cost-sharing and default contracting. In addition to an evaluation of the general robustness of

the statistical models, and the significance of the relevant independent variables, the Logit models are used to show marginal effects. Moreover, a sectoral analysis based upon the Logit models is presented, indicating the likelihood of specific relationship marketing strategies being deployed by NHS Trusts under a range of different local health market scenarios.

Lastly, this chapter concludes with an executive summary of the key findings from the national NHS Trust survey, and the comparative findings from the DHA national survey.

5.2.0 National Survey Findings

5.2.1 NHS Trust Survey

A series of questions were asked which provided contextual background for the analysis of relationship marketing behaviour by NHS Trusts. These are considered after the next section evaluating the response rate of the NHS Trust survey.

5.2.1.1 Overall Response Rate

In total, 372 NHS Trusts in England were contacted with the survey questionnaire and supporting letter in December of 1998. As justified in Chapter 4, the geographic focus was constrained to England, with all NHS Trust types included except for NHS Ambulance Trusts. The justification for excluding the latter was provided in the previous chapter.

The national postal survey received 173 complete responses, indicating an overall response rate of 47%. This response rate compares favourably with comparable empirical studies evaluated in Chapter 3, and especially with Paton's (1998) recent study: in respect of relationship building questions, the latter received 95 complete responses from a survey of all acute, community and combined NHS Trusts in England in 1995/96.

Furthermore, discussions during several face to face case study interviews indicated that recent internal NHS postal surveys of contract managers had typically received response rates between 15 and 25%, and moreover, had included incentives to encourage

responses. Lastly, it should be noted that postal surveys typically receive response rates of around 20-40% (see for example the experiences of such diverse organisations as CLED, Coventry University; KPMG; Ecotec Ltd; Kings Fund Institute etc)

Further pertinent issues relating to the representativeness of the survey sample are considered in the following section.

5.2.1.2 Overview of the NHS Internal Market: NHS Trust Perspective

A primary question was the type of NHS Trust responding to the survey. Analysis of the composition of the responding type of NHS Trusts provides strong evidence on the representativeness of the survey sample.

The theory of relationship marketing (RM) analysed in Chapter 2, identified RM as a means of non-acute NHS Trusts reducing their comparative disadvantage, e.g. in respect of their diminished opportunity for capturing economies of scale, scope and repetition relative to acute NHS Trusts. However, Chapter 3 demonstrated the lack of evidence suggesting hospital type was a primary determinant of the likelihood of relationship marketing occurring (Paton, 1998).

Consequently, the analysis of the NHS Trust data presented in proceeding sections does not distinguish between hospital type. It should also be remembered that the prime focus of the current research was relationship marketing behaviour in general, and be noted that such behaviour was undertaken in the context of NHS Trusts perceptions of the extent of competition for services locally. Among the “competitors” facing a particular NHS Trust there would have been a wide range of NHS Trust types.

However, critics may argue that such analysis is merited, despite the empirical evidence of other studies, so accordingly within the Logit modelling ‘Trust type’ was considered as an independent variable.

Of responding NHS Trusts, the breakdown of Trust types was as follows:

Table 5.1: Percentage of NHS Trust respondents by NHS Trust type

NHS Trust Type	% of respondents (numbers)
Acute	49% (85)
General & Community	7% (12)
Community	7% (12)
Community & Mental Health	17% (30)
Mental Health	5% (8)
Other (composite response identifying more than one of the above categories)	15% (26)

Analysis of IHSM data (IHSM 1998/99) indicates that the response rates by NHS Trust type achieved by the national postal survey were broadly comparable to the actual distribution of NHS Trusts by type in England. The IHSM data indicates the following breakdown of NHS Trust types (ignoring NHS Ambulance Trusts):

Acute Trusts	55%
Community Trusts	25%
Mental Health Trusts	7%
Other (composite group)	13%

Overall, the national survey had 49% of responses from Acute type Trusts, 31% in a broadly defined “Community” Trust type, and 5% from Mental Health Trusts.

A number of caveats should, however, be added. Firstly, in the IHSM (ibid) data, entries for NHS Trusts are typically multi-functional in respect of trust activities, i.e. community, mental health etc. Consequently, the distribution of data presented in the above list reflects NHS Trusts ‘principal’ Trust activities. This can be identified either from the NHS Trusts legal title, e.g. XYZ NHS Community Trust, or from the Trust activities listing provided for each IHSM entry. NHS Trusts described as All District, or General Hospital Trusts were included in the Acute category on the basis of the type and range of secondary services provided by such units.

A second caveat is that caution should be expressed because the respondents to the national postal survey were being asked to categorise their NHS Trust. Thus there is potential bias in their interpretation of Trust type as contracts managers compared to the IHSM's interpretation.

Two further general questions were also posed: firstly the date at which NHS Trust status was awarded. This was of interest in respect of the Logit modeling, to explore the issue of first mover advantage. The other general question identified the numbers of competitors within the respondent's local health market.

The table below indicates the percentage distribution of responding NHS Trusts in respect of different "waves" (i.e. the date) of Trust inauguration.

Table 5.2: Percentage of Responding Trusts by date when NHS Trust status awarded

NHS Trust Wave	% of respondents (NHS Trust Nos)	% of NHS Trusts in England (based on IHSM data*)
First (1991/92)	13% (22)	11%
Second (1992/93)	23% (40)	18%
Third (1993/94)	30% (52)	32%
Fourth (1994/95)	30% (52)	33%
Fifth (1995/96)	2% (3)	5%
Sixth (1996/97)	2% (4)	< 1%

* Note: excludes NHS Ambulance Trusts. Breakdown is only for the years 1991/92 – 1996/97.

Here, IHSM data (1998/99) is useful in identifying whether the sample's distribution of Trust designation dates is representative of the whole Trust population. The comparative evidence suggests that the survey sample was broadly representative in this respect.

Whilst the impact of competition on relationship marketing is explored in more detail in subsequent sections, it is apparent, *a priori*, that the numbers of competitors is likely to

influence the likelihood of relationship marketing strategies being developed by NHS Trusts. Where such numbers are very low, relationship marketing strategies may be hypothesised as being insignificant. Alternatively, where markets are highly competitive in respect of large numbers of competing providers, such strategies are an important means of reducing competitive pressure, and the threat to the NHS Trusts income through building loyalty amongst purchasers.

For practical reasons, the local health market was defined, following Propper (1995b) in respect of a 30 minute travel radius from the responding NHS Trust, the focus being the numbers of “alternative” providers of services. The following table summarises the numbers of competitors facing responding NHS Trusts. The categories are to some extent arbitrary, although of clear importance is the monopoly case and duopoly case. The distinction between 10 competitors and over is of relevance to the Logit models, where this number is perceived to implying a market is highly competitive.

Table 5.3: The market environment facing responding NHS Trusts: Nos. of Competitors

Health Market	% of respondents	Numbers of NHS Trusts
Monopoly case	12%	20
Duopoly case	9%	16
3 – 5 competitors	47%	82
6 – 9 competitors	23%	40
10 or more competitors	9%	15

Clearly, the most prevalent local health market involved between 2 and 5 competitors, although of note, 21% of respondents faced a monopolistic or duopolistic market. Only 9% of respondents faced 10 or more competing providers.

Issues relating to the competitiveness of the market facing NHS Trusts were further explored in several ways. Firstly, respondents identified the extent of their awareness of the service capacity of local competing providers. This provides an implicit measure of the competitive threat facing NHS Trusts: where a “Strongly agree” response on the Likert scale is provided, this reflects awareness of a higher competitive threat than where

the associated response is “Strongly disagree”, the latter, in theory being associated with a monopolistic health market. The average Likert score for the survey sample was above the mid-point at 3.90, with standard deviation of 0.83. The distribution of responses to this question was unsurprising, given the analysis presented above on the distribution of type of health market types. Approximately 2/3 of respondents stated they agreed their NHS Trust was aware of competitors service capacity, with a further 18% Strongly agreeing. A further 5% provided a No opinion response, but only 12% disagreed with the statement.

The second related question was the extent to which a competitive culture existed in local health markets. To gauge this, two separate questions were posed. Firstly, to what extent respondents agreed a genuine purchaser – provider split had been introduced, and also, the extent to which the purchaser was seen as the “customer” after 1991. These are important questions because evidence evaluated in chapter 3 by Ferlie (1994) and others, suggested that the culture of competition had been successfully developed by the 1989 White Paper’s reforms.

In respect of the extent to which providers perceived a genuine purchaser-provider split had been introduced, the average response was relatively high at 4.27 (standard deviation 0.58). This is interesting in light of Propper (1995) and Le Grand & Bartlett (1993) who suggested that the extent of the purchaser – provider split was often over estimated. The distribution of responses was as follows:

Table 5.4: Distribution of Likert scores regarding the extent of the purchaser-provider split

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
31% (54)	66% (115)	0	2% (4)	0

In total, 97% of respondents strongly agreed or agreed that a genuine purchaser-provider split had been introduced in their local health authority area, with only 2% disagreeing. This further highlights the difference in findings between the current research and previous applied research evaluated in Chapter 3.

A related question was the extent to which purchasers were viewed as the “customer” after 1991, with responding NHS Trusts giving an average response of 4.01 (standard deviation 0.769), again implying a high degree of agreement with the statement. A more detailed analysis of the distribution of responses is provided below:

Table 5.5: Distribution of Likert scores for perception of purchaser as the ‘customer’

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
25% (43)	61%(106)	8% (14)	5% (9)	1% (1)

Combined together, 86% of responding NHS Trusts perceived that the purchaser was seen as the “customer” after 1991. Only 6% recorded a negative response to the statement.

Lastly in respect of the nature of competition within local health markets, responding NHS Trusts were asked to identify the extent to which capital resource was a barrier to the introduction of "new" patient services. This provides one measure of the contestability of local health markets for innovative patient services. The average response was above the Likert mid – point at 3.77 (standard deviation 0.86), suggesting that typically capital deficiencies were a barrier to market entry in new services. The actual distribution of responses was as follows:

Table 5.6: Distribution of Likert scores for the perception that capital resources were a barrier to innovation of patient services

Very Important	Important	Neutral	Not Important	Insignificant
20% (34)	46% (80)	27% (46)	7% (12)	< 1%(1)

In total, some 114 NHS Trusts perceived capital resources were a barrier to innovation in patient services, with 1/5 of all respondents stating this was Very Important. These figures compare with only 13 NHS Trusts (approximately 8% of respondents) who provided a negative response.

The theory of quasi – markets (Le Grand & Bartlett, 1993) emphasises a set of arguments in favour of the replacement of bureaucratic planning systems with quasi – markets. These were considered in detail in Chapter 1, but as a reminder were identified as:

- (i) Greater competition between providers
- (ii) Increased provider efficiency
- (iii) Increased responsiveness to local purchaser needs
- (iv) Wider patient choice and access
- (v) Increased power of service users.

The national postal survey asked respondents to rank each of the above in order of importance, 1 being most important and 5 least important. The percentage distribution of responses by category is identified in the following table:

Table 5.7: Perceived Benefit of the NHS Internal Market: Percentage Distribution by Category

Category Benefit of the Internal Market	1st	2nd	3rd	4th	5th
More provider competition	8%	8%	17%	15%	53%
Increased hospital efficiency	21%	28%	23%	19%	9%
Increased responsiveness to local purchaser needs	53%	23%	12%	6%	6%
Wider patient choice and access to patient services	10%	23%	24%	25%	18%
Increasing the power of service users	10%	18%	25%	30%	16%

The data was further analysed to provide a weighted overall ranking of each of the supposed benefits (Le Grand & Bartlett, 1993) of the NHS Internal Market. The results were as follows:

Table 5.8: Overall Ranking of Perceived Benefits of the NHS Internal Market

Benefit of the NHS Internal Market	Overall weighted rank position
More provider competition	5 th
Increased hospital efficiency	2 nd
Greater responsiveness to local purchaser needs	1 st
Wider patient choice & access to services	3 rd
Increased power of service users	4 th

The evidence suggests NHS Trusts perceived greater responsiveness to purchaser needs to be most important, followed by increased hospital efficiency, wider patient choice and access to services, increased power of service users, and lastly increased provider competition. Of note the equity issue is ranked third, and paradoxically, whilst increased hospital efficiency is at the top end of the rank scoring (i.e. 2nd), more provider competition is at the bottom end.

5.2.1.3. Service Augmentation and Customisation

NHS Trusts were asked to identify whether they typically provided services over and above that necessary for contract fulfillment. In total 75% of the respondents (130 NHS Trusts) confirmed that extra benefits are typically offered to purchasers. In addition, NHS Trusts were asked to specify how important this service augmentation was deemed in terms of building closer relationships with purchasers.

The mean score and standard deviation was as follows:

Table 5.9: Importance given to contract augmentation: statistical mean score and standard deviation

Mean Score	Standard Deviation
3.96	0.766

Given the scaling of “importance” (see appendix 1a for the NHS Trust questionnaire), this identifies the significance given to contract augmentation by respondents, i.e. a score of 4 being Important on the Likert scale. Further analysis suggests that of those NHS Trusts confirming their use of augmented contracts, 22% stated such a strategy was Very Important in strengthening relationships with purchasers, with a further 55% stating it was at least Important. Only 5% of responding NHS Trusts stated that contract augmentation was unimportant in building stronger relationships with purchasers, and a further 18% gave a neutral response.

Meanwhile, of responding NHS Trusts, 91 Trusts (53%) stated that they customised generic patient services to meet the demands of specific purchasing agents. Again, respondents were asked to specify how important this customisation was in building stronger relationships with purchasers, with the mean value and standard deviations as in the table below.

Table 5.10: Importance given to contract customisation: statistical mean score and standard deviation

Mean Score	Standard Deviation
3.54	0.974

Of responding NHS Trusts, 53% stated this behaviour was Very Important or Important in relationship building, with approximately 9% stating it was Not Important or Insignificant.

Reflecting the statistical mean score of 3.54, approximately 38% of responding NHS Trusts held a neutral opinion regarding customisation’s significance to their relationship building efforts with purchasers.

Additionally, detailed qualitative analysis enabled identification of the type of contract augmentation and customisation reported by responding NHS Trusts. In total, some 63 respondents specified examples of contract augmentation and customisation, and these are detailed in the table below:

Table 5.11: Types of Contract Augmentation and Customisation

Type of Contract Augmentation	Numbers of responses
Clinical non-core services	
Establishment of “outreach clinics” (providing a range of services)	10
Extra quality audit systems	12
Access to additional, out of hours Facilities	4
Mobile diagnostic clinics	4
Patient transport	2
Management Support	
Information systems support (general)	3
Facilities management support	3
Additional involvement in senior management Decision making	4
Waiting list systems	9

Access to Trust Corporate services	2
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ECR management advice	2
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<i>Type of Contract Customisation</i>	<i>number of responses</i>
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Health promotion activity	2
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One stop cancer clinics	3
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“New” clinical services	5
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Specialised clinical training for GP’s	5
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Access to “zero priced” complementary Medicines	2
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Patient needs assessment systems	3
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Direct computer help lines for GPs To contact hospital specialists	2
---	---

Outpatient specialists brought in-house To GPFH clinics	2
--	---

Integrated care packages for complex Disabilities, e.g. arthritis	1
--	---

(Note: some respondents provided more than one type of contract augmentation or customisation)

The interpretation and economic importance of these findings will be considered in Chapter 7. However, at this juncture it should be noted that the evidence provided

suggests considerable efforts were made by providing NHS Trusts to use contract augmentation and customisation as a means of building stronger links with purchasers, and moreover, these attempts took many diverse forms. This confirms that providers were far more pro-active than traditional economic theory suggests, e.g. Le Grand and Bartlett (1993), and supports the findings of others (Ferlie et al, 1994; Flynn, 1995) who have demonstrated that the “passivity” of purchasers in the contracting process was limited. In respect of the latter it is important to recall that for any given relative bargaining position within the contract negotiation process, contract customisation primarily represents a demand side relationship marketing strategy.

The above evidence also questions the validity of Patons (1998) finding's which showed that only 36% of Acute Trusts, and 52% of Community Tusts claimed they “led” the contracting process. Meanwhile, of the DHAs surveyed by Paton (1998) in the same study only 4 responding Health Authorities (11%) stated the provider led the contracting process; 18 (51%) said it was 50:50, and most importantly, 37% (13 responding HAs) stated they led the process. It should be remembered, however, that Paton (1998) emphasised that perspectives on who led the contracting process were subject to bias arising from local circumstance, and the type of contract under scrutiny.

5.2.1.4 Market Segmentation

All responding providers defined clear output measures as part of their contracts with purchasers which was unsurprising given the emphasis in the NHS on cost- volume as the principal performance measure (Paton 1998). However, of more significance, especially given the emphasis placed by the current reforms (DoH, 1997 White Paper) on quality as a key measure of service performance, only 9% of respondents (15 NHS Trusts) drew up contracts which included clear measures on health outcomes. It was not possible to determine the extent to which outcome measurement within contracts was used principally as a means of differentiating services between different purchasers. Moreover, it is possible that any recorded attempt to monitor quality of outcomes was simply a response to DHA demands for this to be done. This is possible in the context of Paton's findings (1998) which indicated that for 20% of providers the main reason given for any form of contract monitoring was only “because HAs required it!”

Equally of interest, some studies (NAHAT, 1994) have suggested a much higher importance being placed upon the monitoring of quality of outcomes (at least from the Health Authorities perspective) than the current research suggests. NAHAT (ibid) found that the quality of service provision to be of primary concern for DHAs, and, moreover, quality failure to be the main reason for contract switching by DHAs.

A further central aspect of the research was to determine how important loyalty discounts and volume discounts were in segmenting the market for NHS Trusts services. Of all respondents, 18% offered Loyalty Discounts (31 NHS Trusts), whilst a greater proportion of responding providers, i.e. 56% (97 NHS Trusts) offered Volume Discounts.

The proportional response to loyalty discounting among the responding NHS Trusts may be considered to be relatively high. The literature on relationship marketing (see, for example Kotler, 1994) emphasises the importance of building loyalty to ensure the success of relationship marketing strategies, identifying a series of factors most likely to result in “loyal” purchaser behaviour. Here loyalty is reflected in long term, high volume, repeat purchasing behaviour. The relevant factors identified by Kotler (ibid) were habit, indifference, low price, high switching costs, positive attitudes to the quality of service and finally the lack of choice.

In the former NHS Internal Market, it may be argued that habitual purchasing patterns were significant, reflecting sweet-heart relationships formerly developed within the planning bureaucracy of the pre-Internal Market NHS (Propper, 1995a). Indeed, the current research identified that 61% of respondents (105 NHS Trusts) stated that they believed the local DHA had preference for specific local NHS Trusts as contracting partners. Furthermore, as research evidence suggests (see Section 5.2.1.2), local market conditions were often imperfectly competitive in respect of numbers of competing providers, such that choice of contracting partners facing purchasers of secondary care was often constrained. Moreover, given the relatively large proportion of providers offering Volume Discounts (i.e. 56%), which lower the average unit cost of treatments, it may be argued that these relatively low prices would be sufficient to encourage loyalty amongst purchasers.

In addition, providers were asked to identify whether in drawing up contracts with purchasers they negotiated the inclusion of:

- (a) Default measures to correct for mis-alignment of contracts. These enable purchasers and providers to re-allocate funds to other mutual contracts in the event of specific contracts failing. It avoids the need to dissolve the relationship, and avoids the associated switching costs, although higher ex-ante transaction costs are involved in agreeing such contracts.
- (b) Termination of contracts where monitoring indicated unresolvable quality problems with the resulting likelihood that contractual obligations would not be met.
- (c) Cost-sharing agreements specifically designed to help re-align contracts if they were not hitting targets. These have the primary function of reducing uncertainty for the contracting parties by spreading financial risk. NHS Trusts may agree to charge only marginal rather than average costs where volume targets are overshoot. Alternatively, purchasers and providers would agree in appropriate remuneration if volume targets were not met. Through the analysis of the national postal surveys, and face to face interviews it became clear that a plethora of cost-sharing variants were used in the contracting process. However, the term was widely understood by responding contract managers, evidenced by the 100% completion rates recorded on the relevant sections of the postal questionnaire.

Of all responding providers, 58% (101 NHS Trusts) included default measures; 39% (68 NHS Trusts) had the option to terminate contracts written in. Meanwhile, some 84 NHS Trusts (49% of respondents) operated cost-sharing schemes. Later in this chapter (section 5.2.3), Logit models are developed to explain the driving factors behind cost - sharing and default contracting.

However, it should be noted that negotiations around the inclusion of default measures, cost – sharing and termination clauses all add to ex ante transaction costs. Moreover, it should be remembered that if RM results in customisation and augmentation of services, contracts will become increasingly individualised and have a whole range of default

measures or cost-sharing elements which further compound increases in ex ante transaction costs.

This is particularly important because as Le Grand and Bartlett (1993) and Williamson (1985) have argued, these are costs, which are to a large extent unavoidable. Alternatively, Williamson (1985) argued that providing service quality is high, ex post transaction costs will be low because of the subsequent minimal need for regulation and correction of contracts.

A further market segmentation question posed by the research was the extent to which NHS Trusts perceived pricing relative to non-price aspects of contracts to be significant in determining whether purchasers contracted with them. Of all respondents, 28% perceived pricing of contracts to be Very Important; a further 46% claimed it was at least Important. Only 7% stated it was Not Important, or Insignificant, with 19% providing a Neutral response. The statistical mean score was 3.94 on the Likert scale (1-5, with 5 being “Strongly agree”), and standard deviation 0.897. These results are not surprising given the emphasis placed by the Department of Health on cost-volume monitoring of contracts.

Of more interest is the emphasis given to non-price aspects of contracting. This provides further indirect evidence of NHS Trusts deploying relationship marketing strategies, one example being contract augmentation, and the imposition of bespoke monitoring systems. The mean score was 3.80 on the Likert scale, with standard deviation 0.795. Indeed, some 13% of responding NHS Trusts perceived non-price aspects to be Very Important in determining whether purchasers used their services; a further 57% perceived non-price aspects to be at least Important, and of note, only 6% stated it was Not Important or was Insignificant. In addition, 23% of respondents stated a Neutral response.

On balance, however, it appears that NHS Trusts were aware of the overall importance of non-price competitive behaviour in determining the spending patterns of purchasers. Clearly, this provides indirect evidence of the centrality of relationship building, given that contract augmentation, customisation, and direct communications strategies have all been seen to be prevalent within the quasi-market. Moreover, the importance placed upon non-price competition underlines the imperfectly competitive nature of local health markets in England at the snap-shot in time of the postal survey.

Continuing the evaluation of market segmentation, it will be recalled that 61% of responding NHS Trusts perceived the local DHA had preferred provider relationships. To further investigate this phenomenon, the questionnaire also investigated whether the local DHA imposed different contractual requirements on respondents compared to competing NHS Trusts.

The responses were as follows:

Table 5.12: Differential Governance Procedures Imposed by DHAs

Governance Procedure	Percentage of Respondents (NHS Trust numbers)
General Monitoring/Auditing Systems	31% (54)
Outcome Assessment	20% (35)
Output (i.e. volume assessment)	34% (59)
Imposition of Default Clauses by DHA	25% (44)
Contingency for failed contracts	16% (28)

There are some interesting conclusions to be drawn from this data. Firstly, it appears that differential preference patterns of DHAs were extended from simply which NHS Trust they contracted with. DHAs imposed differential governance procedures upon a relatively large number of NHS Trusts. Clearly, this behaviour may be justified, reflecting DHAs concerns over the quality of service delivery. Secondly, the findings imply that a relatively large number of NHS Trusts faced additional transaction costs associated with the contracting process compared to preferred rivals. Moreover, of note, two of the above governance categories relate to ex-post transaction costs, e.g. outcome assessment and volume assessment. This is important in the context of Williamson's (1985) perspective that the most important transactions cost are ex-post because of the unavoidable nature of ex-ante costs.

The questionnaire continued its investigation by considering the impact such governance structures had had upon contract manager's ability to innovate patient services, and also

subsequent limitations set over their autonomy in the contracting process. In respect of the former, the response was as follows:

Table 5.13: Distribution of Likert scores for the extent to which manager's ability to innovate services was curtailed by additional DHA governance procedures

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
3%	25%	20%	45%	7%

The mean score was below the Likert mid-point at 2.734, with standard deviation 1.022. In this instance, it appears that the majority of contract managers did not perceive that the imposition of bespoke governance structures affected their ability to further innovate patient services. Only 28% of respondents Agreed or Strongly Agreed that monitoring/auditing of contracts affected their ability to innovate patient services. Meanwhile, 45% of respondents Disagreed with the statement, with a further 7% Strongly Disagreeing.

Meanwhile when NHS Trusts were asked to state the extent to which the additional auditing/ monitoring of contracts had affected managers' perceptions of control over the contracting process, the mean response was 3.27, with the standard deviation 0.904. The distribution of responses was as follows:

Table 5.14: Distribution of Likert scores for the extent to which contracting autonomy was curtailed by additional DHA governance procedures

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
5%	42%	28%	24%	5%

Combined, 47% Strongly Agreed and Agreed that bespoke DHA monitoring/ auditing requirements had affected contract managers perception of their control over the contracting process. Meanwhile, in combination only 29% Disagreed and Strongly Disagreed with the statement.

This is of interest in the context of Frey's (1997; 1998) work on motivation. Frey (ibid) distinguished between two principal forms of motivation, i.e. extrinsic and intrinsic. The former is driven by outside forces, of which the most important is monetary reward, although it includes less tangible elements such as reputation and peer standing.

Meanwhile, the latter is self-oriented and based upon non-monetary reward. Of note for the current research findings, he emphasised that firstly intrinsic motivation was dominant where goods or services have public or quasi-public goods features, as for the delivery of secondary health care, and relatedly, that regulation in such circumstances will typically reduce such intrinsic motivation.

This crowding out of intrinsic motivation is perceived by Frey (1997; 1998) to occur where managers experience so – called impaired self-determination. This arises where the quality of manager's work is externally policed (e.g. via additional DHA monitoring), or through direct outside intervention. The latter, for instance, would occur if the Department of Health required specific information from NHS Trusts on costs, waiting times, re-admission rates, and throughput of patients. Thus the evidence in the previous table implies implicitly that crowding out of Frey's (1997; 1998) intrinsic motivation is likely to have arisen.

Clearly, the evidence presented on DHAs differential governance treatment of NHS Trusts, is also of relevance in assessing a balanced view regarding the extent to which crowding out of intrinsic motivation did occur. The evidence presented included various penalties for non-compliance with contract targets, e.g. cost-sharing clauses and default clauses. Governance procedures of this type would be described by Frey (1998) as “hard” as opposed to “soft” regulation, the latter being based upon non-punishment for under - performance. Importantly, such “soft” regulation does not imply explicit questioning of managerial competence, or necessarily any change in the locus of control of the contracting process. However, by comparison the “hard” form of regulation does have such implications. Subsequently, hard regulation is perceived by contract managers to be a punishment. Thus as Frey (ibid) argued, the presence of hard regulation has a more negative effect on intrinsic motivation than soft regulation.

5.2.1.5. Direct Communications

One key research issue was the extent of joint information gathering by NHS Trusts and DHAs, and also the extent and importance of joint venture activity by NHS Trusts. The former specifically identified whether NHS Trusts jointly gathered information on the health needs of the local population with the local Health Authority in order to develop

new patient services. Here, some 58% of respondents (102 NHS Trusts) answered in the affirmative.

Furthermore, the research considered the extent to which NHS Trusts had engaged in joint ventures in patient services since 1991. A distinction was made between other NHS Trusts, GP fundholders, non-GP fundholders, and the private sector. The results are subsequently presented in the table below:

Table 5.15: Distribution of Joint Venture Partners Among Responding NHS Trusts

Potential Joint Venture Partner	% of respondents	Nos. of NHS Trusts
Other NHS Trusts	84%	145
GP fundholders	79%	137
Non-GP fundholders	49%	85
Private Sector	46%	80

Of interest, NHS Trusts demonstrated a very high degree of joint venture activity between 1991 and 1998 with other NHS Trust partners, and also GP fundholders. This is surprising for the former group, given the emphasis Government placed upon competitive behaviour within the quasi-market, although we must qualify this statement. It is not known how significant in value terms, i.e. the share of NHS Trust income, or patient numbers, or in which clinical areas these joint ventures occurred. However, a surrogate measure of their significance in respect of NHS Trust – NHS Trust joint ventures is considered below. Meanwhile, the figure for NHS Trust joint ventures with GP fundholders is perhaps less surprising. This is in light of evidence presented in Chapter 6, indicating that GP fundholders were the most powerful group in negotiating advantageous relational contracts with NHS Trusts, despite their relative lack of financial power in local health markets (Paton, 1998). Analysis of the data also suggests that there was a stronger preference for joint ventures with GP fundholders than non-GP fundholders, which again reflects their relative importance to NHS Trusts risk income. It should be remembered that non-GP fundholders were funded via the local DHA, with no autonomy over their unit income, such that they did not represent footloose investors in local health services in the same sense as their Fundholding counterparts.

The questionnaire allowed further investigation of NHS Trusts joint venture activities with other NHS Trusts. Surveyed NHS Trusts were asked to identify to what extent joint ventures with local NHS Trusts had been significant in providing both existing services and “new” patient services since 1991. In respect of existing patient services, the mean score was 3.45, with standard deviation 1.02. The distribution of responses was as follows:

Table 5.16: Likert distributions for the extent of importance of Trust-Trust joint ventures in providing existing patient services

Existing Services	Very Important	Important	Neutral	Not Important	Insignificant
-	10%	46%	30%	6%	8%

From the table we see that 56% of respondents (97 NHS Trusts) perceived joint ventures with other NHS Trusts to be Important or Very Important in delivering existing services, with only 8% stating they were Insignificant (13 responding NHS Trusts). This is interesting in light of Paton’s (1998) evidence regarding the relationship between providers. Of 95 NHS Trusts surveyed, Paton (ibid) found that 42% described their relationship with local NHS trusts as “complementary” compared to 25% who perceived the relationship was “competitive”. The evidence above supports Paton’s (1998) findings: the high degree of localised joint ventures reflects a more co-operative rather than competitive culture. We should, however, be cautious because it is not known to what extent the decision to take up joint ventures was made in relative freedom. In reality, recorded patterns of joint venture behaviour may have been influenced by local health needs, the distribution of local capital assets, and historical referral patterns.

In respect of the significance of NHS Trust – NHS Trust joint ventures in delivering “new” patient services, the mean score was above the Likert mid-point at 3.58, with standard deviation 1.07. The distribution of responses was as follows:

Table 5.17: Likert distributions for the extent of importance of Trust-Trust joint ventures in providing ‘new’ patient services

“New” Services	Very Important	Important	Neutral	Not Important	Insignificant
-	16%	47%	26%	4%	8%

It is interesting to note, that combined, 63% of respondents perceived such joint ventures as Important or Very Important. This again suggests that in the development of new patient services co-operation was more prevalent than competition, at odds with national policy objectives of instilling competitive behaviour. Secondly, if in oligopolistic local health markets such behaviour was widespread, this implies that a collusive oligopoly model is most appropriate (Lyons, 1987). Subsequently, it implies that the contestability of local health markets was limited for new secondary care services.

Meanwhile, the literature on relationship marketing (RM) stresses the importance of personal relationships being strengthened by sellers. The principal argument is that such activity increases the extent of trust, familiarity, habitual contracting behaviour, and the quality of information used in the contracting process, the latter enabling sellers to more accurately identify buyers needs, or reshape buyers perceptions of their needs (Kotler, 1994; Morgan & Hunt, 1994). This in turn implies stronger commitment by the seller to a buyer, which further enhances trust, familiarity etc, and will increase the purchaser's perception of the high switching costs of contracting with alternative providers. This whole process will clearly tend to enhance loyalty of purchasers to providers, and enable a virtuous circle to be established. Whilst as argued in Chapters 1, and 2 that cultural factors and the economic structure of local health markets may engender trust, commitment and loyalty, the research sought to identify how important personal relationship building within RM strategies was considered to be in strengthening purchaser - provider relationships.

In the national survey, 89% of responding NHS Trusts identified that the contracting process was based upon the interactions of a limited number of key personnel, supporting Paton's (1998) findings. This partly reflects the functional organisation of both NHS Trusts and DHAs, and as such is to be expected. It does however, challenge one of the main propositions of the theory of RM (Doyle et al, 1996), which states that RM is less likely where only a very limited number of individuals actually engage in a contracts negotiation. Doyle (ibid) cite Bowen and Lawler (1992) who identified that employee attitude, decision authority and motivation are all reflected in the quality of customer relationships, and consequently conclude that there is an inverse relationship between the

concentration of power in organisations and the likelihood of RM strategies being adopted.

Moreover, the survey considered the extent to which the building of personal as well as formal relationships was deemed vital to the contracting process. Using the Likert scale, the mean score was recorded well above the mid - point at 4.62. Indeed, some 64% of respondents Strongly Agreed with the proposition, the remaining responses being Agree with 35%, and only 1% providing a neutral response. Paton's study (1998) provided similar, indirect evidence, suggesting that in addition to formal contact for negotiating and monitoring contracts

“Most Trusts indicated they were in regular contact with the local HA.” (p. 91)

Further investigating this issue, the questionnaire sought to elicit whether clinical staff were part of the key personnel used directly in the contract negotiations process. This is of interest for a number of reasons: one principal argument behind the NHS Internal Market reforms was the perceived lack of understanding amongst clinicians of the importance of economic efficiency in the allocation of scarce health resource. Reforms were seen as a challenge to the so - called bioengineering view whereby health resource is simply allocated on clinical grounds on the basis of the estimation of needs. It should be noted, of course, that commentators have argued that the bio-engineering view has been over emphasised and that clinicians have always been aware of the opportunity costs of clinical resource decisions,

“There is no such thing as clinical freedom, nor has there ever been. Nor for that matter should there be”

(R. Hoffenburg, President of the Royal College of Physicians, 1989).

Furthermore, there is a high degree of irony in the findings. Anecdotal evidence, based upon one of the face to face interviews with an HA commissioning manager , suggested that a primary driver behind the introduction of the NHS Internal Market had little to do with rolling back the state, efficiency, equity, responsiveness and patient choice (Le Grand & Bartlett, 1993). It was suggested that a media scandal based upon Birmingham

Children's Hospital had resulted in the then Prime Minister, Margaret Thatcher deciding that the influence of clinicians upon resource allocation should be curtailed!

However, of responding providers, 18% (32 NHS Trusts) stated that clinical staff were Very Important to the contracting process, with a further 56% (97 NHS Trusts) stating that clinicians were Important to contract negotiations. Only 7% (13 NHS Trusts) expressed a negative response on the Likert scale. The mean score was 3.84, above the Likert mid-point, and these figures stand in contrast to Paton's (1998) findings which suggest that 38% of contracting relationships were centralised with only a minimal role for clinicians.

A further key element of generating repeat purchasing by providers involves the establishment of long – term relationships (Kotler, 1994; Doyle, 1994; Stone & Woodcock, 1995). NHS Trusts were asked whether they attempted to build such links, i.e. longer than the 12 month annual round of NHS contracting imposed by the Department of Health. Of 173 responding NHS Trusts, 154 (89%) stated that they did attempt to build long term links with purchasers. Moreover, the survey questioned how important these efforts were within the contracting process. The average response was 4.04 suggesting the relative importance given to this behaviour. Reinforcing this perspective, some 34% of responding NHS Trusts stated developing long term relationships was Very Important to the contracting process, with 43% stating it was at least Important. Only 8% in total gave a negative response, representing 13 NHS Trusts.

Finally in respect of direct communications strategies, evidence was elicited to assess whether providers sought information on the satisfaction of purchasers with contracted services. This provides a measure of the perceived quality of health care services provided, and is important in the context of increasing emphasis upon evaluation of user satisfaction within the NHS (Lloyd & Hill-Tout, 1998). It should be noted that this is an additional aspect of measuring satisfaction with the quality of services to formalised monitoring procedures built into specific contracts. What is being measured here is whether providers were using a satisfaction survey approach to assess quality of provision in general.

In respect of the RM literature, there is no single accepted definition of “satisfaction” with services, but Selnes (1993) offers two definitions pertinent to health care. Firstly, that it is “a post -choice evaluative judgement of a specific transaction”. There is obvious importance in this definition for secondary health care, because of the extent of asymmetry of information between the end user, i.e. the patient and the provider. However, given the evidence considered above on the nature and importance of the monitoring of the contracting process, Selnes’ (ibid) definition fails to recognise ongoing rather than simply ex post evaluation.

A second definition offered by Selnes (1993) sites the work of Fornell (1992) who suggests that satisfaction is measured by customers who “have an idea about how the product compares with an ‘ideal’ norm”. This definition is becoming increasingly pertinent in the context of the post Internal Market NHS where, there is increasing pressure towards the introduction of Diagnosis Related Groups (DRGs), and the setting of national clinical standards in secondary health care (DoH, 1997 White Paper).

In terms of the current research’s evidence, 91% of providers (157 NHS Trusts) claimed that they evaluated purchaser’s satisfaction with contracted services. The questionnaire investigated how important such feedback was in further building relationships with purchasers. The average response was 4.21, above the Likert mid-point, identifying that of those NHS Trusts evaluating satisfaction, particular importance was placed upon its outcome. Of all respondents, 24% stated such feedback was Very important, with a further 61% stating it was Important in further building the relationship with purchasers. A neutral response was given by 6%, and the remaining 9% of responding NHS Trusts stated it was Insignificant.

Some caution should, however, be expressed in interpreting the importance of such evidence. As Dawkins and Reicheld (1990) state

“There is no great correlation between satisfaction surveys results and customer defection”, (p. 45)

and this reflects evidence in the private sector (Morgan & Hunt, 1994) where competitive forces may be more significant than in quasi-markets in State health care. Moreover, as

argued above, the possibility of exit (Hirschman, 1970) by purchasers, and indeed even the power concentration of voice will be limited in localised quasi-markets. Those factors encouraging “defection” from providers are thus constrained, and furthermore, this constraint is further compounded by loyalty among local purchasers towards NHS Trust hospitals.

Lastly, whilst the cornerstones of relationship marketing (Stone & Woodcock, 1995) used by the current research are not exactly contiguous with the criteria suggested by Kotler and Andreason (cited in Wilcox & Conway, 1998) for identifying customer oriented marketing, there remains sufficient ‘closeness of fit’. This implies NHS Trusts deployed customer oriented rather than organisation oriented marketing strategies. The former represents a type of strategic marketing, and would be considered integral to any wider relationship marketing strategy (Kotler, 1994). The following table summarises the key similarities between Kotler and Andreason’s criteria for customer orientation, and relevant supporting evidence from the national NHS Trust survey.

Table 5.18: Kotler & Andreason's Criteria for "Customer" oriented marketing behaviour

Customer Orientation Criteria	Relevant NHS Trust Survey Evidence
Customers' views regularly sought	86% of respondents stated seeking 'feedback' from purchasers was "Important" or "Very Important" in building long-term relationships. 86% stated they "Agreed" or "Strongly Agreed" the purchaser was the 'Customer' after 1991.
Reliance on Research	84% of NHS Trusts "Agreed" or "Strongly Agreed" they were aware of capacity in local health markets. 58% undertook joint information gathering with purchasers
Predictions for Segmentation	NHS Trusts showed awareness of importance of non-price competition in purchasers decision to contract with them or not. Strong evidence of preferred provider behaviour, extended to imposition by DHAs of differential governance procedures.
Mature comprehension of role of competition	Awareness of competitors capacity; identification of factors affecting contestability; deployment of relational strategies.
Use of full marketing mix	Wide range of direct communications strategies; contract augmentation and customisation; market segmentation.

5.2.2 National Survey Findings: the District Health Authority Perspective

5.2.2.1. Introduction

This section evaluates the data from the national postal survey of District Health Authorities. To aid comparative analysis with the NHS Trust survey, the results are again sub-divided into contract augmentation; contract customisation; market segmentation, and lastly direct communications. Prior to this, brief consideration is given to the representativeness of the DHA survey sample.

5.2.2.2. Representativeness of the District Health Authority Sample

The national postal survey targeted all District Health Authorities in England, the geographic focus having been justified in Chapter 4. In total, this involved contacting 100 District Health Authorities, with respondents completing the questionnaire anonymously. The selection of an anonymous questionnaire format was itself justified earlier in Chapter 4.

In total 46 completed responses were received such that the survey achieved a 46% response rate which compares favourably with the survey of NHS Trusts considered above, and with comparable academic studies (see Chapter 3). In respect of the latter, Renade's (1995) study was based upon a sample of 18 District Health Authorities, Ashburner et al's (1993) involved 3 District Health Authorities, and Ferlie and Pettigrew's (1996) evaluated only 9 District Health Authorities. Of greater note, perhaps the most comparable study to the current research, i.e. Paton's (1998) study was based upon 33 English DHAs, representing 33% of the total DHA population.

5.2.2.3. Contract Augmentation and Customisation

A fundamental question asked of DHAs was how frequently NHS Trust hospitals offered additional services or benefits over and above that required for a basic service agreement. For responding DHAs, the distribution of responses was as follows:

Table 5.19: Likert distributions for how often DHAs were offered augmented contracts by NHS Trusts

Always	Frequently	Sometimes	Seldomly	Never
-	17%	15%	13%	55%

The evidence implies that DHAs had a much lower perception of the extent of contract augmentation than NHS Trusts, three quarters of the latter identifying that they offered augmented contracts to DHAs.

The average response relating to the data above was only 1.96, with standard deviation 1.19. Clearly, some caution should be expressed in interpreting this result: the distinction in perception between NHS Trusts and DHAs regarding the significance of this element of relationship building behaviour may be the result of sample bias within the DHA survey.

The analysis was further extended to ask DHAs whether contracts were customised by NHS Trusts to meet specific requests from them. Here, the mean response was higher than for contract augmentation at 2.85, and this is reflected in the following distribution of responses:

Table 5.20: Likert distribution for how often DHAs were offered customised contracts by NHS Trusts

Always	Frequently	Sometimes	Seldomly	Never
2%	11%	65%	13%	9%

Some 14 DHAs actually specified the types of contract augmentation and/or customisation they received from NHS Trusts. The numbers of responses by type are listed below demonstrating as for the NHS Trust survey evidence, a diverse range of types.

Table 5.21: Types of Contract Augmentation and Customisation Recorded by DHAs

<i>Type of Contract Augmentation/ customisation</i>	<i>Numbers of times mentioned</i>
a. <u>Augmentation</u>	
Managerial support	3
Top ups to non-priority areas, especially Patient transport	2
Additional “general” patient services	2
“difficult to identify elements of augmentation within overall contract equation”	1
Additional quality systems by provider	1
b. <u>Customisation of Patient Services</u>	
Provision of “outreach” clinics	3
Unplanned specialist provision	7
Funding of consultants at fixed cost only	2
Priority resourcing to target waiting lists	2

(Note: a number of responding DHAs provided multiple examples)

No clear pattern emerges from the above data, although notably there were seven instances of unplanned specialist provision by NHS Trusts.

To compare with NHS Trust responses, DHAs were also asked to identify whether the monitoring of the contract process was standardised across all types of providers. In

total, 40 of 46 responding DHAs (87%) stated the monitoring of contracts was standardised, which stands in sharp contrast to the evidence from the NHS Trust survey, where there was clear evidence of NHS Trusts being treated differently from other competing NHS Trusts. Some 31% of responding NHS Trusts alone reported differential treatment in respect of general monitoring and auditing of contracts with their local DHA.

5.2.2.4 Market Segmentation

Not surprisingly, when asked how important the definition of output measures was in negotiating contracts with providing NHS Trusts, DHAs responded with a very affirmative response, having a mean score on the Likert scale of 4.67 (standard deviation 0.52). Of more interest, in the context of the increasing emphasis given to quality assessment within secondary care in the NHS which was considered above, the mean score was marginally above the Likert mid-point at 3.15. Moreover, the distribution of responses was of interest.

Of responding DHAs, 6% (3 DHAs) perceived defining quality of outcomes as Very Important in the negotiating process with NHS Trusts; a further 30% (14 DHAs) stated it was Important with 41% (19 DHAs) providing a Neutral response. Only 21% of DHAs provided a negative response. This pattern contrasts sharply with the NHS Trust response, where only 9% claimed to define outcomes measures within contracts with DHAs.

Interesting comparisons also emerged with respect to loyalty discounting and volume discounting of contracts. Of responding DHAs 70% (32 DHAs) stated they were offered volume discounts, which is unsurprising in the context of Paton's (1998) findings, and is higher than the equivalent NHS Trust response of 56% presented earlier. Notably, the distribution of responses in respect of the extent to which loyalty discounts were offered to DHAs was as follows:

Table 5.22: Likert distributions for the frequency of loyalty discounting by NHS Trusts

Always	Frequently	Sometimes	Seldomly	Never
7%	2%	7%	2%	83%

The mean score on the Likert scale was low at 1.48 (standard deviation 1.15). Of all respondents, 83% stated they were Never offered loyalty discounted contracts, although, tautologically speaking, the remaining 17% had at some point been offered such contracts. This latter figure is in line with the equivalent figure (18%) indicated by NHS Trusts.

A further related research question asked DHAs to identify whether contracts included the following: default contracting; cost - sharing, and termination clauses. These again mirrored questions asked of NHS Trusts. In total 38 DHAs (83%) stated they included default measures, 19 respondents (41%) included cost-sharing agreements at the initial negotiation stage, and lastly, 35 DHAs (76%) included explicit clauses on contract termination at the initial negotiation stage.

From the evidence, therefore, it appears that within the sample of DHAs there was greater exposure to default contracting than within the NHS Trust sample; there was a broadly similar experience of cost-sharing between the DHA and NHS Trust samples, the relevant figures being 41% and 49% respectively. Of note, the figure for inclusion of explicit termination clauses at the initial negotiation stage was much higher within the DHA sample compared to NHS Trusts, the latter only recording an affirmative response in 39% of cases.

An additional consideration relating to market segmentation was the extent to which DHAs perceptions differed regarding the importance given to price and non-price competition in choosing between providers. The evidence indicates that DHAs placed a relatively low value on the importance of pricing of contracts in determining relational partners: the mean score was 2.76, marginally below the Likert mid-point (standard deviation 1.10). This is reflected in the distribution of responses given below:

Table 5.23: Likert distributions for the importance of contract pricing in determining provider selection

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
2%	11%	65%	13%	9%

As can be seen, only 13% of responding DHAs combined Strongly Agreed or Agreed with the statement, with 65% providing a neutral response, the latter being difficult to interpret. It should be stressed that traditional relational patterns, and the extent of local competition will influence the importance given to pricing or non-pricing in selecting partners (Paton, 1998).

Meanwhile, moving on to non-price competition, DHAs were asked to specify the extent to which this was important in determining relational partnerships. Of particular note, the Likert score here was much higher than for price competition with a mean score of 3.90 (standard deviation 0.65) suggesting DHAs placed a relatively high degree of importance on this aspect of the contracting process. A more detailed consideration of the distribution of responses is possible within the following table:

Table 5.24: Likert distributions for the importance of non-price competitive elements in determining provider selection

Strongly Agree	Agree	No opinion	Disagree	Strongly Disagree
11%	70%	15%	4%	

In this instance, 11% (5 DHAs) Strongly agreed with the proposition, with a further 70% (32 DHAs) Agreeing. Only 4% (2DHAs) provided a negative perspective on the importance of non-price competition.

It is interesting to contrast the findings relating to price and non-price competition for DHAs with NHS Trusts presented earlier in this chapter. In respect of price competition, NHS Trusts considered this to be much more important than did DHAs given their recorded mean score of 3.94 on the Likert scale. Meanwhile, in terms of non-price competition both DHAs and NHS Trusts provided broadly similar results (mean scores of 3.90 and 3.80 respectively). Thus the DHA data provides additional indirect evidence of the significance given to relationship building strategies within the NHS Internal Market, given that such non-price competition would have involved elements of contract augmentation and customisation, market segmentation, direct communications strategies, and the use of specialised distribution services.

Additionally, rather than simply considering whether DHAs could switch partners, i.e. if market exit were possible, the current research also sought to identify whether in situations where market exit were feasible, awareness of the extent of transaction and production costs in so doing influenced switching behaviour. Resounding evidence was provided to suggest DHAs were conscious of the costs of switching partners. In more detail, the mean Likert score recorded was 4.04 (standard deviation 0.98), with 81% (37 DHAs) of respondents stating that awareness of the drawbacks of switching between providers was Very Important or Important in deciding whether such switching did occur. Meanwhile, only 6% (3 DHAs) provided a negative response. Given this evidence, it may be deduced that for DHAs voice rather than exit (Hirschman, 1970) was of more significance in determining relational patterns. It is appropriate therefore to consider the survey evidence relating to DHAs perceptions of the importance of direct communications strategies developed by NHS Trusts.

5.2.2.5 Direct Communications Strategies

District Health Authorities were asked to identify whether providing NHS Trusts placed emphasis upon building close “personal” as opposed to simply formal, functional relationships with them as part of the contracting process, such efforts being central to relationship marketing strategies (Stone & Woodcock, 1995). In total, 38 DHAs (83%) stated that providing NHS Trusts did use this strategy.

Moreover, to further explore the extent of the relational building process DHAs were asked to identify whether they jointly gathered, collated and shared contracting information with various categories of relational partners. The emphasis was upon such joint work with other interested parties, i.e. not just the direct contracting service provider. This will provide implicit evidence of the extent of co-operative rather than competitive type behaviour within the NHS Internal Market, questioning the degree of success of national health care policy associated with the 1989 White Paper reforms.

Table 5.25: The pattern of DHAs sharing of contract related information

Other interested party with whom DHA jointly gathered, collated & shared contract related information	% of all responding Health authorities (sample of 46 respondents)
Non-GP Fundholding practices	91%
GP Fundholding practices	93%
Health Authorities	74%
NHS Trusts	52%
Local Social & Welfare services	46%

Additionally, DHAs were asked to identify examples of such joint information exchange with other interested parties. The responses were subsequently categorised as follows:

Table 5.26: Type of Contract Related Information Shared by DHAs with other Health Care Agencies

Type of Information Exchange Provided by District Health Authorities	Number of references made
Cost pressures facing all local NHS Trusts	4
Analysis of local health needs	3
Details of cash envelopes available for specific clinical services	1
DHA views on quality auditing/ types of auditing employed	2
Impact of specific contract agreements on other potential providers	3
Open information forums for all providers	1
Capacity of competing providers	3

General referral patterns; treatment specific
contract prices; details of monitoring systems

12

(Note: a number of responding DHAs provided multiple responses)

Clearly some caution is necessary in interpreting the above responses, being based upon a small sub-sample. However, a number of interesting inferences can be drawn. At one level, it could be argued that with DHAs sharing competitive data with providers, this mirrors a perfectly competitive market, with DHAs acting as an “auctioneer”. However, the relatively large number of DHAs offering key competitive data to providers (i.e. particularly on pricing, referral patterns, and monitoring systems) is surprising given the accumulated evidence from the current research and other studies (Le Grand & Bartlett, 1993; Propper, 1995; Paton, 1998) which indicate that local health markets are typically oligopolistic. In such markets, assuming non-collusive behaviour among providers, competitive data has a high opportunity cost. In particular, the gains from relational marketing strategies would be diminished if potentially competitive data was not internalised by the contracting DHA and providing NHS Trust.

Finally in this section, DHAs were asked to identify how often providing NHS Trusts sought feedback on their degree of satisfaction with the quality of services provided. The distribution of responses was as follows:

Table 5.27: Likert distributions on the regularity of NHS Trusts satisfaction surveys carried out for DHAs

Always	Very frequently	Frequently	Infrequently	Never
2%	11%	33%	39%	15%

Of note, the mean response was 2.46 (standard deviation 0.96), with 54% (25 DHAs) of respondents stating that such feedback was Infrequently requested or Never requested by NHS Trusts. This stands in sharp contrast to the perceptions expressed by NHS Trusts earlier in this chapter. According to the latter, 91% of respondents undertook satisfaction surveys and, moreover, 85% of those NHS Trusts undertaking such surveys stated they were Very important or Important in cementing the relationship with DHAs. Indeed, only

9% of responding NHS Trusts provided a negative response, i.e. stated it was Insignificant in cementing relationships with DHAs.

5.2.3 Empirical Analysis of the NHS Trust Survey

5.2.3.1 Introduction

The national NHS Trust data on purchaser-provider relationships was used to explore five sets of relationships:

- i) Those factors affecting the likelihood of NHS Trusts augmenting contracts with purchasers (Model A)
- ii) Those factors affecting the likelihood of NHS Trusts customising contracts for individual purchasers (Model B)
- iii) Those factors affecting the likelihood of NHS Trusts discounting contracts. The essence of this behaviour is NHS Trusts offering treatments at reduced step, and marginal costs for repeat business with specific purchasers (Model C)
- iv) Those factors affecting the likelihood of NHS Trusts negotiating cost-sharing contracts with purchasers (Model D)
- v) Those factors affecting the likelihood of NHS Trusts including default measures within contracts with purchasers (Model E).

5.2.3.2 *A priori* reasoning:

For each of the models A through E, the initial stage of the empirical analysis involved identifying, *a priori*, those factors likely to result in the given type of relationship marketing behaviour under scrutiny. Thus *a priori* reasoning was used to develop the hypotheses to be tested. Following Gujarati (1988), it is recognised that when using such thinking, or theoretical principles, it is vital that the hypotheses be identified before the empirical investigation begins. Otherwise, as Gujarati (ibid) states,

“He or she will be guilty of circular self-fulfilling prophecies..... if one was to formulate hypotheses after examining the empirical results, there may be the temptation to form hypotheses so as to justify one’s results. Such a practice should be avoided at all costs, at least for the sake of scientific objectivity” (p 115).

5.2.3.3. Models A and B

The following independent variables were theorised as being important in determining both contract augmentation and contract customisation:

- a. The extent of local provider competition
- b. The extent of surplus capacity in local health markets
- c. The importance of relationship marketing culture to NHS Trust hospitals
- d. The importance of first mover advantage
- e. The strength of competitive culture in local health markets
- f. The importance of preferred provider relationships in local health markets.

A brief explanation of why these factors were deemed important is now provided.

a. Local provider competition

The survey identified the numbers of providers within the local health market. The local health market was defined in respect of a 30 minute travel radius (Propper, 1995) from the responding NHS Trust hospital.

Theoretically, as the local health market becomes more competitive, i.e. the numbers of competing local providers increases, it is perceived that both contract customisation and augmentation will become more likely (Doyle et al 1996). This may lead to the adoption of RM strategies which will build customer (i.e. purchaser) loyalty (Hirschman, 1970), and protect or enhance NHS Trusts income. This is especially important where risk income is concerned.¹

b. Surplus Capacity

It is argued that there is a positive correlation between surplus health care capacity (e.g. in terms of bed spaces) among local NHS Trusts and the likelihood of NHS Trusts augmenting and customising contracts. Where for instance there is a large volume of spare capacity, individual NHS Trusts are likely to use RM to build closer relationships with purchasers to encourage purchaser loyalty and secure NHS Trust income. In essence, such behaviour reduces the “real” choice of providers faced by the purchaser.

c. Relationship Marketing Culture

Surveyed NHS Trusts were also asked to identify the importance placed upon building long term relationships with purchasers. This was taken as an implicit measure of the importance given to RM, especially in the context of the short term, annual rounds of service contracting dictated by the NHS Internal Market arrangements. It was argued that the greater the importance placed upon building long term relationships (i.e. beyond the NHS’s 12 month contracting rounds), the more likely were NHS Trust hospitals to customise and augment contracts as a means of cementing closer contractual relationships.

d. First-Mover Advantage

The survey questionnaire identified when the hospital had been granted NHS Trust status by the Department of Health. It is argued that those hospitals achieving this status in the first wave, were more likely to employ RM strategies.

Using non-price competitive behaviour would enable first movers (Krepps, 1990; Nicholson, 1998) to establish closer relationships with newly emerged

¹ Case evidence for Warwickshire DHA conducted as part of this research suggests that often, the focus of efforts to customise and augment contracts by NHS Trust hospitals was with GP fundholders. In essence, whilst local Health Authorities were tied to local Trusts for acute and elective treatments, with the resulting Trust income being low risk, GP fundholders acted as “foot-loose” exchange partners. They typically selected Trust hospital partners on the basis of non-price competitive behaviour, i.e. principally the extent to which Trusts would customise and augment contracts. Thus for Trusts, GP fundholder income was relatively high risk.

GP fundholders, and build trust, loyalty and repeat contracting which would diminish the effects of potential competition. Moreover, eagerness to take up NHS Trust status rather than remain a Directly Managed Unit responsible to the local Health Authority, represents an indirect measure of the managerial culture of the organisation. With first movers, it may be argued that they had an organisational culture based on a stronger competitive ethos than later wave NHS Trusts. Moreover, case evidence (see Chapter 6) indicates the direct, strong link between taking up early NHS Trust status and the desire to use marketing to develop closer ties with purchasers.

e. Local Competitive Culture

Respondents identified the extent to which a genuine purchaser – provider split was employed in their local health market. This was an important question, given evidence (Propper, 1992; 1995) that in a number of case examples, following the White Paper reforms of 1989, some local health markets continued to operate as bureaucratic planning structures. It was perceived that the stronger importance placed on a genuine purchaser-provider split locally, the more likely Trusts were to use RM strategies to counter the effects of competition in provision.

f. Preferred Provider Relationships

The questionnaire also identified whether NHS Trusts perceived that local DHAs had preferred local NHS Trust providers. This gives indirect evidence of so called “sweetheart” contracting (Propper, 1992; 1995; Gray & Ghosh, 2000a) within the NHS Internal Market. Propper (1992;1995) suggests that often, following the purchaser-provider split, lead purchasers, i.e. DHAs would prefer to deal with specific individuals now working within given NHS Trust hospitals. This preference was based upon close working relationships previously cemented in the days of the pre-reform planning beaurocracy (Le Grand & Bartlett 1993; Appleby 1994; Wistow 1996). Where such behaviour is prevalent, the degree of market contestability is diminished (Baumol, 1982), and it is likely that potential entrants, i.e. less popular NHS Trusts, will use contract customisation and augmentation as a means of reducing entry barriers to the local health market.

5.2.3.4 Empirical Analysis and Results: Models A and B

To conduct empirical tests for all five hypotheses outlined above, based on the large representative sample from questionnaire returns (47% of the NHS Trust population in England), a special form of multiple regression model was adopted. The justification for using this approach, i.e. the Logit method (Maddala, 1983) was justified in detail in Chapter 4. However, it should be reiterated here that the principal advantage of this method is that it enables researchers to deal with the qualitative nature of the dependant variable. In this research, the dependant variables to be explained were not continuous, but were discrete. This means that the data had to be analysed as “yes” or “no” responses rather than, for instance, “how much?” type responses.

For both hypotheses A and B above, all six independent variables, a through f considered in Section 5.2.3.3 above, were tested. However, those independent variables with very limited statistical significance, i.e. those with t-values below 0.6 were rejected. The statistical findings are summarised in the tables below:

Table 5.28: LOGIT Estimate Results for Contract Augmentation*

Variables	Coefficients	t-values **
Numbers of competitors	0.1182	1.91
RM culture	0.7603	1.47
Preferred-providers	0.4376	1.20
Competitive culture	0.1454	0.611
Constant	-0.8651	-0.798
Percentage of Correct Predictions	75.29%	
McFadden Pseudo R ²	0.047***	
Chi-squared at 4 degrees of freedom	9.3146	

Notes regarding Table 5.28

* For each Model A through E care was taken to investigate potential multicollinearity using zero-order correlation matrices.

** Estimated t – values are deemed reportable in published research at different statistical significance levels depending on the academic discipline under

consideration. For instance, in economics modelling reported t-values have a higher significance criteria for reporting than in typical marketing research (see for example, various papers published in 4th ICIT Conference Proceedings, TQM and Innovation, Hong Kong, 1999)

*** (McFadden R^2 is calculated as $(1 - \text{Log } L_{ur} / \text{Log } L_r)$)

The results for the model summarised in 5.28 were found to be significant at better than the 94.63% level, with the other diagnostics supporting the overall result i.e. the figure for percentage of correct predictions being 75%. Thus the model was accurate three quarters of the time in predicting whether NHS Trusts would augment contracts with purchasers. Whilst the McFadden Pseudo R^2 figure is relatively low, it should be recalled that Pseudo R^2 values are typically well below Ordinary Least Squares R^2 values, and moreover, are subject to caveats regarding their interpretation (Greene, 1997; Gujarati, 1992) as argued in Chapter 4. In respect of the independent variables only numbers of competitors (variable a) and relationship marketing culture (variable c) turn out to be significantly different from zero at the 94.35% and 85.85% levels respectively.

The other two independent variables in this model (i.e. preferred – providers and competitive culture) have much lower t-values; but all of the independent variables supported the *a priori* positive relationship hypothesised in the earlier section.

The general interpretation of the results from Model A may be stated as follows:

- the higher the number of competitors (variable a) or, the occurrence of RM (variable c), the greater is the probability of NHS Trusts providing extra services over and above the basic service requirement (i.e. in respect of augmenting contracts).
- more precisely, an increase in the number of competitors from the existing average of four, by one to five, would increase the probability of contract augmentation by over 2 %
- an increase in the incidence of RM from 89 % to all cases, would have raised the probability of contract augmentation by nearly 14%.

This analysis of marginal effects is based on calculations derived from the coefficients presented in Table 5.28 above.

Table 5.29: LOGIT Estimate Results for Contract Customisation

Variables	Coefficients	t-values
Preferred-providers	0.6442	2.00
Competitive Culture	0.5372	2.49
Constant	-2.4719	2.64
Percentage of Correct Predictions	60%	
McFadden Pseudo R ²	0.04	
Chi-squared at 2 degrees of freedom	9.6887	

The results from the model in Table 5.29 were found to be significant at better than 99.21% level, with the model accurately predicting the likelihood of contract customisation by NHS Trusts in 60% of cases. Here, the independent variables for Preferred-providers, and Competitive Culture (i.e. variables f and e respectively), are both significantly positive. This again confirms the *a priori* expectations stated above. We may interpret the results for Model B as follows in terms of the analysis of marginal effects:

- the greater the prevalence of preferred-providers (variable f), or of competitive culture (variable e), the higher is the likelihood of the NHS Trust hospitals customising or “fine tuning” contracts for specific purchasers
- more precisely, an increase in the preferred-provider variable from the prevailing incidence of 61% to all cases, would increase the probability of contract customisation by 16%
- the strengthening of local competitive culture by 20% would have raised the probability of contract customisation by 13%

5.2.3.5. Models C, D, and E: *A priori* reasoning

Again, a number of factors were considered to be likely to affect the remaining models, i.e. loyalty discounting (Model C), cost-sharing (Model D), and default contracting

(Model E). Subsequent statistical testing, however, indicated that for models C through E, various independent variables believed *a priori* to be important determinants of the relationship marketing behaviour under investigation were found to have very limited statistical significance. Consequently, for models C through E the *a priori* reasoning is only explained below in respect of a constrained number of determinants. The latter are now considered in turn for each remaining Logit model.

Model C: Loyalty Discounting

The literature records the importance of volume discounting of contracts by providing NHS Trusts (Propper, 1992; 1995) and the current research evidence suggested this was a common practice, with 56% of responding NHS Trusts offering volume discounts. However, the evidence also identifies that 18% of responding NHS Trusts offered loyalty discounts for repeat business from purchasers. A number of factors relating to the work of Kotler (1994) were perceived to be important in determining the likelihood of loyalty discounting. These were:

First- Mover Advantage

It was perceived that a negative relation would exist between the date at which NHS Trust status was granted by the Department of Health and the likelihood that hospitals would offer purchasers a loyalty discounted contract. Those hospitals with a stronger “competitive” ethos were likely to be granted status in the first and second wave of NHS Trusts and use their new status to build loyalty with purchases and thereby reduce the contestability of the local health market. It is argued that the Case Study evidence presented in Chapter 6 supports this view.

Numbers of Competitors

The numbers of competitors are likely to be positively related with loyalty discounting behaviour (Doyle et al, 1996). As the number of local competitors increases, the threat of income being lost to competing providers increases, *ceteris paribus*. Conversely, as local health markets become more imperfectly competitive in respect of numbers of potential providers, the probability of loyalty discounting arising will fall.

Service Augmentation

A priori, it was perceived that loyalty discounting would be directly related with service augmentation behaviour. Service augmentation involves providers offering elements to contracts with purchasers over and above that of a basic service agreement. This represents an investment cost for the provider, with a higher opportunity cost than basic service agreements should the purchaser decide to switch to another local provider. Moreover, depending on the nature of the service augmentation, there may be an element of sunk cost attached to the contract, and therefore the increased possibility of Williamson's (1985) 'hold up' problem.

Model D: Cost-Sharing

The surveyed NHS Trusts were asked to identify whether they had explicit cost sharing agreements with their purchasers. This would involve NHS Trusts charging for activity (i.e. health interventions) at different marginal rates depending upon whether contracts were under-, or over-performing against volume targets. *A priori*, the following were considered to be important determinants:

First-Mover Advantage

In this case, it was perceived that NHS Trusts were more likely to design cost sharing contracts the earlier they achieved Trust status. First-mover advantage would enable early wave Trusts to enjoy independence of action and better enforce cost sharing on purchasers. Implicitly, first-movers will have a stronger competitive culture, and will use their financial autonomy to pro-actively develop closer relationships with purchasers. Closer ties and stronger loyalty developed through relationship marketing strategies enables NHS Trusts to behave opportunistically, and therefore encourages cost-sharing.

Numbers of Competitors

A priori, it was expected that cost sharing and the numbers of competing local health providers would be inversely related. In the monopoly case, where there is “take it or leave it” provision, the monopoly provider can impose cost sharing upon purchasers as a means of reducing risk should contracts under-perform against volume targets. However, as the market share falls for a typical NHS trust with others joining the local health market, the ability to force cost - sharing on purchasers will diminish.

Outcome Measurement

The survey questionnaire identified the extent to which providing NHS Trusts designed contracts which defined health outcomes as a measure of their performance. In total, 9% of responding NHS Trusts answered in the affirmative. It was perceived that where NHS Trusts did define health outcomes (i.e. treatment quality) as well as health outputs (i.e. activity rates) then there was a higher risk attached to such contracts. This should be considered in the context of the significant problems associated with measuring the health consequences of clinical interventions, which is well documented in the literature (Drummond & Maynard, 1993; Gray, Harrison, & Barlow, 1998). Subsequently it is argued that a positive relationship would exist between cost sharing and the inclusion of health outcome measures within the health contract.

Contract Default Clauses

The inclusion of a default clause in health contracts represents a further form of contingency planning, and a means of reducing risk associated with contracting. In essence, providers and purchasers would agree at the initial negotiation stage a pre-specified set of actions to be implemented should contracts fail to meet agreed targets. The default clause would become relevant if, for instance, activity rates were not met, enabling resource associated with the original contract to be re-allocated in a different form. The latter may then enable the purchaser and provider to fulfil targets on a related contract. Alternatively, the default clause may have required a specific clinical response, if, for example, a random inspection of provider services found them to be sub-standard (as evidenced for instance by the Dudley DHA case presented in Chapter 6). *A priori*, it

was perceived that cost sharing and default contracting behaviour would be positively related given they both reflect the desire to reduce risk in the contracting process.

Service Augmentation

In this instance it was believed that the greater the emphasis given by providers to the importance of augmenting secondary care contracts, the more providers would desire cost sharing agreements. Again, this reflects the importance of risk avoidance where NHS Trusts have invested resource in contracts beyond that of the basic service agreement. The opportunity costs associated with failing contracts is clearly higher where such service augmentation exists, and cost sharing provides some degree of safe guarding of NHS Trusts income.

Trust Type

The coding of the survey data enabled NHS Trusts to be categorised as Acute, Community, Mental Health etc. It is argued potential economies of scale, scope and repetition will tend to be greatest for Acute type NHS Trusts. Typically, these units are the principal providers of acute and elective secondary care within local health markets in the NHS in England. Such competitive advantage will enable a provider to negotiate cost-sharing contracts with purchasers more pro-actively than smaller, more specialised NHS Trusts locally. Thus it was anticipated a positive relationship would exist between cost sharing and Acute Trust hospital status. Subsequently, a dummy independent variable was set up indicating whether NHS Trusts were or were not of the Acute type.

Model E: Default Contracting

This behaviour was explained above in section 5.2.1.4. *A priori*, the principal determining variables were perceived to be as follows:

Service Capacity

It was expected that a positive relationship would emerge between awareness of spare capacity in the local health market (as perceived by NHS Trusts), and the use of default

contracts. Where such awareness is high, this reflects a high perceived level of competitive threat, *ceteris paribus*. In such circumstances competitive conditions would imply an increased degree of risk for a provider's income. Should contracts not perform well, default clauses would identify how the situation could be rectified without need for termination of the contract.

Joint Venture Activity with other NHS Trusts and the Cost-Sharing Contract²

Through the national survey, responding providers identified whether they had engaged in joint health service delivery with other local NHS Trusts. It may be argued that a positive relationship would exist between the likelihood that NHS Trusts would employ default contracting and engage in joint venture activities. Both variables are used as measures for reducing risk of losing Trust income.

A similar argument holds for cost-sharing contracts. NHS Trusts employing one measure to avoid risk, i.e. default clauses, are likely to employ others *ceteris paribus*. In essence, it is argued that NHS Trusts would employ a portfolio of risk avoidance elements within their contracts.

Service Augmentation

A priori, it was believed that default clauses were more likely when NHS Trusts placed emphasis upon augmenting basic service agreements with purchasers. Where health care services were "topped up", there was clearly a higher opportunity cost involved, if, for instance, the contract was terminated because of concerns over quality. Inclusion of default clauses reduced the risk of termination, and moreover, reduced transactions costs associated with contracting. In particular, it was likely to reduce the significance of "hold-up" costs identified by Williamson (1985).

5.2.3.6 Empirical Analysis and Results: models C, D and E

Model C

² Again, it should be noted that for all Logit models A through E, multicollinearity was investigated through consideration of zero order correlation matrices

Table 5.30: Logit Estimate Results for Loyalty Discounted Contracts

Variables	Coefficients	t-values
First-Movers	-0.31	- 1.68
Numbers of Competitors	0.094	1.81
Service Augmentation	1.21	1.88
Constant *	617.07	1.68
Chi-square at 3 degrees of freedom	11.2	
Percentage of correct predictions	82.66	
McFadden Pseudo R ²	0.07	

(* It should be noted that the high value for the constant term was partly the result of having a minimum value of 1991.0 and a maximum value of 1996.0 for the “first mover” independent variable. These dates measured when NHS Trust status had been awarded).

For the model in Table 5.30, results were found to be significant at better than the 98.95% level, with the model accurately predicting whether NHS Trusts would offer loyalty discounts 83% of the time. In this case, all of the independent variables and the constant term turned out to be significant at more than the 90% level. Of interest, the sign on the coefficient for the First-Mover variable was found to be negative as expected.

The following analysis of marginal effects is based on calculations derived from the coefficients presented in Table 5.30 above. Subsequently, the following observations can be made:

- the greater the number of competitors, or the occurrence of service augmentation, the greater is the probability of NHS Trusts offering loyalty discounted contracts
- more specifically, an increase in the number of competitors from the average of four by one to five, would increase the probability of loyalty discounting by 1%. Meanwhile, an increase in the incidence of service augmentation from 75% to all cases would have raised the probability of loyalty discounting by 16%

- for the First-Mover variable, had the Trust moved a year after the typical date of NHS Trust status designation (i.e. November 1992), it would have reduced the probability of loyalty discounting by 4%.

Model D:

Table 5.31: Logit Estimate Results for Cost-Sharing Contracts

Variables	Coefficients	t-values
First-Movers	- 0.30	- 1.96
Nos of Competitors	- 0.061	- 1.20
Outcome Measurement	1.82	2.55
Default Clauses	1.24	3.50
Emphasis on Service Augmentation	0.37	1.70
Trust Type	0.55	1.60
Constant **	599.12	1.96
Chi-square at 6 degrees of freedom	34.62	
Percentage of Correct Predictions	68.39	
McFadden Pseudo R ²	0.14	

(** A similar comment applies regarding the relatively high value of the constant term as for Model C).

The results from model D were found to be significant at better than 99.99% level with the model accurately predicting whether NHS Trusts used cost sharing contracts in almost 70% of cases. Whilst the McFadden Pseudo R² is relatively low (0.14), this compares favourably with similar published values from other Logit research (Bailey & Mallier, 1997; Blanchflower & Oswald, 1999). All of the independent variables apart from Numbers of Competitors, and Trust Type were found to be significant at better than 90%. Moreover, all of the signs on the independent variables were as expected on the basis of the hypothesis developed earlier in this chapter. For Numbers of Competitors the sign was as expected, but significant only at 77%, whereas for Trust Type, it was only significant at the 89% level.

The marginal effects for model D are subsequently presented as follows:

- for the First-Mover variable, had the Trust been awarded status one year after the typical date (again, of November 1992), the probability of cost-sharing would have been reduced by 8%
- for inclusion of health outcome measures in contracts, should the numbers of NHS Trusts incorporating such elements increase to all cases from the average of 9%, the probability of cost-sharing would increase by 45%
- for inclusion of default clauses in contracts, should the number of NHS Trusts incorporating such clauses increase to all cases from the average of 58%, the probability of cost-sharing would rise by 31%
- finally, for the importance placed on service augmentation, an increase in the average reported response from “Important” to “Very Important”, would increase the probability of cost-sharing by 9%.

Model E:

Table 5.32: Logit Estimate Results for Default Contracting

Variables	Coefficients	t-values
Surplus Capacity	0.71	3.20
Joint Service Ventures with local Trusts	0.72	1.60
Cost-sharing Contracts	0.97	2.83
Emphasis on Service Augmentation	0.36	1.61
Constant	- 4.80	- 3.63
Chi-square at 4 degrees of freedom	30.46	
Percentage of correct predictions	70.0	
McFadden psuedo R ²	0.13	

The results for model E reported above were significant at better than 99.99%, with the model accurately predicting the likelihood of default contracting by NHS Trusts in 70% of all cases. Meanwhile, the McFadden Pseudo R² was 0.13. All of the signs on the coefficients for the independent variables support the *a priori* expectations. For Surplus

Capacity, Cost-sharing Contracts, and the constant term itself, the significance level was above 99% in each case. Meanwhile for Joint Service Ventures with local Trusts and Emphasis on Service Augmentation, the relevant figures was nearly 90%.

The marginal effects for model E based on calculations derived from the coefficients in Table 5.32 above are given as follows:

- an increase in awareness of surplus capacity in the local health market by 20% will increase the likelihood of default contracting by 17%
- for an increase in the numbers of NHS Trusts engaged in joint ventures in service delivery from the average of 84% to all cases, this increases the likelihood of default contracting by 17%
- for an increase in the numbers of Trusts using cost-sharing contracts from the average of nearly half the cases to all cases, this increases the likelihood of default contracting by 23%
- should the response to the importance of service augmentation in relationship building increase from the existing average of “Important” to “Very Important”, the likelihood of default contracting rises by nearly 9%.

5.2.3.7. Sectoral Analysis

In addition to the analysis of the Logit regressions presented above, the results were used to carry out a Sectoral analysis (Pogue and Soldofsky, 1969; Gujarati, 1978). As explained in the Research Methodology chapter, for each of the models A through E the consequences of one of three different scenarios were considered: these were described as a “best case”, a “worst case” and an “average” case. To reiterate, in the case of the first scenario, values were selected for the magnitude of the independent variables which would maximise the chances of a given outcome occurring, e.g. loyalty discounting. A similar logic was employed with respect to the worst case.

This section identifies in more detail the logic behind the choice of parameters defining Best, and Worst case scenarios. This is not required for the Average or typical case because the sectoral results were achieved by using statistical mean values calculated by the Limdep 7.0 software (Greene, 1997).

In order to be systematic, the results are presented model by model, A through E. In all cases, the selection of magnitudes of independent variables or their dichotomous values reflects the *a priori* reasoning explained earlier in the development of the respective Logit models. However, in some instances, further explanation is provided where the selection of magnitudes of independent variables may on first sight appear arbitrary, or the selection of values requires more clarity.

Table 5.33: Model A: Contract Augmentation Strategies: Parameter Selection for Best and Worst Case Scenarios

Scenario	Independent variable	Magnitude/Response (0,1)* or Likert score (1-5)**
“Best Case”:	Numbers of competitors	10 NHS Trusts
	Long-term relational strategy	Yes
	Preferred providers	Yes
	Competitive culture	5
“Worst Case”	Numbers of competitors	0 NHS Trusts
	Long-term relational strategy	No
	Preferred providers	No
	Competitive culture	1

* (within the statistical analysis, 1 = yes; 0 = no)

** (where 5 is Strongly Agree, 1 is Strongly Disagree)

For the Best Case and Worst Case scenarios, the spectrum of competition ran from monopoly to a highly competitive environment defined in respect of 10 competing NHS

Trusts. To some extent, this latter parameter could be argued to be arbitrary: however, as Neoclassical economic theory explains, there is no specific number defining “perfect competition”. Rather the number is sufficient that none of the firms perceive they have power to influence prices in the market. Here, a parallel argument is used: it is perceived that 10 NHS Trusts is a sufficiently large number for each providing unit to realise that they are not market leaders. Subsequently, NHS Trusts in this situation would be more likely to use contract augmentation to overcome potential competition than, for instance, a local health market where numbers of competitors is relatively low, e.g. 4, and significantly greater than where numbers of competitors are significantly lower, e.g. within a duopoly case.

Table 5.34: Model B: Customisation of Contracts: Parameter Selection for Best and Worst Case Scenarios

	Independent variable	Magnitude/ response (0,1), or Likert Score (1-5)
“Best Case”	Preferred providers	Yes
	Competitive culture	5
“Worst Case”	Preferred providers	No
	Competitive culture	1

In respect of competitive culture, respondents had been asked to identify the extent to which they had treated purchasers as “customers” following 1991. On the Likert scaling, a response of 5 indicated they “Strongly agreed”, whilst a score of 1 indicated they “Strongly disagreed”.

Table 5.35: Model C: Loyalty Discounting: Parameter Selection for Best and Worst Case Scenarios

	Independent variable	Magnitude/ response (0,1), or Likert Score (1-5)
“Best Case”	1 st Mover (Trust date)	1991.0
	Numbers of competitors	10 NHS Trusts
	Contract augmentation	Yes
“Worst Case”	1 st Mover (Trust date)	1996.0
	Numbers of competitors	0 NHS Trusts
	Contract augmentation	No

Here, a similar logic holds regarding the spectrum of “competition” as for Model A explained above. A figure of zero NHS Trusts identifies monopoly in the local health market, and 10 NHS Trusts indicates a highly competitive health market environment.

Table 5.36: Model D: Cost-sharing Contracts: Parameter Selection for Best and Worst Case Scenarios

	Independent variable	Magnitude/ response (0,1), or Likert score (1-5)
“Best Case”	1 st Mover (Trust date)	1991.0
	Numbers of competitors	0 NHS Trusts
	Outcome measures	Yes
	Default contracting	Yes
	Emphasis on contract augmentation	5
	Hospital type (Acute or “other”)	(Acute, yes)
“Worst Case”	1 st Mover (Trust date)	1996.0
	Numbers of competitors	10 NHS Trusts
	Outcome measures	No
	Default contracting	No
	Emphasis on contract augmentation	1
	Hospital type (Acute or “other”)	(Acute, no)

Responding NHS Trusts had identified the extent to which augmentation of service contracts had been important in strengthening relationships with purchasers. A Likert score of 5 indicated it had been Very Important, compared to a Likert score of 1 indicating it was Insignificant. In addition, the data for hospital type had been reclassified, breaking down the original categories into just two types of NHS Trust, i.e. Acute NHS Trust or other type of NHS Trust. The justification was provided in the *a priori* section for Model D earlier in this chapter.

Table 5.37: Model E: Default Contracting: Parameter Selection for Best and Worst Case Scenarios

	Independent variable	Magnitude/ response (0,1), or Likert score (1-5)
“Best Case”	Awareness of competitive capacity	5
	Joint venture activity	Yes
	Cost-sharing contracts	Yes
	Emphasis on contract augmentation	5
“Worst Case”	Awareness of competitive capacity	1
	Joint venture activity	No
	Cost-sharing contracts	No
	Emphasis on contract augmentation	1

Emphasis on contract augmentation was measured on the Likert scale as for Model D above. In respect of the competitors capacity measure, NHS Trusts had been asked to identify whether they were aware of capacity of local competing providers. This was taken as a surrogate measure of the potential competitive threat posed to given NHS Trusts, and justified earlier. A Likert score of 5 corresponded to Strongly agree, whereas a Likert score of 1 corresponded to Strongly disagree.

5.2.3.8. Sectoral Calculations and Summary Findings

Using the data from the tables above, and the relevant coefficients from the regression equations for each Logit model, it was possible to estimate the likelihood of each of the

three scenarios occurring. For illustrative purposes, the sectoral analysis of Model B (contract customisation) is explained in detail in the following text box. To simplify the illustration, only the “Best” case scenario is considered:

Sectoral Calculations: Model B (contract customisation): An Illustrative Example

Best Case = constant + (1* X1 [preferred-provider])+(5*X2[competitive culture])

$$= - 2.4719 + (1*0.6442) + (5*0.5372)$$

$$= 0.8583 \quad \text{anti - log} = 2.3591$$

Probability¹ Pi (Y) (contract customisation) = 2.3591/3.3591 * 100 = 70.2%

¹ Note: the calculation of probability of event Pi (Y) was explained in respect of first principles in Chapter 4.

A similar set of calculations was carried out for each Logit model, and each scenario, the findings being summarised in the following table:

Table 5.38: Sectoral Calculations: Summary Results for Models A through E

Model/ Scenario	“Best Case”	“Worst Case”	“Average Case”
Contract Augmentation	90.4%	32.8%	76.1%
Contract Customisation	70.2%	12.9%	52.4%
Loyalty Discounting	50.3%	2.4%	19.4%
Cost-sharing Contracts	96.5%	2.4%	38.7%
Default Clauses	90.3%	2.34%	59.1%

Of particular interest are the following:

- firstly, supposition regarding the relative values for the three scenarios for the independent variables generated the expected probabilities
- this confirms the preponderance of NHS Trusts risk avoidance strategies measured by loyalty discounting, cost-sharing, and default clauses, because of the relative magnitude of the probabilities for the best and worst case scenarios

- the results also confirm the preference for relationship building through contract augmentation, and to a lesser extent through contract customisation, given the relative probabilities for the worst and best cases.

5.3.0 Research Findings from the National Postal Surveys: An Executive Summary

NHS Trust Survey: Overview

- 5.3.1** The national surveys of NHS Trusts and District Health Authorities in England achieved strong response rates. For the former the response rate was 47%, and for the latter it was 46%. These figures compare favourably with other academic studies and internal NHS audit research.
- 5.3.2** The NHS Trust sample was representative of the whole English Trust population in respect of Trust type and date of Trust inauguration. Some 12% of NHS Trusts were monopolists in their local health market, with a further 70% in markets approximating to oligopolistic markets, i.e. with between three and nine competing NHS Trusts. Only 9% of NHS Trusts faced ten or more competing providers of secondary care.
- 5.3.3** The NHS Trust contract managers surveyed reported considerable awareness of the purchaser – provider split, and also demonstrated a high degree of awareness of competitor’s capacity (around 2/3 of respondents). Moreover, capital resource was perceived an “Important” or “Very important” impediment to market entry in new services by 66% of responding NHS Trusts. The latter suggests limited contestability in innovative and inventive patient services.
- 5.3.4** NHS Trusts perceived greater responsiveness to purchaser needs as the most important benefit of the NHS Internal Market, which is important in light of the evidence on the significance of relationship marketing strategies deployed by NHS Trusts. Of interest, issues relating to equity were deemed of limited importance: NHS Trusts ranked “Power of service users” as the 2nd least important of six categories, and of equal note in respect of Department of Health policy objectives, improving competition in health care was ranked least important overall. Moreover in terms of quality of contracts, only 9% of

responding NHS Trusts explicitly included health outcome measures in their negotiations with DHAs.

5.3.5 NHS Trust Survey: Key Findings

There is considerable evidence that NHS Trusts deployed relationship marketing strategies. Some 75% of responding NHS Trusts augmented basic service agreements, countering comparable studies findings (Paton, 1998) that such behaviour was unimportant in the NHS Internal Market. In addition, 1/3 of Trusts augmenting contracts stated it was Very important in building stronger relations with DHAs. A smaller number, 53% of NHS Trusts customised contracts, with 53% of these stating such behaviour was Very important or Important in building closer bonds with purchasers.

5.3.6 The survey identified a vast array of types of contract augmentation and customisation affecting patient services, ranging from core clinical services to patient support. This highlights the issue of patient equity: access to these innovated services depends upon the distribution of relational marketing strategies between different DHAs, and the evidence from the case studies reported in the following chapter will identify that this distribution was uneven. Thus patients health outcomes were dependent upon local health market conditions in respect of the emphasis given to contract augmentation and customisation. Moreover, this is clearly at odds with one of the prime objectives of the quasi-market reform in health outlined in Chapter 1, i.e. achieving greater access and choice of services for all.

5.3.7 NHS Trusts were pro-active in driving the relationship between purchaser and providers. This challenges Paton's (1998) evidence that, for example, in the case of Acute NHS Trusts, only 36% of them led the relationship building process, with the equivalent figure for Community Trusts being 52%.

5.3.8 NHS Trusts often used contract negotiations to reduce risk regarding potentially lost Trust income should contracts not meet specifications. Some 58% included default clauses within contracts; 39% had explicit termination clauses, and a further 49% operated cost-sharing contracts. Whilst these add to Williamson's (1985) unavoidable ex ante transaction costs, the primary benefit is lower ex post transaction costs.

- 5.3.9** Non-price aspects of contracting were deemed as important as pricing aspects in developing relationships with DHAs. Some 70% of respondents claimed non-price elements were Very important or Important in this respect, providing further implicit evidence of the significance of relationship marketing methods, e.g. contract augmentation and customisation.
- 5.3.10** In part, the evidence identifies the incentive for deploying relational marketing strategies as a response to the differential treatment of NHS Trusts by local DHAs. Supporting Propper's (1992; 1995) evidence, 61% of NHS Trusts stated their DHAs had preferred-providers. Moreover, these "sweet-heart" relationships were seen to relate to governance procedures. Of respondents, 31% stated DHAs treated them differently in terms of the monitoring and auditing of contracts; 20% stated differential requirements were made of them in terms of outcome assessment, and a further 25% regarding the need for inclusion of default clauses.
- 5.3.11** However, contracts managers in NHS Trusts did not typically believe bespoke governance structures affected their ability to innovate patient services, with 52% Disagreeing or Strongly disagreeing that governance impeded such behaviour. In contrast, 47% stated such governance did affect their perception of control over the direction of the contracting process. It was argued, supporting Frey's (1997; 1998) perspective, that such governance was likely therefore to have resulted in crowding out of contract managers intrinsic motivation.
- 5.3.12** Central to the interpretation of RM is the extent to which local health markets were competitive. It was argued that where markets were co-operative, such strategies were least likely, and subsequently, consideration was given to the extent of joint venture activities between NHS Trusts. According to responding NHS Trusts, 84% were jointly developing existing patient services with other NHS Trusts, 79% with GP fundholders and 46% with the private sector. This presents paradoxical evidence compared to that highlighted above regarding the extent to which contracts were augmented and customised in order to reduce the effects of potential competition.

- 5.3.13** Such joint venture activity was found to be important in terms of innovations to patient services, with 63% of responding NHS Trusts stating they engaged in such relational exchanges with other local NHS Trusts. This strengthens the evidence regarding limited contestability of markets in service innovations arising from capital resource constraints faced by providing Trusts highlighted in section 5.2.1.2.
- 5.3.14** Where it occurred, the deployment of relationship marketing strategies depended upon small numbers of negotiators, and moreover was based upon “personal” as well as “formal” relationship building. In respect of the former, this is at odds with the theory of relationship marketing, which perceives successful relationship building to depend on inclusion of all members of an organisation. Clearly, however, the historical predominance of traditional bureaucratic management models within the NHS will limit attempts to make RM strategies inclusive of all relevant personnel.
- 5.3.15** In respect of emphasis upon “personal” relationship building, some 64% of responding NHS Trusts stated these were vital to the relationship building process. Moreover, this evidence was further supported by the DHA survey’s findings: 83% of responding DHAs stated their providing NHS Trusts deployed relationship marketing strategies based on personal rather than simply formal contacting procedures.
- 5.3.16** Clinical staff were considered to be central to the actual negotiations stage of contracting. Of all NHS Trusts in the survey, 18% stated they were Very important, with a further 56% stating they were at least Important at that stage. This provides indirect evidence questioning the success of national health policy in achieving its objective of shifting resource allocation decisions away from clinicians towards professional managers.
- 5.3.17** The research considered the efforts NHS trusts made in building long term relationships with purchasing DHAs. In total, 89% stated they tried to extend this relationship beyond the annual statutory NHS contracting round. Furthermore, of these, 34% stated such behaviour was Very important in strengthening relationships with purchasing DHAs and a further 43% identified it was at least Important on the Likert scale.
- 5.3.18** To support this approach, 91% of NHS Trusts sought feedback regarding purchaser’s satisfaction with their services through satisfaction surveys. This was in addition to

feedback arising from the governance procedures for contracts. Some 24% stated this was Very important in strengthening purchaser-provider relations, with 61% stating it was at least Important on the Likert scale.

5.3.19 DHA Survey: Key Comparative Findings

DHAs had a much lower perception of the importance of contract augmentation and customisation. Only 17% of DHAs stated they Frequently benefited from service augmented contracts. Supporting this pattern, only 13% of DHAs recorded on the Likert scale that they Frequently or Always received customised service contracts from NHS Trusts.

5.3.20 Conflicting perceptions between DHAs and NHS Trusts also emerged regarding imposition by the former of differential governance structures on the latter. In total, 87% of responding DHAs claimed governance structures were standardised across all types of providing unit, compared to conflicting evidence that 31% of NHS Trusts perceived they were discriminated against in this respect. These differences may be explained by bias in the DHA national survey sample, or alternatively by bounded rationality of DHA commissioning managers. In the context of recent research in quasi – markets (Finlay, 1996), it has been demonstrated that managers may be subject to particular types of relational behaviour, but have a limited recorded awareness of this.

5.3.21 DHAs placed greater emphasis upon the evaluation of health outcomes than NHS Trusts. Some 36% of the former sample group stated inclusion of such performance measures were Very Important or Important in designing contracts. It should be remembered that of responding NHS Trusts, only 9% explicitly included measures of health outcomes in their contracting.

5.3.22 DHAs and NHS Trusts had similar perceptions regarding the importance of loyalty discounting to the contracting process in developing closer purchaser-provider relations. Only 17% of responding DHAs were offered loyalty discounts. However, there was greater exposure to default contracting among responding DHAs: indeed, broadly similar figures were recorded by DHAs and NHS Trusts, i.e. 41% for the former and 49% for the latter.

- 5.3.23** DHAs attached less importance to price competition in the selection of contracting partners than NHS Trusts. Only 13% of DHAs stated they Strongly agreed or Agreed that such pricing was important in partner selection. Meanwhile, DHAs placed greater importance on non-price competition in selecting contractual partners, with a mean Likert score of 3.90 for non-price competition compared to 2.76 for price competition. Furthermore, 81% of responding DHAs stated non-price competition was Very important or at least Important in partner selection. In essence, this indicates implicitly that DHAs would be receptive to NHS Trusts relationship building strategies, and again provides implicit evidence of the high likelihood of such behaviour occurring.
- 5.3.24** Survey evidence indicates that in situations where market exit was feasible, awareness of the associated production and transaction costs involved was central to determining whether DHAs did switch between providing NHS Trusts. Some 81% of responding DHAs stated such awareness was Very important or Important in driving contract switching behaviour, with a mean Likert score of 4.04. This indicates the likelihood of market exit was very low.
- 5.3.25** Of particular note, evidence suggests DHAs were involved heavily in joint information gathering, collation and sharing. Moreover, this process was extended beyond the direct, contractual partner to include other interested parties, including competing NHS Trusts. Examples included capacity figures (e.g. bed spaces), and information on governance procedures relating to different competing providers. This is at odds with the NHS Internal Market objective of encouraging a competitive relationship between local DHAs and potential providing NHS Trusts based on adversarial, Classical type contracting.
- 5.3.26** Conflicting evidence emerged relating to the role of feedback on purchaser satisfaction with NHS Trust services. Some 54% of DHAs stated such feedback was Infrequently or Never sought, compared to 85% of responding NHS Trusts carrying out such analysis who perceived it was Very important or at least Important in strengthening purchaser – provider relations. Again, this may reflect DHA commissioning manager’s bounded rationality.

5.3.27 NHS Trusts: Logit Analysis

In terms of the empirical analysis of the NHS Trust survey, five hypotheses were tested based upon the development of five Logit models.

5.3.28 Model A's (contract augmentation) overall performance proved disappointing, only being significant at the 94.63% level, although the figure for the percentage of correct predictions was 75%. In terms of the independent variables, only numbers of competitors was significant at better than the 94.35% level. Of note, accepting the limited robustness of Model A, the marginal effects imply that an increase in the numbers of competitors from the average of four, by one to five, would raise the probability of contract augmentation by just over 2%. This confirms the limited impact the number of competitors within a local health market had on the likelihood of relationship marketing strategies being deployed.

5.3.29 For Model B (contract customisation), the overall result was more robust, with the model significant at better than the 99.21% level. However, again, a number of variables expected *a priori* to be significant proved not to be so. These were first-mover advantage; long-term relational strategies; awareness of local competitive capacity, and numbers of competitors.

5.3.30 Despite this, the variables for preferred – providers and competitive culture were found to be significant. Furthermore, from the analysis of marginal effects it appears that the strengthening of competitive culture in local health markets by 20% would increase the likelihood of contract customisation by 13%. Meanwhile, if the existence of preferred – provider scenarios increased from the existing 61% to all cases, the likelihood of contract customisation would increase by 16%.

5.3.31 The overall results for Model C (loyalty discounting) were less robust than the previous model. The model was significant at the 98.95% level, but with the figure for correct predictions being higher than that of Model B at approximately 82%. Again, the signs on the coefficients for the independent variables were correctly predicted, including, of particular note the negative sign on the first – mover variable.

- 5.3.32** Meanwhile, Model D (cost-sharing contracts) was found to be significant at better than the 99.99% level, with interesting results for particular independent variables. Apart from the variables for numbers of competitors and NHS Trust type, all remaining independent variables were significant at better than the 90% level. Of particular note, the estimated t-values were -1.96 for first-movers; +2.55 for Outcomes measurement, and + 3.50 for default contracting.
- 5.3.33** In terms of the marginal effects for Model D, an important result was found in light of Government's current emphasis on quality assessment. An increase in the numbers of NHS Trusts incorporating outcome measures in contracts from the current 9% to all cases would increase the probability of cost-sharing by 45%. Also of interest from the perspective of risk avoidance strategies and relationship building, should the incidence of NHS Trusts including default measures increase from the average of 58% to all cases, the probability of cost-sharing would increase by 31%.
- 5.3.34** The overall result for Model E (default contracting) was significant at better than the 99.99% level, with the percentage of correct predictions figure at 70%. In respect of the independent variables for awareness of competing capacity, cost-sharing contracts, and the constant term, the significance level was above 99%. The remaining independent variables, i.e. joint-ventures with other NHS Trusts and emphasis on service augmentation, performed less well, but were close to 90% significance.
- 5.3.35** From the analysis of marginal effects for Model E, it is predicted that an increase in awareness of potential competitive capacity by 20% will increase the likelihood of default contracting by 17%. Meanwhile, an increase in the tendency for NHS trusts to cost-share from the prevailing average of around one half of cases to all cases, will increase the probability of default contracting by 23%.
- 5.3.36** Developing *a priori* reasoning, a sectoral analysis was conducted for each of the models A through E. In the "best case" scenario the probability of service augmentation based on Logit model A was 90.4% compared to 32.8% for the "worst case". For model B (contract customisation) the respective figures were 70.2% and 12.9%

5.3.37 The spread between calculated probabilities for the best case and worst case scenario was considerably wider for Model D (cost-sharing contracts) and Model E (default contracts). The relevant figures were 96.5% (best case) and 2.4% (worst case) for cost-sharing contracts, compared to 90.3% (best case) and 2.34% (worst case) for default contracting.

5.3.38 Some caution must be expressed in evaluating NHS Trusts relationship marketing strategies as a means of avoiding risk. Following Paton (1998), it should be stressed that it is difficult to identify ‘risk to whom?’ Failure to develop relationship marketing strategies increases the likelihood of NHS Trusts losing income, whereas from the DHA perspective they may, e.g. lose capacity to meet local needs. Moreover, a related and yet more complex problem is the extent to which any risk is asymmetrically distributed between purchasers and providers.

Having provided an executive summary of the central comparative findings arising from the national NHS Trust and District Health Authority surveys, the following chapter evaluates the evidence drawn from the supporting Case Study analysis.

CHAPTER 6

Case Study Analysis

6.1 Introduction

This chapter presents and evaluates the findings from the two case studies, i.e. Warwick and Dudley local health markets. Its principal aim is to consider three of the four key items on the semi – structured interview agenda. They were as follows:

- (i) The importance given to relational marketing strategies, in particular contract augmentation and customisation strategies. This provided the opportunity to contrast case findings with those from the national postal survey findings, and for NHS Trusts only, the outcomes from the Logit models developed in Chapter 5. It should be noted that consideration of the extent of contract augmentation and customisation within the Case Studies provides indirect evidence on the extent of Sako's (1991; 1992) "goodwill trust".
- (ii) The downside, or negative consequences of NHS Trusts relationship marketing (RM) strategies. This extends the analysis beyond the *a priori* identification of the likely costs of relational strategies identified in Chapter 2, and those identified following consideration of the empirical findings in Chapter 5.
- (iii) The nature and role of "trust" in the contracting process. This was based upon Sako's (1991; 1992) framework, i.e. consideration of contractual, competence and goodwill trust. For operational effectiveness during face to face interviews, trust was defined, following Morgan and Hunt (1994) as "confidence in an exchange partners reliability and integrity". In all cases, there was the possibility to compare and contrast the NHS Trust and DHA perspective, and compare perspectives across case studies, e.g. Case 1 DHA versus Case 2 DHA perspective.

It should be noted that the fourth agenda item covered by the face to face interviews was the likelihood of relationship marketing continuing to be an integral element of contractual relationships within the "new" co-operative NHS environment associated with

the 1997 White Paper reforms. The relevant findings from the Case Studies are used to draw tentative conclusions in the final chapter.

Additionally, this chapter will present the findings from the postal survey of all GP fundholders located in the Warwick and Dudley DHAs. This survey sought to identify whether there was a different perception of the importance of relational marketing strategies between the interviewed NHS Trusts, the District Health Authority, and local GP fundholders. Moreover, comparisons could be drawn between each sub – sample of GP fundholders. The postal survey of GP fundholders was designed around Stone and Woodcock's, (1995) cornerstones of relationship marketing strategies. It is intended here, however, only to report those aspects pertinent to an evaluation of how much, and which types of relational marketing behaviour respondents experienced.

6.2 Case 1: Background

The selection of the case studies was justified in Chapter 4. However, it is important to provide a brief background to each case.

Case 1 involved interviewing the Commissioning Manager from Warwickshire District Health Authority (DHA) and contracts managers from two competing acute NHS Trusts within the area, i.e. South Warwickshire General Hospital NHS Trust and Walsgrave Hospitals NHS Trust.

Warwickshire DHA covers a population of 494 000, with a budget of £251m in 1998/99. Within the district, there are 82 GP practices, of which 12 are single handed practices, and 57 are GP fundholders. There are four principal NHS Trusts contracting with the Warwickshire DHA in the provision of secondary care. South Warwickshire General Hospitals NHS Trust, Walsgrave NHS Hospitals Trust, George Elliot NHS Trust, and Rugby NHS Trust.

Of these, the first two were interviewed because of the differences between them in respect of scale and scope of patient services, and Trust income. Walsgrave NHS Hospital Trust had an income of £120m for 1998/99 (IHSM data), with three principal in - patient units:

- a. Coventry and Warwickshire Hospital,
- b. Coventry Maternity Hospital,
- c. Walsgrave Hospital.

Their principal purchasers were local GP fundholders, and the district health authorities for Coventry, Warwickshire, Leicestershire, and Solihull.

Meanwhile, South Warwickshire General Hospitals NHS Trust had a budget of £460m for 1998/99 (IHSM data), with two principal in – patient units:

- a. Warwick Hospital
- b. Stratford – upon – Avon Hospital

Their principal purchasers were local GP fundholders, and the DHAs for Warwickshire, Coventry, Oxford, Solihull, Gloucester and Worcester.

6.2.1 Relationship Marketing Strategies: NHS Trusts Perspective

Warwick NHS Hospital Trust

In the Warwick Hospital case, interview evidence confirmed the empirical evidence from the national NHS Trust survey, i. e. that extensive use was made of contract augmentation and customisation as central elements of RM strategies. The face to face interviews identified a number of causal factors, although few of these related closely to the empirical findings from the national survey.

It will be recalled that the Logit models identified the statistically significant factors to be the numbers of competitors in respect of contract augmentation, and the extent of competitive culture and existence of preferred providers in the case of contract customisation.

However, in terms of the theory of relational marketing, the Warwick Hospitals case was supportive, the contract manager arguing, “I think the key element was retaining loyalty.

If you can augment a service for instance with some services which are mobile, you can actually set up bespoke services and actually ensure loyalty and stability of service.”

He emphasised further that generating further NHS Trust income from such strategies was not always deemed important, “for instance, in pathology you could augment the service, having some new facilities which do not generate income but do generate additional security for provider and purchaser”. Ignoring the issue of relative power – dependency within the Warwickshire local health market, the interviewees comments do provide evidence of support for Mauss’s (1966) view. In building loyalty, The Trusts behaviour, “was neither purely voluntary, spontaneous nor disinterested, as the interest lies in putting people under obligation and in winning followers”, (Mauss, 1966, cited in Sako, 1995, p.44).

A further driver of contract augmentation and customisation was the desire to use spare organisational capacity. The contract manager at Warwick stressed, “we were also looking at services where we had some capacity or skills which we were not using effectively. This allowed us to offer extra services support for some purchasers and actually develop our organisation. So there is a win, win situation”.

This comment is interesting in the context of Leibenstein’s work (1966). The principal tenet of his argument was that the entrepreneur, often through incremental changes or innovations, would address the issue of “slack” within their organisation. Following Finlay (1996) and his parallel findings in quasi – markets in Education in England, it is perceived that opportunities existed for entrepreneurial behaviour within NHS Trusts through the deployment of relational strategies. Entrepreneurial contract managers were striving to eliminate organisational waste or slack, “by imitating where possible, ‘good business practice’, and by improving on the efficiency of the organisation”, Finlay (ibid, p47).

Further supporting the theory of relationship marketing, the Warwick NHS Trust hospital contracts manager argued that, “with eighty percent of an organisation being its people, we looked at our relational strategies as a means of using the organisations staff more effectively, and further developing their skills”. This implies that their relational strategy was incorporating all relevant personnel. Additional evidence of this view was provided,

“we developed a relational marketing strategy and a lot of that was about the culture of the organisation, and trying to develop not only the senior management but all tiers of the organisation”. Evidence suggests, however, that efforts to change the orientation of Warwick NHS Hospitals Trust towards a relational approach were hard fought, “the relational marketing function was a fairly fundamental function to the Internal Market. It was fairly hard to instil it early on, but it did become easier over time as people began to identify with it. Towards the end, when new clinical staff came in they would say, ‘well, standards and relational marketing are second nature these days’”.

In general, it appeared that the use of contract augmentation and customisation was fragmented, with a widely unequal distribution even amongst GP fundholders, the latter being perceived as prime movers in demanding additional service benefits. Consequently, there is a clear question regarding how equitable such relational behaviour was in respect of purchaser and patient choice and access.

Moreover, as well as the uneven distribution of additional services between purchasers, there were differences in terms of the range of services attracting such contract augmentation and customisation. According to the Warwick contracts manager, “I think a lot less attention was paid to emergency compared to elective services in terms of augmentation of services”, and this appears to have been the consequence of political reasoning. In essence he argued that augmenting emergency services would have been a more visible, higher profile relational strategy which would have attracted unwanted interest from central authorities within the Department of Health. From this perspective, the Trust was seeking self interest with guile (Williamson, 1985).

Walsgrave NHS Hospital Trust

The Walsgrave Case provided a stark contrast to that of Warwick. The interviewee suggested that whilst augmentation and customisation did occur, the emphasis was more upon financial elements within contracts, i.e. cost – sharing agreements should contracts under or over- perform. These do represent a form of relational strategy in that they are intended to reduce risk to NHS Trust income, as argued in Chapter 5.

In terms of additional service benefits the contracts manager stated,

“We didn’t do too much in terms of added service benefits except in terms of the margin, for instance additional phlebotomy services”, although he recognised that failure to develop a wider RM strategy had opportunity costs by stating “we think we lost business on that basis”.

The interviewee did not place any emphasis upon preferred provider behaviour, the extent of competitive culture locally, the desire to use up surplus service capacity, or the importance of relational strategies. Thus the Walsgrave case provided no supporting evidence for the Logit models developed to explain contract augmentation and customisation.

The alternative reasons suggested for the Walsgrave position on relational strategies appeared to be three fold. Firstly an ethical position was adopted, “that (*i.e. relational marketing*) was a debate we were not prepared to have” based upon the strong belief that all purchasers should be treated equally, and secondly, it reflected the NHS Trusts financial position. In terms of the latter, it was emphasised that “although we had some very commercially aware purchasers who could afford to buy from providers offering augmented services or offering reduced waiting list times, Walsgrave could not afford to do any type of activity it didn’t get paid for. The income not coming through the front door meant we couldn’t balance the books”.

The third reason was the perceived strong market position afforded Walsgrave by the scale and scope of patient services compared to smaller local providers. The contracts manager identified a local example of a smaller competing provider with a narrower services base, *i.e.* St. Cross Hospital, which had been pro – active in augmenting and customising services. He stated “St Cross had a problem with their smallness, and we noticed they were setting up out reach clinics. Their consultants were based in practices which was expensive in terms of getting the consultants out there, but the benefit was that all the in – patient work came out to the consultant in St Cross. When we took it over (*i.e.* merged with St Cross Hospital), there must have been fifteen consultants going out to different parts of Leicester or Northampton. St. Cross had a clear business message: to go out and steal market segments covered by other NHS Trusts and bring it back to St Cross”. This supports one theoretical perspective considered in Chapter 2 that smaller

NHS Trusts may deploy RM strategies to counter their competitive disadvantage in terms of limited opportunities for economies of scale, scope and repetition.

On reflection, considering the driving factors behind contract augmentation and customisation in general, the interviewee argued “I don’t think it was one factor, and it would depend on the individual NHS Trusts circumstances”. However, he did offer a further suggested cause for such behaviour, i.e. the rise of managerialism in the NHS Internal Market. He suggested, “there has been a lot of money spent on ‘the management’ and we understand much more what goes on than ever before. Thus by definition we want to manage the system much more than we did before”. Furthermore, combined with a “top down culture from the NHS Executive of performance management and achievement” it was perceived that development of a managerial culture at the NHS Trust level could “create pressures to develop closer relationships with purchasers through augmentation of services”. Of note, this view supports Paton’s (1998) belief that, “managers are captivated by playing market games” (p.75)

6.2.2 Relationship Marketing Strategies: the Health Authority Perspective

Warwickshire District Health Authority

The DHA perspective mirrored that of Warwickshire General Hospitals NHS Trust, recognising that contract augmentation and customisation was widespread locally. However, unlike the Warwick hospital case, clear distinction was made between the extent to which GP fundholders as opposed to the DHA benefited from NHS Trusts relational strategy. The suggestion was that contract augmentation and customisation was centred upon GP fundholders rather than the DHA. It was perceived that NHS Trusts locally took DHA contracts and related income for granted, but recognised that for NHS Trusts, critical risk income came from GP fundholders who were perceived as “footloose” purchasers. The commissioning manager stated, “there has been far more contract customisation for the relatively minor purchases of GP fundholders than is commonly realised”, and this comments importance should be seen in the context of Paton’s (1998) findings regarding the break – down of NHS Trusts income. Typically, the source of

NHS Trust income was identified as follows:

- Local DHA = 70%
- Other DHA = 12%
- GPFH = 8%
- Other = 10%

Moreover, at least in respect of negotiating additional service benefits, the case evidence contradicts Paton's (ibid) assertion that

"DHAs were liable to have a significant effect on the activities and decisions of local providers" (p72).

The Warwickshire commissioning manager went on to identify a range of causal factors behind contract augmentation and customisation. Firstly, he stated it was primarily a means to encourage purchaser loyalty, supporting the theory of relational marketing. In addition he stated that it was a business development strategy aimed at increasing NHS Trust income, and also "to attract other GP fundholders who hear that this guy here has got a good deal". Lastly, it was suggested that GP fundholder income was the "bottom line" for many NHS Trusts: the principal financial cost of GP fundholders switching between providers being the subsequent inability of the NHS Trust to break even.

Despite this, the commissioning manager argued that augmentation of contracts afforded the DHA by NHS Trusts was limited to negotiation of additional activity in contracts, i.e. volume of treatments rather than the "topping – up" of patient services. In turn this was the consequence of NHS Trusts realising that if activity per contract was not increased "it would bankrupt the Health Authority, which further down the line would impact on them if we decide to restructure services. These NHS Trusts are fully aware that a hospital could be closed in the Coventry and Warwickshire area without radically reducing service provision. We could drive more efficiency, and we could further reduce costs in this way". Ironically, despite the subsequent negotiation strength this provided the DHA, the offer of additional service benefits via contract augmentation was not extended from GP fundholders to them.

6.2.3 Cross – comparisons: the NHS Trust – District Health Authority Perspective: Warwickshire Case

The evidence suggests major differences between the emphasis given to RM strategies by the two principal providers in the Warwickshire case. Walsgrave's primary objective was equitable patient provision throughout contracting DHAs and GP fundholders, in stark contrast to Warwick General Hospital NHS Trusts. The latter viewed relational strategies to be fundamental, and that on balance the benefits of such strategies outweighed the total costs. Warwick General Hospitals NHS Trust perceived RM strategies as a means of increasing purchaser loyalty, reducing risk to Trust income, and as a central tenet of human capital development.

Of note, there was little reference to those independent variables considered *a priori* to drive RM strategies outlined in Chapter 5. However, in the Walsgrave case, some reference was made to the role of Trust type, especially the importance of benefiting from the scale and scope economies associated with Acute type units. It was stated that non – acute Trusts without scale and scope advantages, were more inclined to augment and customise contracts. Additionally, the Walsgrave NHS Trust and Warwick Hospital case did introduce a number of additional “independent variables” driving relational strategies, including the opportunity to capture income from meeting latent demand, and the rise of managerial professionalism within the NHS.

The Warwickshire DHA had a lower perception of the extent of relation marketing than that of the providers. This supports the national survey evidence, i.e. that HAs perceived they had experienced a lower level of exposure to relational based strategies than the comparative NHS Trust evidence implied. However, the key outcome of the DHA interview was the perception that RM strategies were most vigorously pursued by NHS Trusts with GP fundholders not DHAs. It was argued DHA income was taken as given by NHS Trusts, whilst it was recognised that GP fundholder income was high risk because of their flexibility in allocating patients between providers.

6.2.4 Relationship Marketing Strategies: the GP fundholders Perspective in Warwickshire

The postal survey supporting the Warwickshire Case achieved 29 complete responses, representing a 51% response rate, which compares favorably with that of the national surveys, and other academic studies cited in Chapter 3.

Of responding GP fundholders, 86% stated that local NHS Trusts placed emphasis upon building close “personal” as opposed to simply formal relationships as part of the contracting process. Meanwhile, the survey also considered whether feedback on the quality of services provided by NHS Trusts was sought from GP fundholders. The average Likert response was marginally below the mid – point at 2.72 (where Always = 5, Never = 1).

However, little emphasis was placed on developing purchaser loyalty. When asked how often NHS Trusts offered GP fundholders loyalty discounts in contracts, the average Likert score was well below the mid – point at 1.48 (standard deviation 1.121), compared to a figure of 3.4 on the Likert scale regarding how often GP fundholders were offered volume discounts (standard deviation 1.12).

In terms of how often GP fundholders were offered augmented contracts, the response was well below the Likert mid – point. The average Likert score was 1.45 (standard deviation 1.06), which appears at odds with the perspective of at least one provider in Case Study 1, i.e. Warwick General Hospital NHS Trust, and stands at odds with the national NHS Trust survey evidence. When asked how often GP fundholders were offered customised contracts, the mean score was however much higher, i.e. 2.76 on the Likert scale, only marginally below the mid – point (standard deviation 0.87). This more closely reflects the Warwick General Hospital NHS Trust perspective, and the national NHS Trust survey findings.

More importantly, when asked to identify the extent to which GP fundholders agreed that non – cost related aspects were more important in choosing between different NHS Trusts, the resulting average Likert score was 3.5, above the mid – point (standard deviation 0.91). This identifies the significance given to non – price competitive aspects of the contracting process and thereby provides indirect support for the findings of the national NHS Trust survey. Some caution in interpreting this evidence is necessary,

however, because we cannot identify the exact form such non – price competitive elements took.

Thus on balance, it appears that there was a higher awareness among GP fundholders regarding relational behaviour by NHS Trusts. This is unsurprising given

- a) One key providing NHS Trust, i.e. Warwick, had a very “aggressive”, corporate wide, well developed RM strategy deployed in the local health market.
- b) The emphasis given by the DHA commissioning manager to relationship building efforts by local NHS Trusts “at the margin”. In other words, NHS Trusts were perceived to focus such relational efforts in areas where risk to NHS Trust income was greatest, i.e. footloose GP fundholders.

6.3 Case 2: Background

Dudley DHA covers a population of 316 000 with a budget of £129.748m for 1998/99. It’s principal contractors are the Dudley Group of Hospitals, Dudley Priority Health NHS Trust, Wolverhampton Hospital NHS Trust, and local GP fundholders. In total, there were 63 GP practices of which 26 were GP fundholders. It was stressed in Chapter 3, that one prime reason for Dudley being chosen as a comparative case for Warwickshire was the lower take up of GP fundholder status among GP practices.

Meanwhile, Dudley Hospitals Group NHS Trust represents an acute unit, with a budget of £100m for 1998/99. Moreover, it is comprised of the following hospitals:

- a. Guest Hospital (Tipton)
- b. Hayley Green Hospital (Halesowen)
- c. Russells Hall Hospital (Dudley)
- d. Wardsley Hospital (Stourbridge)

6.3.1 Relationship Marketing Strategies: NHS Trust Perspective

The contract manager who was interviewed was responsible for the four hospitals listed above. He identified only marginal importance to the augmentation and customisation of service agreements with purchasers, one fundamental reason being that, “there haven’t been tremendous swings and movements in contracts in Dudley”. This in part confirms the view that the Dudley DHA area was less market oriented than Warwickshire, with referral patterns, “reflecting historical patterns rather than the impact of relational strategies”, according to the interviewee. This perspective supports Proppers’ (1995) view regarding the important impact pre-Internal Market culture had on limiting the likelihood of market behaviour emerging in local health economies.

However, there was a strong recognition that contract switching by GP fundholders could occur, but primarily because of changes in the marginal cost of contracts rather than the offer, or otherwise, of additional service benefits (i. e. non-price competition). In response to questioning about the extent of additional services being used as an incentive to tie purchasers in more closely, the interviewee stated, “I am sorry if this is disappointing, but it is largely an economic decision in that the protection of income is important. If you have to make a slight change to the cost of contracts, in terms of the balance of risk it would be a sensible and logical thing to do”. He further added, “Certainly this NHS Trust did offer discounts in order to maintain business with GP fundholders, and they were similar to those marginal cost deals offered to HA’s”.

Interestingly, however, he was aware of the potential for opportunism through relational strategies within the NHS Internal Market. Indeed, given the relative financial power of GP fundholders compared to non-GP fundholders, he argued that the former were naïve in terms of recognising their potential power to request contracts offering additional service benefits. The interviewee stated, “I don’t think GP fundholders quite realised how powerful the economic argument was, and were then reluctant to suggest more radical things like the augmentation of contracts we discussed. I think local NHS Trusts would have responded to radical requests for these service ‘top-ups’. There was a lot of shadow boxing around augmenting and customising contracts in the sense of changes to basic service provision”.

Thus, implicitly, the interviewee recognised the conditions under which relational strategies could have played a more significant role locally. In particular, he stated that had information regarding local service capacity, the relative contribution GP fundholders made to NHS Trust income, and the opportunity costs to the NHS Trust of contract switching by GP fundholders been less asymmetric, RM behaviour would have been more likely in Dudley.

Where the interviewee did recognise the deployment of relational marketing strategies he focused upon professional managerialism as one driving factor, arguing “I think there was a lot of managerial time wasted on the pursuit of those type of opportunities throughout the NHS Internal Market in general. It is true to say that some people enjoyed the ‘market’ process, and enjoyed the negotiations that went with it. However, the opportunities raised by the new market culture were grossly overstated”.

Equally of note, the interviewee stressed that even if conditions locally had resulted in a greater emphasis upon relational behaviour, “the amount to which you could flex a contract around service changes was limited in my view”. In his opinion, this was primarily because of the “panoply of legislation which covered us in terms of the contracting process”.

Before leaving the Dudley Hospitals Group, it was interesting that whilst they seldom provided “topped – up” services to purchasers, they did augment contracts in the sense of providing additional performance monitoring of contracts for some purchasers. He stated, “we broke corporate reports on contract performance right down to individual clinical directorates, to individual consultants, individual patients, and episodes of care within that. We fed detailed, additional contracting data to some of our purchasers because we believed it would improve their management information service”. This supports the strong evidence of direct communications strategies being deployed by NHS Trusts identified by the national NHS Trust survey presented in Chapter 5.

Moreover, early within the Internal Market the Dudley Hospitals group had attempted to build closer links with purchasing GP fundholders in recognition that there could have been contract switching within the local health economy, and subsequently risk to The Trusts income. The contract manager argued, “we embarked on a program of service augmentation of sorts. We had a program educating GPs and other practice staff on how

our hospitals were run. I think these were very successful in building up trust, and a quasi – preferred – provider relationship”.

6.3.2 Relationship Marketing Strategies: the Dudley District Health Authority Perspective

The DHA evidence for the second Case Study supports that of the Dudley Hospitals Group. The interviewee stated, “I cannot say we have experienced differentials in service provision because providers were augmenting contracts, but I’m not saying I haven’t read about it.” The commissioning manager perceived that this was the consequence of a number of factors peculiar to the Dudley local health market. Specifically, these factors were perceived to be a more co-operative approach to purchaser – provider relations than in bordering DHA’s and the lower take up of GP fundholders, the latter reflecting a less “business oriented culture among local GP’s”. Further supporting the importance of the lack of GP fundholding in driving the low emphasis given to developing RM strategies locally, he argued that “GP fundholding seemed to be very localised even within the borough, but the average was 50% or below”. However, in respect of the assessment of opportunism, contractual and competence trust explored later in this chapter, it was notable that he stated, “perhaps the fact that I’m not aware of any significant efforts by NHS Trusts locally to build stronger relations, through the augmentation you described means it never happened. More worryingly perhaps it’s that the providers have done a good job in pulling the wool over our eyes”.

Whilst the commissioning manager identified a limited exposure to RM strategies by local NHS Trusts, he did identify that NHS Trusts did operate one element of direct communications strategies in that they attempted to “wine and dine” DHA representatives. He stated, “you certainly had contract managers trying to influence GP fundholders and to a lesser extent the Health Authority, especially when it came to innovative service developments”. Of note though, he did perceive that this relational strategy was not a phenomenon unique to the NHS Internal Market, stating, “I think this sort of relational behaviour was certainly the case well before any contracting was developed”.

6.3.3 Cross comparisons of NHS Trust and District Health Authority Perspectives on Relationship Marketing: the Dudley Case

In the second case study there was only limited evidence of RM strategies being deployed which focused on contract augmentation and customisation. Interestingly though, both interviewees showed a wider awareness that such behaviour was occurring in other local health markets, and suggested similar, “necessary” conditions for such behaviour to occur. The commissioning manager at Dudley DHA also perceived that GP fundholders had failed to recognise their potential for requesting additional services as part of contract negotiations, identifying similar reasons as his NHS Trust counterpart.

Notably, where contract augmentation and customisation was mentioned, any explanation of such behaviour showed little similarity with the evidence from the empirical analysis presented and evaluated in Chapter 5.

6.3.4 Relationship Marketing Strategies: GP fundholders Perspective in Dudley

The Dudley GP fundholder survey achieved a response rate of 50%, with 13 complete GP fundholder responses. This compares favorably with that achieved by the Warwick GP fundholder survey and the national NHS Trust and DHA postal surveys.

When questioned whether NHS Trusts placed emphasis on building “personal” as opposed to purely formal relationships within the contracting process, 92% of respondents (12 GP fundholders) replied in the affirmative. Furthermore, when asked how often NHS Trusts sought feedback on the quality of provided services, the average Likert response was slightly below the mid – point (i.e. “frequently”) at 2.54 (standard deviation 0.66). As in the Warwick sub – sample, little evidence emerged of the loyalty discounting, with the average Likert response of 1.61 well below the mid – point. Once more, there was a greater exposure to volume discounting with a mean Likert score of 3.61, where 4 represents “frequently” and 3 represents “sometimes” on the Likert scale. These results do, however, confirm the national survey evidence on the greater prevalence of volume discounting compared to loyalty discounting identified in the previous chapter.

The response to how often contracts were augmented was as expected on the basis of the interview evidence from the DHA and Dudley Hospitals Group. The average Likert score was well below the mid – point at 1.61 (standard deviation 1.04), although it is noted that this is at odds with the national NHS Trust survey evidence. Meanwhile, somewhat stronger support was given to the view that customisation of generic patient services (core related activity) was prevalent. Here, the average Likert score was just below the mid – point at 2.50.

Lastly, when asked about the extent to which GP fundholders agreed non – cost aspects were more important than cost in determining contractual partners, respondents recorded an average Likert score above the mid – point at 3.31 (standard deviation 1.11). This provides indirect evidence of the importance of non – price competition in the selection of contracting partners, and taken together with the evidence regarding local GPs exposure to customisation, suggests that there was greater local exposure to RM strategies than the District Health Authority and NHS Trust interviews suggest.

6.4.1 Relationship Marketing Strategies: Cross - Case Comparisons

The key distinction between cases is the greater level of exposure to contract augmentation and customisation in Case Study 1 (Warwickshire). This appears to be the consequence of a number of factors.

Firstly, a more intense spirit of entrepreneurship among GP's in Warwickshire, a “shadow” measure of such entrepreneurial behaviour being the higher take up rate of GP fundholder status than in the Dudley DHA. Moreover, one of the hospitals studied, i.e. Warwick General Hospital, appears to have had a contract manager particularly pro – active in building relational based strategies. This evidence identifies the deployment of a corporate wide RM strategy with a whole portfolio of relational elements.

However, the apparently lower exposure to relational behaviour by NHS Trusts recorded by the Dudley DHA was countered, to some extent, by the stronger evidence of its importance reported by Dudley based Fundholders.

Furthermore, there was only limited similarity between the suggested causes of contract augmentation and customisation offered by interviewees in both case studies (and across purchasers and providers), and those causal factors identified by the Logit analysis presented in Chapter 5.

The apparent limited importance of contract augmentation and customisation suggested by the case studies stands in stark contrast with the national survey findings. In respect of what Sako (1991; 1992) defined as “goodwill” trust, it appears that this was fairly limited. Where exchange is based upon obligated contractual relations (OCR) as opposed to arms length contractual relations (ACR), it is perceived that augmentation and customisation of contracts will be widespread. Thus the limited record of such behaviour within the selected Case Studies could be used to deduce the predominance of ACR behavior. This in turn is important in the context of Sako’s (1991; 1992) work because it implies market type behaviour, indicating that exchanges were driven more by hard - nosed, “bottom line” financial decision making with a view to increasing efficiency. Clearly, this provides some indirect evidence of the success of the Department of Health’s policy objectives arising from the 1989 White Paper.

There could be a number of reasons for the distinction between the national survey and case study findings regarding the extent of “goodwill” trust.

Primarily it may reflect the peculiarities of the case studies chosen, given the overwhelming evidence from both the national survey of NHS Trusts and DHAs for the importance given to the “topping up” and fine tuning of basic service agreements within the NHS Internal Market. Additionally, it is feasible that the contracts and commissioning managers were party to relational based strategies but did not recognise the extent to which they were involved. Recent management research in the public services field (Finlay, 1996) suggests this is a common difficulty facing researchers. Moreover, this problem may be compounded because of the differences in technical terminology deployed by academic researchers and health professionals, even though efforts were made to limit misinterpretation by offering generic definitions of concepts to the interviewees. Lastly, as Section 6.5 demonstrates, the DHAs and NHS Trust interviewees, suggested a mature understanding of the negative aspects of relationship marketing (RM) in the NHS Internal Market. It is possible to argue that if RM was

insignificant in the respective local health markets, the interviewees perspective regarding the ‘downside’ of RM would have been more naïve than that recorded.

6.4.2 GP fundholder Comparisons

The critical finding is that despite the face to face interview evidence suggesting that the exposure to Trusts relational strategies was much lower in the Dudley case, the supporting GP fundholder survey appears to contradict this. In respect of the average Likert score on the extent to which GP fundholders were offered augmented contracts the figure was higher, although only marginally, at 1.62 for Dudley compared to 1.45 for Warwick. Clearly both suggest a relatively low level of experience of contract augmentation in general, and this finding appears to be at odds with national survey evidence provided by NHS Trusts.

Meanwhile, in terms of the exposure to contract customisation this appears greater than that of contract augmentation in both sub – samples, and, moreover, the figure for Dudley DHA area is only slightly less strong than that for Warwickshire DHA. In addition, both sub – samples recorded average Likert scores above the mid – point when asked about the extent to which non – cost aspects were more important than cost aspects in selecting providing NHS Trusts. The relevant Likert figures were broadly comparable at 3.45 on the Likert scale for the Warwick GP fundholders sub-sample and 3.31 for the Dudley equivalent.

Thus on balance, the GP fundholder surveys provided support for the national survey findings regarding the significant emphasis given to relationship marketing strategies by providing NHS Trusts.

6.5.1 The Downside of Relationship Marketing Strategies: Case 1: NHS Trust Perspective

For Warwick General Hospitals NHS Trust, the key impact was seen to be upon differential access for patients, itself of note given the relatively low ranked priority the national NHS Trust survey recorded for patient access as a key benefit of the Internal Market. The Warwick contract manager stated, “the access to some of the ‘innovations’ were not equally shared across the whole population, and I think it was difficult because

people in Trusts, and the clinical staff on wards could see the benefits and wanted it offered to everybody, but we couldn't".

Furthermore, the Warwick interviewee was concerned over the extent of duplication arising from contract augmentation and customisation. He stated, "this NHS Trust set up an outreach physio – therapy service and so did a competing community NHS Trust down the road. This contract customisation as you described it is not necessarily cost – effective. It has generated some duplication of capacity, management structures, and in some cases capital investment".

The Warwick case also identified an increase in ex – post transaction costs associated with contract augmentation and customisation. According to the interviewee, "we went through a very difficult phase in the middle of the fourth year of the Internal Market. We were invoiced for every patient, every patient contact, and every element of the contract including the 'top – ups'. It reached the stage where purchasers would say 'we don't think this patient has had all the procedures or benefits you offered". At this point, ironically, Warwick had clinicians and managers talking about the flow of invoices rather than the actual, augmented services delivered!

The concluding comment on the drawback of relationship marketing strategies made by the interviewee was that such strategies reflected a corporate raider mentality in the NHS. He perceived that from the overall NHS perspective there was a "robbing Peter to pay Paul" outcome from contract augmentation and customisation. He stated that Warwick NHS Trust spent considerable efforts at building personal relationships with potential purchasers, focusing upon eliciting information on what they perceived competing providers weaknesses to be in respect of contract pricing, monitoring, quality, additional service benefits and so on. He stated the Warwick perspective on relationship building was subsequently, "look we could do really well because the other Trust is weak and vulnerable: we've got additional service benefits to offer so let's raid the resources". He added that whilst such behaviour may appear Machiavellian in the context of the new co – operative NHS framework of the 1997 White Paper reforms, "there was a real incentive for somebody to identify weaknesses in other organisations, establish an augmented service, and go for the income". There was consequently no overall concern with the

impact of relational marketing strategies on the Pareto optimality (Jackson & Brown, 1988; Cullis & Jones, 1993) of resource allocation.

Meanwhile, given the relative lack of emphasis given to contract augmentation and customisation by Walsgrave NHS Trust, the interviewee's comments were limited. However, he did comment in respect of the likely additional costs facing St. Cross hospital in Rugby, who were known to be extensively using relational marketing strategies. The perception was that transaction costs would rise as the monitoring of contract's performance became more complex, and that duplication of patient services was likely.

6.5.2 The Downside of Relationship Marketing Strategies: Case 1: the DHA Perspective

The commissioning manager at Warwickshire DHA identified three principal downsides to the process of relationship building via augmentation of secondary care services. Primarily he believed it impacted significantly on the equity of distribution of services, stating "the two – tier system of GP fundholder versus non – GP fundholder in terms of waiting list times was well recognised. But the augmentation and customisation of contracts exacerbated the inequity", the interviewee stating that the pattern of inequity was extremely complex. Different GP fundholders were themselves being offered different levels of additional service benefits, so that inequity was multi – tiered. He argued further, "what the marketing culture did is give GP fundholders the best deal because the competition occurred at the margin with the smaller purchasers and their risk income".

The second drawback was perceived to be the development of latent demand, "the market came in place and providers saw, outside the bog standard work, the opportunity to develop service augmentation, a classic example being acnophobia outreach clinics. This is mainly for middle aged men who start snoring in the middle of the night and wake themselves up because the body is saying wake up or you're going to snuff it. Now the potential demand for that is limitless". The prime outcome of "fuelling" such latent demand as the interviewee put it, is "we have seen a plethora of services growing in the NHS which are not considered by anybody to be a priority". Clearly, the latter should be seen in the context of the continuing funding crisis facing the UK NHS.

The final downside according to the Warwick commissioning manager was the increase in expectations caused by the augmentation and customisation of patient services. Moreover, expectations were raised for both patients in respect of the range of services they expected to access, and also clinicians. In respect of the latter, “it is quite interesting to watch GP fundholder behaviour in the context of the ‘new’ reforms. Those who most enjoyed relational building exercises with providers are getting ‘uptight’. They think it’s their right to get extra service benefits for their patients, and wrongly assume this will continue in the ‘new’ environment. I enjoy telling them ‘sorry, now fundholding is abolished, money and patient services have to be more evenly spread”.

6.5.3 Case 1: Downside of Relationship Marketing Strategies: Comparison of NHS Trust and DHA Perspectives

The common theme across the case study was the agreed negative impact relational marketing strategies had on equity, although caution must be expressed because of the difficulties associated with defining this concept (Mooney, 1993; Le Grand & Bartlett, 1993). A related view was that in addition to differential access to “topped up” services, pro – active RM behaviour by NHS Trusts had actually changed priorities in the NHS through efforts to meet latent demand. This confirms the earlier assertion that some NHS Trusts were, “enjoying playing the market game”, and supports Paton’s view (1998).

Furthermore, in respect of inequity it was argued by the DHA and Warwick Hospital NHS Trust that relationship marketing strategies had exacerbated differential access to care. Indeed, the extent of this was such that even among GP fundholders, there was a multi-tiered system in respect of different patient group’s exposure to additional service benefits. This should be considered in light of the heightened expectation of fast track treatment or additional levels of service provision created by relationship marketing strategies by both patients and clinicians.

Of note, the Warwick Hospital NHS Trust and Walsgrave NHS Trust both identified repetition of services, and a number of increased transactions cost elements as drawbacks. This supports the theoretical consideration of the impact of relational marketing strategies outlined earlier in Chapter 2.

6.5.4 The Downside of Relationship Marketing Strategies: Case 2: NHS Trust Perspective

Given the lower emphasis placed upon RM strategies by the Dudley Hospitals Group, explanations of the downside of such behaviour were unexpectedly less mature. The contract manager did, however, argue that where they had offered additional service benefits within contracts there were, “other additional costs you got. These were in terms of information, time, and policing of such contracts. There was a big role for policing those type of contracts: it was a very substantial role in terms of reflecting our performance levels back onto purchasers to encourage repeat business, and in some ways increase purchaser loyalty”. He did, however, reiterate that such behaviour, i.e. contract augmentation or customisation was of only marginal financial importance to the NHS Trust.

6.5.5 The Downside of Relationship Marketing Strategies: Case 2: Dudley DHA Perspective

Again, because of the lower awareness of relational behaviour in the Dudley DHA case study, the interviewee provided a limited response. However, he did identify that where NHS Trusts in other HA districts were providing additional service benefits there would be a number of drawbacks. The interviewee stated, “the main downside would be in terms of the additional bureaucracy and the time taken to make the thing work. It would also mean considerable extra energies because these augmented agreements would have had to be renegotiated year on year, and of course require additional agreements on how they should be monitored compared to ‘standard’ type contracts”. It thus appears that both the Dudley Hospital Group and Dudley DHA recognised the likely rise in ex – ante and ex - post transaction costs associated with the development of relationship marketing strategies.

6.5.6 Downside of Relationship Marketing Strategies: Cross - Case Comparisons

The central cross - finding is the very different level of awareness of the likely costs of relational strategies between the Warwick and Dudley cases, the former having a more thorough, mature perspective. However, this simply reflects the much greater exposure of Warwick DHA to relational behaviour by secondary care providers, or as argued above

(Finlay, 1996), the possibility that NHS managers were engaged in relational type behaviour but were not aware of this. Moreover, it should be noted that it could also reflect bias in the second case study: it may be that interviews with another lead provider of secondary care within the Dudley DHA would have provided stronger evidence of the importance of RM strategies.

6.6.1 Contractual and Competence Trust: Case 1: Warwickshire

The NHS Trust Perspective: Warwick General Hospital

The contract manager at Warwick General Hospitals NHS Trust placed a high degree of importance on trust within the relationship building process. He stated, "I think the issue of trust is a key one and has changed over time. For us, building long term relationships with purchasers became much more of a priority, the issue of trust became much keener for us".

Moreover, it appears that the real test of the extent of trust in the contracting process was in respect of risk income. The evidence presented earlier indicated the importance of risk income in defining and targeting RM strategies for The Trust: the Warwick General Hospitals NHS Trust was very sensitive to footloose spending patterns by GP fundholders locally. It is perceived this had implications for the degree of Sako's (1991; 1992) contractual and competence trust.

In the context of Warwick NHS Trusts RM strategies, the interviewee argued, "the contracts became much more complex during this period, and more time was spent with GP fundholders refining contracts and making the contracts more responsive to the changes both parties wished to see." He reinforced the importance of RM strategies in determining the extent of competence trust, "I think it was the added value we put into our contracts. GP fundholders were always asking, 'what other values can you bring to this contract?' Even though it was not a legal document, we put in significant efforts to ensure user trust. We considered what would happen if we couldn't deliver contract augmentation or customisation: it wasn't simply an issue of straight forward payment mechanisms. There was quite a lot more information on how we both know what was going on, which puts more emphasis upon monitoring of contracts". Moreover, the NHS

Trusts strategies deployed to discourage GP fundholders switching risk income, also changed the focus of monitoring away from purely physical measures, i.e. numbers of treatments, numbers of additional transports provided and numbers of patients using outreach clinics. More specifically, there was movement towards greater emphasis on monitoring quality within these augmented and customised contracts. The interviewee stated, “I think there was more emphasis upon quality of outcomes with risk income contracts than core Health Authority work. GP fundholders would occasionally be saying, ‘look we’ll consider at the margins looking at different payment methods because you assured us our patients will be seen by a consultant rather than a more junior doctor at their first hospital appointment’. In there, inherently, there was a question of monitoring quality issues more fully because the patient was, or was not being seen by the top dog rather than a junior team member”.

Thus ironically, the Trusts relational strategies resulted in increased goodwill trust, but at the same time, the augmentation and customisation of service agreements resulted in more questioning of competence trust, and also much more rigid planning for contingencies. In relation to Sako’s (ibid) framework this suggests a lower level of contractual trust.

Lastly, the Warwick contract manager placed significant emphasis upon the impact the development of the NHS Internal Market had had upon the degree of confidence in exchange partners reliability and integrity. He argued, “the division of the organisation into purchasers and providers led to people trying to establish their market position, and there was quite a lot of macho posturing, ‘we’ll use our position to show you what needs to be done’. From the NHS Trusts point of view people were asking why these people should be telling us what to do!” This process was perceived to become less aggressive and adversarial, and more conciliatory as the NHS Internal Market matured. However, in the early years the interviewee left no doubt regarding his opinion that, “for the first few years there was less trust and some people used it to settle a few ‘old scores’. Some purchasers were very clear about them now having the money and being in charge of the negotiations process”.

This last comment is of note given the view supported by Paton (1998) that a primary driving factor behind the NHS Internal Market reforms was, “the heavy rhetoric against ‘provider domination”, (p 42).

The NHS Trust Perspective: Walsgrave NHS Trust

The contract manager at Walsgrave placed particular emphasis on his Trusts openness with purchasers, and although he stated “Walsgrave was not whiter than white”, he placed low importance on the Trust behaving opportunistically. This is despite him being aware of the possibilities for such behaviour, “in the early days we could probably have been more creative with the interpretation of certain types of activity. It didn’t take much to say if somebody has walked onto a ward, providing a doctor had at least seen them, then we could count them as a day case and charge purchasers accordingly. We tried to move away from that and say, look, that kind of opportunistic behaviour is just artificial.” This correlates with the low emphasis Walsgrave placed upon developing relational strategies.

However, The Trust was aware of the costs of such openness, “There have been commercially painful occasions, to our dis- benefit, arising out of our openness”. As an example, the interviewee referred to the case of deploying another consultant, and the resulting costing of their activities for purchasers. Typically, Walsgrave would openly specify the separate costings for the consultant’s time, and the extra variable costs relating to the required administrative support. He recognised that a rational, opportunistic response to these costings would be, “it’s a management issue, the way you organise your services, and the cost of support structures is your problem!” The interviewee referred to, but would not name other local NHS Trusts who would mask costs of administrative support time, simply adding these to consultant costs which enabled these Trusts to transfer some of the incidence of additional cost onto the purchaser.

Meanwhile, in terms of The Trusts wider experience of opportunism, the interviewee supported evidence from the Warwick Hospital care that the extent of opportunistic behaviour was unevenly distributed between purchasers. In particular, he perceived the majority of opportunistic behaviour was amongst GP fundholders rather than DHAs, and that within GP fundholders there was a wide variation in the extent to which they were prepared to behave opportunistically. He stated, “some were very principled. However, others were much more cut throat in a business sense, and were prepared to move activity around in contracts at the margin to make the most they could out of the system. I could give examples of several local GP fundholders who made several hundred thousand pounds worth of savings”.

The Walsgrave case also supported the Warwick NHS Trust evidence regarding increasing maturity in the degree of contractual trust as the NHS Internal Market developed, arguing, “I think the contracting process has matured, certainly in the last couple of years. We have gone past the point of very detailed service agreements to look at the key issues. What are the clinical issues that you want to invest in at Walsgrave?” Indeed, in the wider context of the degree of opportunism in the early days of the Internal Market the interviewee stated, “I think there was initially quite a high level of distrust in my view. In those days it was perceived that there was a battle, because they were establishing their domain”. This was partly explained by the contract manager as a result of increasing managerial professionalism in the infant NHS Internal Market, “learning the rules as they went on, Chief Executives in first and second wave NHS Trusts believed they were very much there to ‘manage’. If they saw an opportunity to use marketing to identify a niche, or develop a market segment, they would tread in very heavily to get it”.

This is at odds with Paton’s (1998) findings. He had identified a, “comparatively low priority that trusts have given to developing the marketing function within their unit”, (p. 74).

The Warwickshire Health Authority Perspective

It will be recalled that the DHA perspective was that there was a low level of “goodwill” trust between NHS Trusts and The DHA. In particular, the commissioning manager took the view that efforts by NHS Trusts to augment and customise contracts were focused upon GP fundholders and their risk income, with DHA income being taken “as given” by local NHS Trusts. The lower level of goodwill trust experienced was compounded to by the DHAs experience of a lower level of contractual trust.

The interviewee emphasised that, for example, opportunism was widely experienced with respect to the funding of patient admissions, with the “currency of contracts” being in respect of finished consultant episodes. Thus the interviewee argued that some local NHS Trusts would attempt to have several, named consultants see a patient within their hospital stay, each classified as a completed episode of care with subsequent monies flowing from

them. In his view the difficulty was, “getting the hospitals to demonstrate their trust and integrity by having open financial book arrangements”.

Paradoxically, whilst 90% of local NHS Trusts income comes from the Warwickshire DHA, the DHA and NHS Trust relationship was not perceived as mature as might be expected “for instance in the commercial sector”. The commissioning manager argued that “if a company exists because 90% of what it does goes to a single company, there is a completely open relationship. The person you rely on for supplies comes into your organisation: they live it and breathe it! They know how many staff you employ, how they are trained, their salaries etc etc etc”.

Apart from the consequence that the DHA did not enjoy the same contract augmentation and customisation of contracts as local GP fundholders, there were also serious quality issues in key treatment areas arising from the low level of goodwill and contractual “trust” in the Warwick DHA – local NHS Trust relationship. The commissioning manager argued that it was of most concern in respect of emergency care that NHS Trusts behaved opportunistically by masking information on numbers of staff in such departments and their skills mix. He cited government research that identified “the strong linkage between skills mix and the quality of care in this area”. However, Warwick DHA had experienced a significant unwillingness of providing NHS Trusts to develop an open relationship based on sharing such data within the contracting process. Whilst he argued, “the situation with NHS Trusts refusing to offer freely the information we need is unlocking, but it’s still far from open book in terms of them realising, ‘we depend on this organisation for our income so we’ll give them the information they need’”. This identifies the relatively low emphasis providing NHS Trusts placed on direct communications strategies, which are seen as a cornerstone of relational marketing strategies (Stone & Woodcock, 1995).

Ironically, the interviewee did identify conditions where the DHA itself behaved opportunistically in the contracting process. This opportunism was prevalent when they were commissioning “new” patient services which provided the opportunity to hold competitive tendering interviews with potential providing NHS Trusts. At such interviews, negotiations were focused upon quality, additional un-costed service provision (i.e. providing evidence of contract augmentation), and organisational capacity. This

emphasis was at the expense of focusing simply upon unit cost or provision of new or innovated services.

Furthermore, supporting evidence from the NHS Trust interviews in Case Study 1, the commissioning manager did identify that the development of the NHS Internal Market had affected perceptions of the integrity and reliability of exchange partners. He stated, “what the ‘market’ did, was to divide the relationship often in an acrimonious way. There was often a lot of bitter meetings, and very bitter correspondence between us and our providers”. Drawing a comparison with days before the NHS Internal Market he added, “I’d often comment to people, do you remember when we were on the same side of the table? Usually my counterparts in NHS trusts would agree, yes, you’re right we did use to be on the same side”. However, of note, unlike the NHS Trust interviewees he did not perceive that the degree of integrity within the NHS Trust - DHA relationship had improved during the life time of the NHS Internal Market. He argued, “even today, when I go to meetings with local NHS Trusts, and I’ve got a £50m contract waiting to be signed, they make me feel like I’m not important. What’s more, the relationship is not mature: we cannot deal with problems sequentially on a case by case basis.”

In terms of the latter, he argued there was a high dependence on what Sako (1992) called contractualism. Within Sako’s framework, obligated contractual relationships were based upon case by case resolution, the emphasis being “with much appeal to the diffuse obligation of long – term relationships” (1992, p11). In the case of Warwickshire DHA, the commissioning manager provided evidence of a large number of instances where within the contracting process the only way to resolve conflict was through credible threat making (Lyons, 1991; Dixit and Skeath, 1999). The DHA when threatened with arbitration by providing NHS Trusts had, “written formally to them to say if arbitration goes the wrong way, we would consider despite the lead time involved, in giving them notice of our intention to terminate all contracts with them”. Concluding the interview he added, “now that doesn’t say much about the evolved state of integrity and reliability of the purchaser – provider relationship, does it?”

6.6.2 Contractual and Competence Trust: Case 2: Dudley

The second case study provided less insight into the extent of competence and contractual trust than the preceding Warwickshire case. In part, this reflects the low priority apparently given to market type behaviour by both NHS Trusts and the DHA in this local health market, and the slower evolution of the quasi – market in health in Dudley than in the Warwick case. The Dudley Hospitals Group contract manager argued, “the take up of market ideals, and especially GP fundholding was lower and indeed slower than elsewhere. GP fundholders, for instance didn’t get into it until the third and fourth waves. It’s a typical Dudley pattern: we let other people make the mistakes, and I think that was true to a large extent regarding the downside of market behaviour. Opportunism seemed to be something most purchasers and providers strongly wanted to avoid here”.

The NHS Trust interviewee did, however, identify a degree of opportunism among GP fundholders early on in the development of the local NHS Internal Market. He stated, “there were people (*GP fundholders*) who tried to gain the upper hand in the exchange relationship, but in Dudley that was quite quickly and quite vigorously beaten back”, although the contract manager did emphasise that the Dudley experience may have been somewhat unique.

Moreover, recognising the importance of GP fundholders risk income to his NHS Trust, he did identify that around 70% of his time was spent negotiating for 15% of Trust income with GP fundholders. However, both the NHS Trust and Dudley DHA were aware of the inevitability of this, given some potential for GP fundholders to be footloose investors. The key, however, according to the interviewee was that such behaviour was deemed acceptable to the NHS Trust and the DHA as long as, “in the longer term, benefits arising to GP fundholders patients from these extended negotiations were passed on to all the Health Authorities patients”.

Meanwhile, drawing on his wider professional NHS experience he suggested that opportunism was quite widespread in other DHA districts in the West Midlands, and of note recognised that such behaviour was not confined to GP fundholders and NHS Trusts. Supporting the Warwick DHA case evidence, he claimed, “purchasers certainly saw opportunities to gain advantages over providing NHS Trusts. They were able to exert

pressure by making the threat, which could have been made credible, to withdraw contracts wholesale”.

Additionally, the Dudley DHAs commissioning manager perceived opportunism, even in a competitive NHS setting, to be a non issue. He argued, “I think we have a long track record of dealing with hospitals and GPs. It isn’t as if in a commercial sense one is going out to do something new, or contract with the unknown. One has a good understanding of what went on before the Internal Market, and peoples record of performance and integrity.” This appears to suggest local policy on the introduction of market forces was strongly at odds with national policy, and supports the wider evidence that the purchaser – provider split was often more imagined than real (Propper, 1994; Le Grand & Bartlett, 1993). Of interest, however, the DHA commissioning manager was conscious of the negative aspects of choosing not to vigorously implement the 1989 White Paper. He stated, “I don’t think there was the same challenge and expectation to challenge here in Dudley as the market ethos suggested. Therefore it didn’t translate itself into a case of trusting or not trusting people. The management functions of purchasing and providing were carried out by the same people as before the Internal Market. I suppose it was probably too ‘comfortable’ a position such that it didn’t challenge the best use of resources in delivering care, or perhaps encourage more focus on quality as well as efficiency”.

6.7 General Conclusions

This section highlights the central findings from the Case Studies. It is argued that the insight into relationship marketing strategies and the role of trust in contracting they have provided justifies their inclusion alongside the national postal surveys. Moreover, there is consequently strong support for the initial decision to adopt a joint research methodology considered in detail in Chapter 4.

6.7.1 The Extent of Contract Augmentation and Customisation

On balance, the case evidence supports the view that relationship marketing strategies based on the augmentation and customisation of contracts was wide spread. This conclusion is based upon the weight of evidence from the Warwick Hospital example, and

general awareness among interviewees in both case studies of the prevalence of such non-price competitive behaviour. Moreover, the case evidence for Warwickshire shows that considerable efforts were made by NHS Trusts to deploy relational strategies with GP fundholders, principally to reduce risk to NHS Trusts income arising through contract switching by GP fundholders. Whilst the evidence on the importance of RM strategies at the margin of NHS Trusts income is important, it is not clear to what extent this pattern of relational behaviour was national rather than local. It is possible that this marginal behaviour was unique to the case selected, and that the Warwickshire case is atypical. Clearly some caution is warranted because the national NHS Trust and DHA survey do, in general, suggest the practice of contract augmentation and customisation was much more widely spread than the prevailing literature suggests, and not confined solely to NHS Trust – GP fundholder negotiations.

Secondly, there was limited similarity between the suggested determinants of contract augmentation and customisation gained from the comparative evaluation of case study and national NHS Trust survey data. There was, however, limited support for the importance of loyalty building, and also the type of NHS Trust in determining the likelihood of RM strategies being deployed. In respect of the latter, the key issue was the extent to which different hospital Trust types could reap economies of scale, scope and repetition.

It should be noted, however, that the case studies did identify a further set of causal factors. The most cited reasons were the growth of managerial professionalism among NHS Trust management, and the desire to meet latent demand, although with the latter it was recognised that this behaviour had changed resource allocation priorities in health care. The latter is important in the context of wider evidence that a major downside of relational strategies was the skewing of patient access and choice in favour of those patients whose GPs were pro – active in requesting contract augmentation and customisation.

It is notable from the perspective of research methodology that the Case Study interviews illustrated the importance of professional managerialism in driving NHS Trusts desire to implement RM strategies. The difficulties associated with operationalising questions

designed to detect this variable's influence on RM behaviour via a questionnaire would have been considerable.

6.7.2 The Downside of Contract Augmentation and Customisation

Both Case Studies support the view that relational marketing behaviour had a detrimental impact on the equity of service delivery. Moreover, there was perceived to be a complex pattern of inequalities arising from relational behaviour, with the distinction being not simply between GP fundholders and non- GP fundholders, but between different fundholders.

There was perceived to be quite high levels of duplication of services through NHS Trusts using relational strategies to secure GP fundholder income. The Warwickshire case interviews suggested physical duplication of services, e.g. in terms of physio-therapy, duplication of capital costs where additional facilities had been provided, and management structures where, for instance, additional monitoring of augmented contracts had been implemented.

More particularly in terms of transaction costs, there was widespread evidence suggesting relational marketing strategies had increased Williamson's (1985) ex ante costs because of negotiators' desires to cover a wider range of contingencies. In respect of Sako's (1991; 1992) terminology meanwhile, this implies that there was a lower level of contractual trust. This increase in transaction costs was seen to be extended to include ex – post costs in terms of how augmented and customised contracts were to be re – aligned if they did failed to meet performance targets. The latter implies in respect of Sako's (ibid) terminology that there was a decrease in some elements of competence trust.

Lastly, it is noteworthy that both Cases Studies provided evidence that the fuelling of latent demand through relational marketing strategies had not only changed health priorities, but had importantly changed expectations amongst GP fundholders. The latter had come to expect differential service standards, not only as is well evidenced (Propper, 1995a; Paton, 1998) in respect of favourable volume discounting, and access to shorter waiting times, but also in terms of the nature of the care package received. It is suggested that this has increased conflict between DHAs and lead providers within the new Primary

Care Groups because these GPs, often those who were most “entrepreneurial” in the former NHS Internal Market expect such differential benefits to be continued. Equally of note, patients will have become acutely aware that additional care benefits had arisen where their GP was pro – active in developing stronger relations with NHS Trusts, and would expect these additional benefits over other patients to continue under the new NHS arrangements (DoH, 1997).

6.7.3 The Role of “trust” in Relational Behaviour

The Application of Sako’s (1991; 1992) Framework

As specified in the introduction to this chapter, one objective of the case analysis was the exploration of the nature and role of trust within DHA and NHS Trust relationships. This was evaluated using Sako’s (ibid) framework, focusing upon contractual, competence and goodwill trust. The evidence presented on the wide extent of contract augmentation and customisation by both the case studies and the national survey of DHAs and NHS Trusts suggests an important role for goodwill trust.

A more thorough consideration of Sako’s (ibid) framework is justifiable, enabling a more detailed consideration of the extent to which the case evidenced supports the predominance of arms length contractual relations (ACR) or obligated contractual relations (OCR). It will be recalled that the latter reflects a relational market, with a significant emphasis upon relationship marketing strategies, whereas the former closely reflects the market ideal espoused by Neoclassical economists. In the case of the latter relationship marketing would be irrelevant as was argued in Chapter 2.

In respect of contractual trust, defined by Sako (1992) as,

“Keeping promises regarding universalistic ethical standards”,

the case evidence suggests that early on in the life of the NHS Internal Market contractual trust was lowered by opportunistic behaviour by NHS Trusts, e.g. in terms of the way patients consultant episodes were recorded to gain additional income. Moreover, there was supporting evidence that GP fundholders behaved similarly.

However, apart from the Warwick DHA case, it was universally agreed that such behaviour became less prevalent within the contracting process as the NHS Internal Market developed beyond its infancy.

Moreover, researchers should be cautious in interpreting the existence of low levels of contractual trust as explicit evidence of opportunistic behaviour. As argued in Chapter 2, opportunism may simply be the result of bounded rationality (Simon, 1962). Indeed, support for this view came from the case study in Dudley where the hospital contract manager emphasised the lack of “commercial sophistication in terms of the way NHS Trusts were collecting, collating and interpreting contract data”.

Meanwhile, regarding competence trust it appeared that this was universally high across both case studies. The nature of past performance of providers was argued to be well known by the DHAs interviewed, with the latter seldom deploying monitoring practices which questioned the physical quality of care provided. For instance, in the Dudley case it was stressed that where any doubt existed about provider’s competence, they would deploy radical monitoring of performance, i.e. other than standard monitoring of a contracts progression and completion. These included random spot checks of provider’s quality of care, although such monitoring was argued to be “very much outside the norm”. The emphasis on experiential knowledge of provider’s abilities is important in the context of one of the anticipated costs of developing trust in relationships. Sako (*ibid*) argued that, “trust may be detrimental to organisational efficiency in the short – run, due to high set up costs. The initial search costs of finding worthy partners may be quite high”, (p48). In general it appears DHAs and NHS Trusts experienced a high level of competence trust which suggests OCR was predominant.

In respect of the nature of documentation in the contracting process between DHAs and NHS Trusts it appears that the augmentation and customisation of contracts did result in greater ex – ante transaction costs. In respect of Sako’s (1991; 1992) terminology, contracts were subsequently “substantive in terms of contract terms and conditions”. Ironically this approach to contract documentation is associated with ACR rather than OCR type behaviour.

However, in terms of technology and training transfer, the evidence supports OCR rather than ACR behaviour. In respect of the latter the Warwick NHS Trust example, and to a lesser extent the Warwickshire DHA, confirmed that technology and training transfer between The Trust and local GP fundholders was widespread. For instance, Warwick NHS Trust provided

- a. A direct hotline between GPs and hospital based clinical experts;
- b. Specialist training for GPs, e.g. in terms of rheumatology;
- c. Out – reach consultants based in GP practices;
- d. Upgraded management information systems in GP fundholder surgeries;
- e. General up – dating of clinical skills for GPs and their nursing staff.

It should be emphasised that the interviewees identified that these services were not fully costed. This would suggest non-price competitive behavior associated with OCR behaviour as opposed to ACR behaviour.

Sako (1991; 1992) uses communication channels as a further technique for distinguishing between OCR and ACR models. The case evidence for Warwick NHS Trust showed a corporate wide relationship marketing strategy, and it is true of all of the DHAs and NHS Trusts interviewed that regular, multiple channels of communication were available regarding contracting. Furthermore, there did appear to be an emphasis upon these channels being “personal” rather than formal. Additionally, all of the NHS Trusts identified deployment of purchaser satisfaction surveys in addition to the normal monitoring of contract performance. Indeed, the importance of personal rather than simply formal relationships, and the use of purchaser satisfaction surveys was also strongly evidenced by the national NHS Trust survey. Subsequently, it is perceived that in terms of communications channels the DHA – NHS Trust relationship was OCR rather than ACR oriented.

Lastly, Sako (ibid) classified ACR or OCR behaviour in respect of attitudes to risk. In the case of the former there is no formal agreement to spread risks through, for instance, cost – sharing agreements. Indeed, within an ACR model, the only strategy for spreading risk is contracting with a multitude of supplying firms. However, the Case Study evidence suggests that cost – sharing in contracts was widespread and again, the national NHS

Trust survey supported this view. Thus, supporting Sako (1991; 1992) the Case Studies show that, “the relative share of unforeseen loss or gain is decided on a case by case basis applying some principle of fairness”, (p 12). Subsequently it is argued that this further demonstrates the predominance of OCR rather than ACR behaviour.

Thus in the local health markets studied through case studies there is a mix of OCR and ACR behaviour. It is not possible, without further empirical estimation, to weight the relative significance of competence trust, contractual trust, goodwill trust, documentation, communication channels and so on in the Case Study examples. Thus it is not possible to incorporate some form of cardinal measurement of the extent of OCR compared to ACR type behavior. However, given this caveat, it appears on balance, that measured in an ordinal sense, OCR rather than ACR behavior predominated in the Case Studies. Nevertheless, it remains difficult to place the case studies on the horizon between “pure” ACR and “pure” OCR models. Most significantly, the latter implies it is difficult to gauge the success of Department of Health policy in achieving its objective of securing a predominantly ACR based NHS model as argued in Chapter 1.

6.7.4 Implications for Performance of the Case Study Local Health Markets

Firstly, in respect of transaction costs there is an important paradox. Sako’s (1991; 1992) analysis implies that “current” transaction costs will be higher in ACR models because there is a higher expectation of opportunism by suppliers, and also because there are multiple supply relationships. On the other hand, “investment” transaction costs will be lower because there are no efforts to build stronger links with suppliers through RM strategies. In contrast, Sako’s (ibid) analysis suggests that for models which are predominantly OCR (i.e. on balance the Case Studies), current transaction costs will be relatively low because of assumed lower levels of opportunism, and because exchange links are made with fewer partners. Moreover, the investment component of transaction costs is anticipated to be higher in OCR models because of efforts to build closer ties with suppliers.

In respect of the case evidence, it could be argued that whilst the extent of goodwill trust was apparently high (especially in the Warwickshire case), the relational strategies involved “topping up” service benefits such that additional monitoring systems were put

in place. The latter will have increased current transaction costs and compounded the relatively high investment element of transaction costs anticipated to accompany goodwill trust.

However, it should be remembered that Sako (1991; 1992) did argue OCR models achieve lower total production costs than ACR alternatives because, “the normative values governing OCR elicit greater work effort, and hence higher X – efficiency” (p 22). Indeed, this view is supported by Dore’s (1983) research.

Despite this, and to maintain a balanced perspective, it should be noted that OCR models could inhibit contestability of local health markets, with subsequent considerations for their relative performance. As Sako (1992) recognised, “goodwill trust is a powerful springboard to unleash effort, but at the same time is prone to closing off access by outsiders. The beneficial effects of trust in creating constant, reliable expectations, may thus turn into excessive rigidity”, (p48). Indeed, this view should be considered in light of the evidence from the national NHS Trust survey indicating that contestability was already an important problem in terms of capital constraints, and the existence of complex patterns of preferred – provider behaviour.

Lastly, care should be taken in assessing the impact of trust on health markets through a constrained number of case studies. Accepting the systems or institutional approach (Hodgson, 1988), it is clear that purchaser – provider relations will depend upon a range of causal factors (as Chapter 5’s empirical evidence suggests). Furthermore, these factors will be economic, political, ethical, historical and sociological. Thus interpreting evidence on the nature of trust in the local health markets studied, and then developing general theories from these findings is difficult because of the “white noise” generated by this vast range of economic and non – economic causal factors. This reaffirms the arguments of Granovetter (1985), Etzioni (1988), and others critically reviewed in Chapter 3. As Etzioni (1988) argued, any market, including a local quasi – market in health care is,

“A subsystem of a more encompassing society, polity, and culture. It is assumed therefore that the extent to which it is efficient cannot be studied without integrating social, political and cultural factors”, (p 5).

CHAPTER 7

Conclusions, Future Prospects and Recommendations

7.1 Introduction

This chapter presents the principal conclusions drawn from the current research as a whole. These highlight the study's contribution to the academic literature. Individual chapters concentrated on specific issues in detail, e.g. Chapter 5 provided an evaluation of the national postal survey of NHS Trusts and District Health Authorities in England. Throughout, there has been an emphasis upon critical consideration of theories, applied studies, research methodologies, and research findings.

In addition to presenting the key conclusions, this chapter has a number of related objectives. Firstly, some tentative predictions are made regarding the likelihood that relationship marketing strategies will continue to be of importance following the “new” co-operative NHS arrangements associated with the 1997 White Paper. These predictions are driven by evidence from the Case Studies, and the LOGIT models developed from the national NHS Trust database. Secondly, this chapter makes a number of recommendations on how the current research could be extended to further fill gaps in the existing literature.

7.2 Restatement of the Central Hypothesis and Related Objectives

This study is based upon a central hypothesis, and a number of related objectives.

A. Central Hypothesis:

H₁: the extent to which NHS Trusts deployed relationship marketing strategies within the NHS Internal Market has been greatly underestimated. Subsequently, analysis is required to identify the causal factors behind such behavior.

Meanwhile, the null hypothesis, H₀, stated that:

Relationship marketing strategies were of minimal importance to NHS Trusts within the NHS Internal Market. Subsequently, there is no justification for attempting to identify the causal factors behind such behavior.

B. Related Objectives:

It was also argued that trust was central to the successful development of relationship marketing strategies. Subsequently, a series of Case Studies was used to provide qualitative evidence on the relative importance of Sako's (1991; 1992) competence, contractual, and goodwill trust within the contract process. In addition, it was recognised that these Case Studies could be used to provide evidence regarding the negative aspects or downside to relational strategy development by NHS Trusts, and the likelihood that relational marketing strategies would become more or less important under the "new" NHS arrangements (DoH, 1997).

7.3 Key Conclusions

7.3.1 The existing literature has underestimated the importance of relationship marketing within the NHS Internal Market, and more significantly, its impact on the operation of quasi – markets in social welfare in general. There have been few efforts to systematically study pro – active relationship building by quasi - market providers, and the subsequent experiences of their purchasing agents.

7.3.2 The paucity of such literature is an overriding consequence of the predominance of Quasi – market theory (Le Grand & Bartlett, 1993) in the evaluation of the NHS Internal Market. With its basis principally in Neoclassical economics, this Theory treats the firm as a "black box", with governance as an exogenous factor. This approach subsequently ignores that governance procedures and the social environments within which they work, affect stakeholders. The only sense within which purchasers build or do not build a relationship with a provider is in respect of their evaluation of the relative marginal costs and benefits associated with adversarial contracting.

7.3.3 Where studies based on Quasi – market theory do refer to relational strategies, the evidence is subsequently often only anecdotal (Prevezer, 1996). Moreover, where studies

have evaluated relationship building in a more systematic way (Ferlie, 1994; Ferlie & Pettigrew, 1996), this has been achieved through the analysis of networking rather than the application of the relationship marketing paradigm. Most importantly, underlining the contribution of the current research, those studies (Wilcox & Conway, 1998; Hatton & Mathews, 1996) which make explicit attempts to apply relationship marketing, were only at an embryonic stage. Hatton and Mathew's (ibid) study was only based upon two NHS Trust case studies, whilst Wilcox and Conway's (1998) provided only anecdotal evidence, focusing more upon why relationship marketing was relevant to the NHS Internal Market. Ironically, in drawing their conclusions, both studies called for further detailed research of relational strategies within the NHS to be carried out.

7.3.4 The current research also demonstrates that whilst alternative theoretical frameworks for the evaluation of relational oriented strategies do exist, i.e. Contract theory, Reputation theory, Porter's model, and Evolutionary theory, they are associated with a great number of theoretical and conceptual problems in their application. Moreover, none of them provide a systematic, relevant framework for evaluating relational behavior within a quasi-market in health. Consequently, in Chapter 2, a strong case was made for the application of the relationship marketing (RM) paradigm, although it was noted this paradigm was closely allied with a number of other paradigms, e.g. networking.

7.3.5 Whilst there are some caveats associated with the postal survey analysis, and the need for caution in generalising results drawn from the limited number of case studies presented, the current study has provided strong evidence that NHS Trusts practiced relationship marketing strategies within the NHS Internal Market. Thus there is strong evidence of the predominance of Sako's (1991; 1992) "goodwill" trust being fundamental to the operation of the quasi – market in health. Of note, whilst the intensity of exposure to RM recorded by DHAs was lower than the analysis of the NHS Trust database would imply, it was found that DHAs had widely experienced RM strategies. This is significant because previous evidence, e.g. (Paton, 1998) suggested that where efforts by NHS Trusts were made to build closer relationships, this was focused primarily upon GP fundholders. Indeed, the Case Studies presented in this study suggested in part that because of the importance of GP fundholders risk income, some NHS Trusts did concentrate efforts upon this group of purchasers rather than DHAs. However, the national postal survey evidence, based on a large and representative sample, suggests risk income was only one

factor driving NHS Trusts relational strategies, and that both DHAs and GP fundholders experienced such behavior.

7.3.6 Moreover, in addition to evidence regarding the great extent to which relational strategies occurred, the complexity of relational behavior in the NHS Internal Market is further suggested by the array of types of strategies deployed. Typically, NHS Trusts used a portfolio of relational marketing strategies including contract augmentation, contract customisation, and a whole series of risk avoidance measures.

The latter included loyalty discounting, default contracting, and the inclusion of cost-sharing elements within contracts.

7.3.7 More generally, the postal survey analysis demonstrated the importance of “strategic” oriented marketing behavior by NHS trusts. Evidence was presented in Chapter 5 indicating the strong customer orientation of NHS Trusts towards their purchasers.

7.3.8 Despite the strength of supporting evidence for the existence of relational contracting driven by RM strategies within the NHS Internal Market, the research also identified elements of the contracting process associated more closely with other theoretical models of contracting, i.e. classical, regulatory, and pseudo contracting. However, it should be noted that the extent of support for the predominance of the relational contracting model is overwhelming, and suggests the alternative contracting models are far less significant than others expected (Bennett & Ferlie, 1996). Moreover, whilst Bennett and Ferlie’s (ibid) limited empirical evidence suggested it was not possible to identify the direction of change towards the predominance of any specific theoretical model of contracting, the current research refutes this claim. The Case Studies in particular identified the predominance of adversarial, classical based contracting in the early stages of the Internal Market, giving way to relational oriented contracting by its demise, with particular importance placed on Sako’s “goodwill” trust (1991; 1992).

7.3.9 The empirical analysis and Case Studies identified an important set of drivers of NHS Trusts relational marketing strategies. However, it was noticeable from the Logit analysis that a number of independent variables believed, *a priori*, to be statistically significant were found not to be so. Of particular note was the relatively poor performance of the number of competitors in explaining NHS Trusts predilection towards relationship

marketing (RM) strategies. There is an important paradox for economists in the interpretation of relational strategies: primarily, economists perceive RM as a means of providers reducing competition, by ensuring health markets are less contestable. This is unsurprising given that orthodox economics assumes exchange takes place in an adversarial environment. On the other hand, marketeers perceive RM enables more effective competition through co – operation!

Of note for economists, the evidence suggests that of the two most significant relationship marketing strategies, identified through evaluation of the national postal surveys, one was demand side and the other supply side oriented. Contract augmentation was initiated by providers, i.e. was supply side led, whilst contract customisation was initiated by purchasers, i.e. was demand side led. However, evidence from the case study suggests in each case negotiated outcomes were reached, although power relations differed between specific purchasers and providers. Despite this, implicit evidence of mutually agreed outcomes occurring is provided by the strong evidence of purchasers and provider agreeing be-spoke governance systems for monitoring the performance of augmented and customised contracts.

7.3.10 In respect of the empirical analysis of the NHS Trust survey, the Logit method proved to be a powerful tool for analysing the questionnaires dichotomous responses. The models for Contract customisation, default contracting, and cost – sharing provided robust general results. However, a number of important caveats should be specified. Firstly, it should be stressed that the actual drivers of relational behavior are complex. RM strategies in quasi – markets take place under conditions of “social embeddedness”, such that researchers face significant problems from “white noise”. The latter results from the interaction between government policy and legal frameworks, cultural traditions, social and moral norms, and individual preferences. Moreover, the latter factors are integrated with a wide set of economic factors including the nature of entrepreneurship, financial systems, and market conditions. An additional problem is the potential for mis-specification of variables. The Case Study interview with Warwickshire DHA revealed the importance of this potential difficulty: the Commissioning Manager stated “the problem with our sort of discussions is that you are framing them from a particular academic perspective, in contrast to reality”.

7.3.11 The Case Studies identified a series of causal factors behind NHS Trust's relationship marketing strategies. These were used for benchmarking with the findings from the empirical analysis of the national NHS Trust postal survey. Of note, the principal common factors identified were the desire to meet latent demand and also the rise of managerial professionalism, both of which would have been difficult to operationalise in respect of survey questionnaire design. Equally of importance, evidence from the national postal survey suggests clinical staff were central to the relationship building process between purchasers and providers, and central to contract negotiations. This in turn implies a limited success for national policy, (i.e. the 1989 DoH White Paper) in reducing the predominance of bio-engineering decisions made by clinicians in the allocation of health resource.

However, a number of caveats regarding interpretation of the case study evidence should be considered in order to inform proceeding research. Firstly, caution should be expressed regarding the predictive power of the case evidence, although in section 7.4.1 such evidence is used to tentatively consider the likelihood of relationship marketing becoming more or less prevalent under the "new" NHS arrangements.

It is conceivable that had the research selected a localised quasi - market in health in central London, for instance, important differences may have emerged regarding the extent of contract customisation and augmentation, the nature of trust, degree of opportunistic behaviour and perceived drawbacks of relationship marketing activities. This is primarily because the drivers of such behaviour, e.g. the extent of local competitive culture, importance of joint ventures in the provision of patient services and the importance of risk income may have differed widely from the selected case studies, e.g. the Warwickshire case.

It is further noted that in order to reduce potential case study response bias and improve the predictive power of the case study findings an adaptation could have been made to the national postal survey questionnaire. It would have been possible at the end of the questionnaire to identify whether respondents to the national postal survey of NHS Trusts and District Health Authorities would have been willing to participate in face to face semi - structured interviews. This would have enabled the development of a larger number of contrasting case studies, although practical difficulties would have arisen in matching

specific NHS Trusts with the appropriate District Health Authority given the importance placed on anonymity in completing the postal questionnaires. It was argued in Chapter 4 that anonymity in completion of the national postal questionnaires had a positive impact on the response rate given the commercial sensitivity of the requested contracting information.

7.3.12 Of note, in the Warwick Case Study a further driver of RM behavior was identified. Through offering “packaged” contracts, inclusive of a number of different elements within an episode of care, there was a dual incentive for purchaser and provider. The Contract Manager at Warwick General Hospital NHS Trust argued,

“For purchasers it reduced uncertainty in the forward planning process because patients were guaranteed seamless episodes of care. Furthermore, the ‘packaging’ of services reduced the uncertainty element for us, ensuring the stability and viability of Trust services into the future”.

Moreover, there was evidence of “side – payments” within the contract negotiations where as a consequence of packaging of contracts, the purchaser was increasing the degree of support for the minimisation of Trusts spare capacity.

Importantly in the context of current NHS reforms (i.e. March 2000), a good example would be side – payments made in terms of NHS Trusts operating facilities. These are typically used in two shifts between 8.30am and 6pm from Monday to Friday, and additionally in the case of acute emergencies. Moreover, NHS Trusts set prices for these facilities in April each year on the basis of capital charges and overhead costs.

The case evidence clearly identifies financial gains for the NHS Trust, if as a consequence of contract ‘packaging’, purchasers are persuaded to use such assets outside of general hours. This occurred in the Warwick case, enabling the Warwick General Hospital NHS Trust to partly recover its fixed costs, and enabled contracts to be negotiated on the basis of variable cost elements.

Similar dual incentives emerged where closer, personal oriented contracting relationships were developed through RM behavior by the Warwick General Hospital NHS Trust. The

subsequent increase in both Sako's (1991; 1992) goodwill and competence trust enabled The Trust and local GP fundholders to jointly re – evaluate the latter's spend on their drugs budget. Subsequently, GPs were encouraged to reallocate funds from this source to negotiate greater throughput of elective surgery. The consequence was again an increase in The Trusts utilisation of fixed assets, and a reduction in fundholder's waiting list times.

It is argued that a similar pattern of dual incentives favouring relationship marketing's development is likely to have occurred in other local health markets in England.

7.3.13 Equally of importance, the national survey evidence indicates that the pattern of preferred – provider behavior is much more complex than previous studies have suggested. Some 61% of NHS Trusts stated they had DHAs with preferred – providers. More importantly, this differential treatment of NHS trusts by DHAs was extended to cover governance procedures. From evaluation of the NHS Trust survey it was discovered that 31% of NHS Trusts experienced differential monitoring of contracts compared to other providers. Meanwhile, a further 20% of respondents recorded differences in the way outcomes of contracts were assessed compared to fellow Trust providers; and lastly, some 25% of responding NHS Trusts recorded differences in DHAs requirement for inclusion of default elements. This suggests the degree of Sako's (1991; 1992) competence and contractual trust was relatively low within a number of local health markets in England.

7.3.14 From a national health policy perspective, despite the rhetoric of market forces, it appears a high degree of co – operative behavior was active within the NHS Internal Market. In particular:

- a. NHS Trusts demonstrated their responsiveness to purchaser needs through contract augmentation and customisation
- b. Contract negotiations were built around “personal” rather than simply formal relationships
- c. Evidence suggested a high degree of joint – venture activity in the development of service innovation, and also existing service delivery

- d. There was a heavy emphasis upon building long – term relationships, i.e. beyond the annual contracting rounds imposed centrally on the NHS Internal Market
- e. On balance, DHAs as well as GP fundholders were exposed to NHS Trusts relationship marketing strategies
- f. Survey evidence demonstrated the wide portfolio of relational strategies deployed by NHS trusts. This implied NHS Trusts had corporate wide, well designed and implemented relational strategies to a far greater extent than researchers previously believed, e.g. Paton, (1998).
- g. DHAs typically exchanged commercially sensitive information with supposedly competing providers. It is notable that Government perceived the latter was relatively untypical behaviour in that the 1997 White Paper stresses potentially competitive data must be shared by all commissioning agents (DoH, 1997 White Paper).

These factors listed a through g above, limit the likely success of the “new” NHS arrangements in generating additional co – operative behavior. Moreover, this evidence is important because it demonstrates the failure of national policy for reasons other than the evaluation of static economic models, i.e. an evaluation of the extent to which local health markets did or did not generate Le Grand and Bartlett’s (1993) necessary conditions for their success. Meanwhile, from the perspective of relationship marketing theory it demonstrates that co – operation was used extensively, via relational strategies, as a means of reducing the potential impact of competitive forces.

7.3.15 The recorded high incidence of purchaser – provider joint ventures associated with the deployment of RM strategies in the NHS Internal Market has a further important implication.

Evidence provided by the Warwick case study highlighted the potential impact of such behavior upon both health output (i.e. the volume of treatments) and also health outcomes, i.e. changes in health status of patients. The Warwick General Hospitals NHS

Trust had, for example established partnerships with local dental and general medical practitioners. The consequence of these partnerships had been:

- a. Improved quality of the local primary care skills base through the up – dating and up –grading of clinical knowledge
- b. A reduction in excess demand for local health services of specialist consultants employed by The Trust
- c. The increased volume of patient throughput at the primary care level, supporting Government’s ambition for a primary care led NHS (Meads, 1996). The latter had arisen through the increased supply of higher skilled clinical staff in the local health market, and subsequent improvements (i.e. lowering in) referral rates by GP fundholders.

It is perceived that these results will have been repeated where local health markets had NHS Trusts committed to pro – active RM strategies.

7.3.16 A complex pattern of “trust” associated with the relationship building process was revealed through the Case Study analysis. The development of relational strategies by NHS Trusts has increased the degree of Sako’s (ibid) “goodwill trust” within the NHS Internal Market. However, ironically, this has in part been at the expense of lower competence and contractual trust: the use of augmented and customised contracts resulted in greater ex ante and ex post costs associated with necessary adaptations and extensions to existing monitoring systems. The reduction in competence and contractual trust is somewhat surprising from a theoretical perspective. Given the predominance of social norms and values in public service markets (Granovetter, 1985; Appleby, 1994; Wistow, 1996) and the greater relative importance of intrinsic motivational factors (Frey, 1997; 1998), it would be assumed that an increase in goodwill trust will not be accompanied by a comparative decline in competence and contractual trust.

The evidence on the high degree of importance placed upon goodwill trust is interesting in the context of the objectives of the NHS Internal Market reforms. Central to those reforms, Webster (1998) argued that purchasers would “place contracts for the delivery of

care with independent ‘arms length’ suppliers”, (p 5). The latter is associated with Sako’s (1991; 1992) ACR model, seen to be over – shadowed by the predominance of his OCR model within the context of the NHS Internal Market.

It appears on balance, based on the Case Study findings, that both competence and contractual trust increased as the quasi – market in health developed. Consequently, it may be argued that relational behaviour within the NHS Internal Market did increase trust between contracting partners. Subsequently, it is anticipated that purchasers and providers were able to economise upon

- a. bargaining costs
- b. monitoring costs
- c. insurance costs
- d. costs of dispute settlement

It was, however, not possible to quantify these changes.

7.3.17 The current study also enabled a qualitative evaluation of the downside of relational behavior by NHS Trusts. It is interesting to consider these in respect of the supposed benefits from quasi – markets identified by Le Grand and Bartlett (1993), evaluated in detail in Chapter 1.

7.3.18 In terms of responsiveness, it is argued that the large degree to which NHS Trusts augmented and customised contracts, established direct communications strategies, and responded to market segmentation, provides indirect evidence of greater responsiveness of providers to purchasers needs. Indeed, one of the postal survey questions asked NHS Trusts to rank the potential benefits of the quasi – market in health, and responsiveness to purchaser needs was deemed most significant.

7.3.19 Meanwhile, in terms of efficiency it is only possible to draw some tentative conclusions, given the lack of detailed information necessary to estimate the impact of relational behavior on economic or technical efficiency. However, it is suggested that the high degree of Sako’s (1991; 1992) goodwill trust identified through the Case Studies, and also the evaluation of NHS Trust and DHA surveys, implies a high degree of Liebenstein’s

(1966) x – efficiency. It will be recalled that Dore (1983), and Sako (1991;1992) perceive that gains in x – efficiency associated with obligated contractual relations more than compensate for the loss in economic efficiency arising because purchasers and providers exchange on a relational rather than adversarial contract basis.

7.3.20 Meanwhile, in respect of patient choice and access, the evidence strongly suggests that inequalities arose through the operation of relationship marketing strategies. Moreover, this pattern of inequality was complex in respect of a specific GP fundholder compared to another GP fundholder, GP fundholders compared to non – GP fundholders; GP fundholders compared to DHAs, and so on. Furthermore, of most significance, the evidence demonstrates that inequalities arising through relational behavior were measured in terms of levels of service provision, i.e. treatment quality. Many authors (Klein et al, 1996; Littlejohns & Victor, 1996; Paton, 1998) have documented the existence of a two tier primary care system resulting from the competitive advantage GP fundholders held over non – GP fundholders. However, these researchers have only measured inequality in respect of choice between hospitals or waiting list times.

Importantly, the current research has shown that some patients also benefited from additional service benefits, either peripheral to, or core to their physical care package. The latter arose where patient's GP fundholders or DHAs successfully negotiated augmented or customised contracts with providing NHS Trusts. Moreover, a further aspect of inequality arose through the development of relationship marketing strategies. Case Study evidence suggests that relational behavior by NHS Trusts raised the expectations of both GPs and patients regarding the types of extra service benefits they could typically expect to receive relative to others. If the “new” co-operative NHS arrangements result in a different pattern of relationship building, these patients and GPs may be disappointed if formally received additional service benefits are discontinued or phased out.

7.3.21 However, it is clear from such a qualitative analysis it is impossible to identify the net benefits of relational oriented behavior within the NHS Internal Market, and furthermore, it is not possible to identify the counterfactual model.

7.3.22 It is further argued that the wide extent to which relationship marketing strategies were used in the NHS Internal Market has consequences for Le Grand and Bartlett's (1993) necessary conditions for the success of quasi – markets evaluated in Chapter 2.

7.3.23 Some reference has already been made to efficiency, and it is only pertinent here to reiterate that on balance, evidence from the national postal surveys and supporting case evidence would imply the predominance of OCR rather than ACR (Sako, 1991; 1992) behaviour within the NHS Internal Market. Thus, *de facto*, following Dore (1985) and other relational contract theorists it is argued that total costs are anticipated to have been lower in the NHS Internal Market than would have prevailed within a health quasi-market dominated by adversarial contracting. What is not possible, is to gauge whether total costs would have been lower still within a bureaucratically planned system of health care.

7.3.24 In respect of information, it appears that relational marketing strategies were responsible for the generation of additional management information of relevance to the contracting process. For instance, there was widespread evidence of:

- a. development of “personal” channels of communications between buyers and sellers;
- b. widespread co – sharing of data collection, collation, and analysis regarding the contracting process, (even commercially sensitive data);
- c. deployment of regular purchaser and patient satisfaction surveys;
- d. development of specialised management information systems for purchasers at zero accounting cost;
- e. development of bespoke monitoring systems for contracts

Of importance, the development of information elements of relational strategies by NHS Trusts supports Penrose (1959) view of the “learning organisation” considered in Chapter 1. However, the Case Studies revealed that there was a perception among purchasers and providers that the quality, breadth, and coverage of information regarding contracts was

still limited. One interesting possibility is that relational behavior further highlighted the deficiencies of contracting information systems.

7.3.25 Theoretically, it may be argued that relationship marketing strategies reduce contestability (Dore, 1983; Sako, 1991, 1992), their priority being to tie in purchasers to specific providers. It is not clear from the evidence, however, whether the widespread deployment of relational strategies would, per se, make health markets less contestable. The postal surveys did indicate a series of factors perceived to be important in determining contestability. These included capital constraints; the extent of preferred – provider behavior; the extent to which contract related information was shared amongst purchasers and providers; and also the extent to which NHS Trusts were engaged in joint service delivery. The latter was argued by Appleby et al (1994) and Renade (1995) to be of only marginal importance in determining the extent of contestability, although the weight of evidence from the current research refutes this claim.

Clearly, DHAs were highly aware of the importance of “exit” costs in determining whether switching between providers occurred. Indeed, this awareness resulted in an emphasis on “voice” as opposed to exit mechanisms (Hirschman, 1970), the former being an integral element of relationship marketing, e.g. achieved through direct communication strategies.

7.3.26 The evidence also suggests NHS Trusts widely deployed risk avoidance strategies, i.e. default elements in contracts, cost – sharing agreements, and efforts to develop purchaser loyalty through offering additional service benefits. In principle, these will reduce ex post transaction costs but at the expense of higher ex ante transaction costs. It is important to recall, however, that Contract theory (Milgrom & Roberts, 1982; Grossman & Hart, 1986) stresses it is not feasible to plan for all possible contingencies in the face of uncertainty, given the omniscience of bounded rationality. Moreover, evidence suggests that contracts offering additional service benefits required additional monitoring systems, which in turn increased the possibility for dispute ex post. These may have counter – balanced any reductions in ex post costs associated with risk avoidance measures. It is vital, theoretically, to recognise that,

“For a given level of benefit (a given level of cost and quality) the costs of contracting for welfare services, including ex ante and ex post costs, must be less than the costs of the administrative system they replace”, (Le Grand & Bartlett, 1993, p.30).

However, it is infeasible to estimate whether the relational strategies of NHS Trusts improved, or reduced the Internal Markets ability to satisfy this condition.

Despite this, it is possible to argue that cost – sharing and default contracting strategies will reduce the importance of Williamson’s (1979; 1996) ‘hold – up problem’. This is because there is less uncertainty regarding providers’ income stream flowing from particular purchasers where such contract elements are included.

Relationship marketing strategies will tend to make purchasers less foot – loose, providing more certainty over the share of pay – off from a specific investment by an NHS Trust (Grossman & Hart, 1986). This is especially important where sunk costs are significant, e.g. as with investment in CAT body scanning units.

The sectoral analysis presented in Chapter 5 supports this argument, with empirical evidence suggesting that over one third of responding NHS Trusts drew up cost – sharing contracts for the “average” case scenario. Meanwhile the appropriate figure for loyalty discounting was nearly a fifth, and the corresponding figure for default clauses was nearly two thirds.

Equally important, from a theoretical perspective (Grossman & Hart, *ibid*) is the inclusion in default type contracts of additional performance measures at the initial contract negotiations stage. These will typically deal with a range of financial and non- financial contingencies. Whilst it is not feasible to include all possible contingencies (given bounded rationality), default contracting does enable purchasers and providers to commit to a sale price for health services under many circumstances. This reduces the possibility for opportunistic behavior by the purchaser, which is of considerable importance where demand for health services is volatile.

7.3.27 Lastly, following Le Grand and Bartlett (1993), it is recognised that in principle, quasi – markets establish a correspondence between need and consumption in health, and thereby ensure equity in service provision. The arguments regarding possible failure of quasi –

markets to achieve this due to cream – skimming behavior are widely reported (Propper, 1995; Le Grand & Bartlett, 1993) and evaluated in Chapter 2. In essence the debate has focused upon structural aspects of contracts:

- with cost per case contracts, with equal prices per patient regardless of patient needs, there is an incentive to cream – skim patients
- similarly, with block contracts, with no explicit reference to volume, there is a positive incentive to cream skim patients

However, this focus fails to recognise that the evaluation of the impact of contract design on cream skimming needs to be adapted to include consideration of relationship marketing elements. Case Study evidence indicated that NHS Trusts successfully used contract augmentation and customisation to cream skim those purchasers whose income was relatively foot – loose, i.e. GP fundholders. It should be recalled, however, that the case studies presented represented only a statistically small sub - sample of all localised quasi - markets in health in England.

7.4 Future Prospects for Relational Strategies

As of the 1st April 1999, the NHS Internal Market was abolished, being replaced with a system based upon the co-operative rather than competitive provision of secondary health care (DoH, 1997).

This section briefly considers whether relationship marketing strategies will become more or less likely within the “new” NHS arrangements. It is sub – divided into two sections: one presents evidence from the face to face Case Study interviews, and the other makes a number of predictions based upon the Logit models of Chapter 5. It is emphasised that in predicting the likelihood of relationship marketing becoming more or less prevalent under the “new” NHS arrangements, caution should be expressed given the methodological caveats associated with the Logit modeling and case analysis which were considered in detail in Chapter 4.

7.4.1 Case Study Evidence

One key aspect referred to by all interviewees was the significance of increased buyer concentration associated with the establishment of Primary Care Groups (DoH, 1997 White Paper). The general perception was summed up by the contracts manager for Warwick General Hospital NHS Trust,

“In the PCG there is a lot more muscle there, and potentially if it were abused it could seriously affect relationships”.

This concern was further supported by the Dudley DHA commissioning manager who claimed,

“From the perspective of the PCG, I think it will add to the discerning nature of the purchaser. PCGs are less fragmented than GP fundholders were and will probably have, therefore, more chances to behave opportunistically in their relationship with NHS Trusts”.

Furthermore, he expressed the view that extra monitoring would be required of Primary Care Trusts, reflecting an expectation of low levels of contractual trust (Sako 1991; 1992) during their “take off” phase. More specifically, he perceived there was an opportunity for PCGs and Primary Care Trusts to destabilise NHS Trust hospitals,

“There is going to be a need for additional control and very close monitoring when combined, PCGs and Primary Care Trusts will be exercising considerable power for the first time. It’s quite a vulnerable, misty position for NHS Trusts”.

This was a significant comment, given earlier evidence for the Dudley case that their local health market was primarily based upon co – operative behavior, with contract switching very rare. Equally of note, the DHA commissioning managers counterpart at the Dudley Hospitals Group had a diametrically opposed opinion regarding the impact of greater buyer concentration on the future of relationship marketing strategies,

“I think there is even less possibility for fragmentation of service levels. I also think the importance of ‘risk income’ will also be minimalised”.

Moreover, in general his perspective was that the former pattern of relationships operating in Dudley under the NHS Internal Market, (i.e. a low emphasis on relational strategies) would continue. He claimed,

“There’s recognition this time round that we are all in it together. It would be great folly, therefore, to start making major movements in contracts unless there is a very serious break – down in quality”.

A second recurring theme was the importance of learned behavior on future relational strategies. In essence there was concern that a “quality gap” (Willcox and Conway, 1998) would emerge following the reforms. GP fundholders who were used to being offered additional service benefits would now witness a difference between their expectations and actual service levels. It should also be recalled from Chapter 6 that interviewees had argued this quality gap would also be perceived by the patients. The Walsgrave NHS Trust contracts manager stated,

“It is noticeable to me that those GPs who were at the forefront of GP fundholding appear still to be at the forefront of PCGs. By definition, they will bring forward some of their agenda from fundholding, especially negotiation of preferential contracts into their PCG boards”.

This view was further supported by Walsgrave’s former Internal Market competitor, i.e. Warwick General Hospital NHS Trust. The contracts manager stated,

“I think that those interested in setting additional service benefits, or quality standards, or monetary targets within GPFHs will continue to push on these aspects within the Primary Care Groups”.

Moreover, he stressed that regardless of the impact of learned behaviour, there was necessarily a transition phase between the cessation of the NHS Internal Market and the

“new” NHS arrangements, stating there was “a lot of relationship building to be done”. He further argued,

“There has to be a stabilising factor, so that augmented contracts can be continued, or withdrawn with some way of dealing with the exit costs”.

The third recurrent theme regarding the future of relationship marketing within the reformed (DoH, 1997 White Paper) NHS was the focus on incentive mechanisms within the “new” arrangements. The contract manager at Warwick General Hospital NHS Trust stated,

“We’ve still got service agreements; we’ll still have risk income, and yes, we’ll still have incentives to move, and reshape services”.

This view was supported by his counterpart at the DHA, who perceived that a completely new form of contract would emerge. He argued that these new service agreements would not focus upon volume and monetary aspects, which would be, “left for managers to brush up on”, but instead,

“will increasingly focus upon putting in more things like additional services, quality protocols, the shape of services, and so on”.

On balance, it appears there is overwhelming support for relationship marketing strategies continuing to be of importance under the “new” NHS arrangements. Clearly, however, this view is drawn tentatively within the context of the continual fine - tuning of national policy in health care. As one interviewee argued,

“Government has got a path worked out. One gets the feeling that things that are discussed now, centrally, are probably not more than three months ahead of where we are now! I wouldn’t say policies are developed on the hoof, but not far from it.”

7.4.2 Predictions from the Logit Analysis

A key consideration is the impact of reforms on relationship building between purchasers and providers. Of most importance is the transition from GP Fundholding towards new Primary Care Groups. For instance, in the Dudley DHA this means the replacement of sixty-three GP practices with five Primary Care Groups, which in essence are large multi-fund GP Fundholders.

The strongest suspicion, based on economic theory, is derived from consideration of the new demand and supply conditions in the “new” NHS. The designation of Primary Care Groups (DoH, 1997) implies a higher degree of concentration on the demand side (i.e. purchasers). Moreover, further Department of Health reforms (DoH, 1997) will tend to heighten concentration on the demand side, i.e. through the evolution of Primary Care Trusts from Primary Care Groups. An excellent summary of Primary Care Trusts objectives is to be found in Pearson and Merry (1998). Of particular relevance to the evaluation of relational marketing, however, Primary Care Trusts will have the following functions:

- a. The commissioning of health services for their populations
- b. The monitoring of performance of NHS Trusts against targets
- c. The development of primary care by joint working across practices
- d. The development of integrated primary and community care services
- e. The encouragement of closer joint working between health and social services in the provision of seamless episodes of care

Given these stated objectives, it is notable that the current research has provided strong evidence that the development of relationship marketing strategies within the NHS Internal Market had resulted in

- i) The bespoke monitoring of augmented and customised contracts offered by NHS Trusts
- ii) The widespread use of joint ventures in the provision of existing and innovative patient services between supposedly competitive providers

- iii) The use of a wide portfolio of relationship marketing elements by NHS Trusts, e.g. loyalty discounting, default contracting and customised contracts to develop closer relationships with purchasers

Furthermore, given that the supply side (i.e. providers) will remain typically oligopolistic due to geographic constraints on the number of providers, and the lack of extra contractual referrals (ECRs) the most likely outcome is movement towards bilateral monopoly. The latter would imply a higher incidence of collective bargaining in secondary health care, both in respect of the prices of contracts (i.e. cost per activity level), and non-price competitive elements (Varian, 1998). Of particular importance to the current research, the latter involves more intensive bargaining towards the types of relationship marketing analysed in Chapters 4 and 5, i.e. contract augmentation and customisation, cost -sharing and default contracting.

However, taking demand side effects in isolation, *ceteris paribus*, it may be argued that for NHS Trusts, the significance of risk income associated with formerly footloose GP fundholders will disappear. Subsequently, it may be argued that there will be less incentive to customise and augment contracts as a means of encouraging purchaser loyalty. To counter balance this perspective, (that efforts to augment and customise contracts will diminish), it may be argued that former GP fundholders have come to expect contracts to be augmented, and customised under the NHS Internal Market. As the Case Study evidence cited above demonstrates, their experiences and expectations then form part of learned behaviour for the Primary Care Group as a whole. Moreover, this learned behaviour may be transferred to Primary Care Trusts as they evolve from Primary Care Groups.

Furthermore, should a Primary Care Trust make a credible threat (Lyons, 1991) in respect of their intention to switch contracts between providing NHS Trust hospitals, the risk to an individual NHS Trusts income will be heightened. This is primarily because the Primary Care Trusts relative share of the NHS Trust hospitals total income will be statistically more significant than that of a former individual GP fundholder or indeed a multi - fund practice. Subsequently, to protect risk income NHS Trusts will find it necessary to continue with such non-price competitive strategies associated with relational oriented contracts developed during the operation of the NHS Internal Market.

Some caution should be expressed in interpreting the predictions made from the Logit models presented below. Apart from the general caveats regarding Logit models considered in Chapter 5, it should be noted that:

- a. The reforms associated with the "new" NHS arrangements (DoH, 1997) are complex and at an early stage of implementation at the time of writing.
- b. The evidence on which the development of the Logit models is based relates to relational behaviour within the former NHS Internal Market.

In respect of the likelihood of loyalty discounting continuing, the impact of the "new" NHS arrangements are more predictable. In theory, the transition to a co-operative NHS culture, the extension of service agreements from one to three years, and the development of local Health Improvement Programmes (DoH, 1997 White Paper) will reduce its relevance. Moreover, it should be recalled that only nine percent of responding NHS Trusts responding to the national survey incorporated loyalty discounting in their relationship building strategies.

With closer reference to the Logit modelling of Chapter 5, a number of predictions are offered consistent with the theory outlined above. From Model B (contract customisation) it is predicted that transition to the "new" NHS arrangements will reduce the influence of a number of independent variables, i.e. the importance of preferred-providers and competitive culture to contract customisation strategies. Similarly from Model A (contract augmentation) it is argued that development of a co-operative, non-competitive culture will lead to a reduction in the significance of the independent variables for preferred-providers, and competitive culture. Consequently, a reduction in contract augmentation is likely.

In respect of loyalty discounting, the empirical results support the theoretical reasoning. The co-operative commissioning of secondary health care services will effectively reduce supply side conditions to the monopoly case. Subsequently, the effective reduction in numbers of competing providers will reduce the impact of this independent variable on loyalty discounting. Moreover, the likely decline in service augmentation behaviour in a

co - operative NHS environment will further reduce the importance of loyalty discounting.

From model D, (cost-sharing) it is predicted that increasing emphasis on quality in addition to the cost and volume of episodes of care will increase the likelihood of cost-sharing. Furthermore ex ante transaction costs may rise with associated additional costs of monitoring the quality of health outcomes, the latter lending itself to considerable disagreement regarding appropriate measurement (Drummond & Maynard, 1993; Gray, Harrison, & Barlow, 1998).

Furthermore, from Model D (cost-sharing), it is predicted that an increase in outcome measurement would increase the likelihood of cost sharing, which in turn could result in an increase in default contracting as analysed in Model E (default contracting). We may add further for Model E that within a co-operative NHS, individual NHS Trusts will increasingly undertake joint ventures in service provision, such that default contracting is likely to become more prevalent.

7.5 Recommendations for Further Research

This section evaluates a number of opportunities for extending the current research programme, and undertaking related research.

Proceeding research could deploy Stone and Woodcock's (1995) 'cornerstones' framework to evaluate the extent of and determinants of relationship marketing (RM) behaviour under the "new" NHS arrangements (DoH, 1997).

In respect of the institutional focus, evidence could be drawn from the principal agencies in the newly restructured NHS, i.e. Primary Care Groups, Primary Care Trusts, District and Regional Health Authorities and Social and Community Care providers.

A national postal survey questionnaire could be designed and sent to all of these principal agencies. This is viable given that the current research demonstrates:

- a. The feasibility of managing national postal surveys with multiple groups of respondents
- b. That the investigation of the complex concepts of relationship marketing can be operationalised via questionnaires in such a way as to encourage high rates of response and completion of questionnaires.

Moreover, the survey questionnaire could be used to identify potential participants for face to face interviews. In turn, these could be used to generate a series of contrasting case studies. It will be recalled that increasing the numbers of case studies beyond the limited number presented in the current research would reduce statistical bias and increase the predictive power of the case studies. However, it is re-emphasised here that there is a strong general case for the use of a combined research methodology regardless of the number of case studies selected.

The combined research methodology would enable:

- a. A comparative analysis of differences in the extent and nature of RM between the former NHS Internal Market and the "new" NHS arrangements drawing upon evidence from the current research
- b. Identification of similarities and differences between the drivers of any RM behaviour observed under the NHS Internal Market and the "new" NHS arrangements

In respect of points a and b above, there is the clear caveat, however, that the negotiators involved in developing RM strategies under the different NHS structures will be different and have different sets of objective functions and incentives to develop RM strategies. Researchers must overcome this hurdle.

- c. Development of the theory of relationship marketing. For instance, empirical investigation of RM behaviour under the "new" NHS arrangements may result in adaptations and extensions to Stone and Woodcock's (1995) framework. This new framework may be more appropriate to the investigation of the

nature and extent of relationship marketing behaviour not only in health care, but also in related areas of social welfare.

d. An exploration of how structural changes to the NHS influence the likelihood of relationship marketing behaviour. This requires further empirical investigation, given that the case study analysis suggests that some elements of relationship marketing strategies prevailed prior to the introduction of the NHS Internal Market, whilst the national postal survey identified that RM behaviour was complex and widespread during the years of the NHS Internal Market. One key issue to be further explored is how structural changes to the NHS change the incentive mechanism for deployment of RM strategies.

Moreover, the proceeding research could extend the current research in several ways. Firstly, in respect of the empirical investigation, the proceeding research could employ multinomial Logit models (Maddala, 1983; Greene, 1997). This would enable the statistical investigation of the extent of respondent's agreement or disagreement with statements. Thus questions can be designed and analysed which do not simply involve discrete choices, i.e. "do you agree or disagree?" with a limited option of responses of "yes" or "no" (see Appendices 1,2 and 3). With multinomial Logit models, investigators can evaluate the statistical significance of respondent's strength of agreement or disagreement across, for example a 5 or 6 point Likert scale (Maddala, *ibid*; Greene, *ibid*).

An additional extension to the current research would be a greater emphasis given to the evaluation of the impact of relational behaviour on a wider range of stakeholders in health care services. Evidence from the current research indicates the impact relationship marketing behaviour within the NHS Internal Market had on patient's access to and choice of health services. For instance, pro - active GP fundholders, acutely aware of their ability to switch contracts were able to demand customised contracts from providing NHS Trusts. This was primarily because GP fundholder's income was critical risk income to the NHS Trust. As a consequence, their patients received customised care packages which patients of less pro - active GP fundholders or none - GP fundholders did not.

Given the caveats expressed in Chapters 4, 5 and 6 regarding the statistical significance of findings based upon a limited number of case studies, it is argued that the case study

evidence is noteworthy. The evidence presented regarding the impact relationship marketing had upon the distribution of customised or augmented care packages among service users suggests the need to directly evaluate the impact of relationship marketing upon patients well being. One possibility is the deployment of focus group analysis (Gray, Harrison and Barlow, 1998) or the incorporation of Quality Function Deployment methods (Tang and Puay-Cheng Lim, 1999) to gauge the impact of relationship marketing upon the perceived quality of patient care. The latter is justifiable, given that regardless of the structure of health care provision adopted by the NHS, the principal - agent problem maintains its presence (Mooney, 1994).

A further extension to the current research would be a technical evaluation of the nature of trust within relationship marketing strategies of NHS Trusts. An empirical analysis could be undertaken which measures outcomes of trust, for instance, deploying a structural model similar to Morgan and Hunt's (1994). This would enable detailed analysis of the key elements of trust, including:

- a. The extent of acquiescence, and propensity to "exit" within purchaser – provider relationships
- b. The nature of co – operation
- c. The impact of functional conflict in relationship building
- d. The impact of uncertainty on the form of contract negotiations.

These factors all have relevance for economists as well as marketers, and the focus of the research could be the nature and impact of trust within the new NHS commissioning process for secondary care services. This would allow cross- comparisons to be made of differences in the nature and importance of trust between all commissioning agents, i.e. Primary Care Groups, NHS Trusts, Primary Care Trusts, DHAs and Local Authorities. This research would be of primacy in the context of the deepening emphasis the Department of Health places upon co – operative delivery of seamless health and welfare services.

It is also argued that recent structural reforms to the NHS (DoH, 1997) provides the opportunity to further investigate the extent, determinants and impact of networking

behaviour (Ferlie and Pettigrew, 1996). The networking paradigm evaluated in Chapter 2 is closely allied with relationship marketing with its shared emphasis upon:

- a. The centrality of trust and reputation in exchange relationships
- b. The importance of joint - ventures in enhancing networks
- c. The centrality of long - term relationship building between exchange partners
- d. Ensuring the benefits from networking are being maximised where there is a high value added in service provision.

It is clear, however, that in order to systematically investigate networking in NHS health care a series of fundamental methodological difficulties must be overcome. These were considered in detail in Chapter 3. It is, however, pertinent here to highlight the problems of operationalising the core concepts associated with the networking paradigm (Nohria, 1992; Best, 1993).

In particular, proceeding research will have to develop surrogate measures for entrepreneurial behaviour, corporate broking and social embeddedness. Despite these difficulties, the current research demonstrates through the application and evaluation of Sako's (1991; 1992) typologies of trust, how complex and commercially oriented concepts can be suitably adapted in support of the objectives of academic research.

Finally, the paucity of studies systematically evaluating relationship marketing strategies in health care in England is mirrored within other public services, e.g. in secondary State education. Moreover, the extent of opportunities for this type of research are perceived to be large given the continuation of a relatively large number of quasi – markets in the public services, and the ever growing emphasis placed upon public – private partnership in the delivery of welfare in the UK. A similar methodology to the current study could be used to build a national database on secondary education and develop a series of relational hypotheses, which could subsequently be statistically tested using Logit modeling techniques. Supporting case studies would enable the application of Sako's (1991; 1992)

concept of trust. Thus the nature and extent of goodwill, contractual and competence trust could be explored.

It is anticipated that the national postal survey and supporting case studies would focus upon the relational interface between secondary schools, institutions of further and higher education, Local Education Authorities and other relevant government and private sector agencies.

Furthermore, the statistical models developed could be refined to include multinomial Logit techniques. This would allow the author to model qualitative data in terms of strength of response (Maddala, 1983; Greene, 1997), e.g. the extent to which respondents agreed or not on a five point graduated scale, rather than restrict the Logit modeling to discrete, 'yes' or 'no' responses.

APPENDIX 1

NATIONAL PURCHASER - PROVIDER SURVEY

Trust Questionnaire

1 (a) Please indicate the type of Trust unit.

- Acute Hospital
- Community
- General & Community Hospital
- Community & Mental Health
- Mental Health
- Other (Please specify)

(Please tick box)

1 (b) When did you achieve Trust status?

--

 Year

1 (c) Please indicate the number of alternative providers of services in your area (ie within a 30 minute car travel radius).

No's

--

1 (d) To what extent would you agree a genuine purchaser/provider split was implemented within your health authority area?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

1 (e) To what extent would you agree your Trust was aware of the service capacity of competing providers in your area?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

1 (f) Did your Trust attempt to measure the capacity of competing service providers in your area?

Yes	No
<table border="1" style="display: inline-table; width: 80px; height: 20px;"></table>	<table border="1" style="display: inline-table; width: 80px; height: 20px;"></table>

(Please tick box)

If yes, please give brief details of the capacity measures used.

Type of capacity measure

1 (g) Please indicate the importance of capital resources as a barrier to your Trust introducing 'new' treatment services.

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

- 2 (a) Does your Trust jointly gather data on local health needs with the Health Authority in order to develop 'new' patient services?

Yes No

--	--

 (Please tick box)

- 2 (b) Please specify with whom you have organised joint ventures in service delivery since 1991.

- Other Trusts
- GPFH's
- Non-GPFH's
- Private sector

Yes	No

(Please tick box)

- 2 (c) To what extent have joint ventures with local Trusts been significant in providing existing services and developing 'new' patient services since 1991.

	Very Important	Important	Neutral	Not Important	Insignificant
Existing Services					
New Services					

 (Please tick box)

- 3 (ai) Was the contracting process based on a close working relationship between a few key Trust personnel?

Yes No

--	--

 (Please tick box)

- 3 (aii) How important was the involvement of clinical staff in the contracting process?

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

- 3 (aiii) To what extent do you agree building **personal** relationships with purchasers is a vital part of the contracting process?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

- 3 (aiv) How important did you consider your **formal** relationship with the purchasing bodies within the contracting process?

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

- 3 (bi) Did the Trust attempt to develop long-term relationships with purchasers as part of the contracting process?

(Long-term here implies longer than the 12 months standard accounting period).

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

- 3 (bii) How important were these long term relationships with purchasers within the contracting process?

Very Important	Important	Neutral	Not Important	Insignificant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

- 3 (c) Did contracts with purchasers define clear output (ie volume) measures?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

- 3 (ci) Did contracts with purchasers define clear health outcome measures?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

- 3 (d) Please specify whether your Trust offered the following to purchasers as part of the contracting process:

- Loyalty discounts
- Volume discounts
- Other, please specify

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

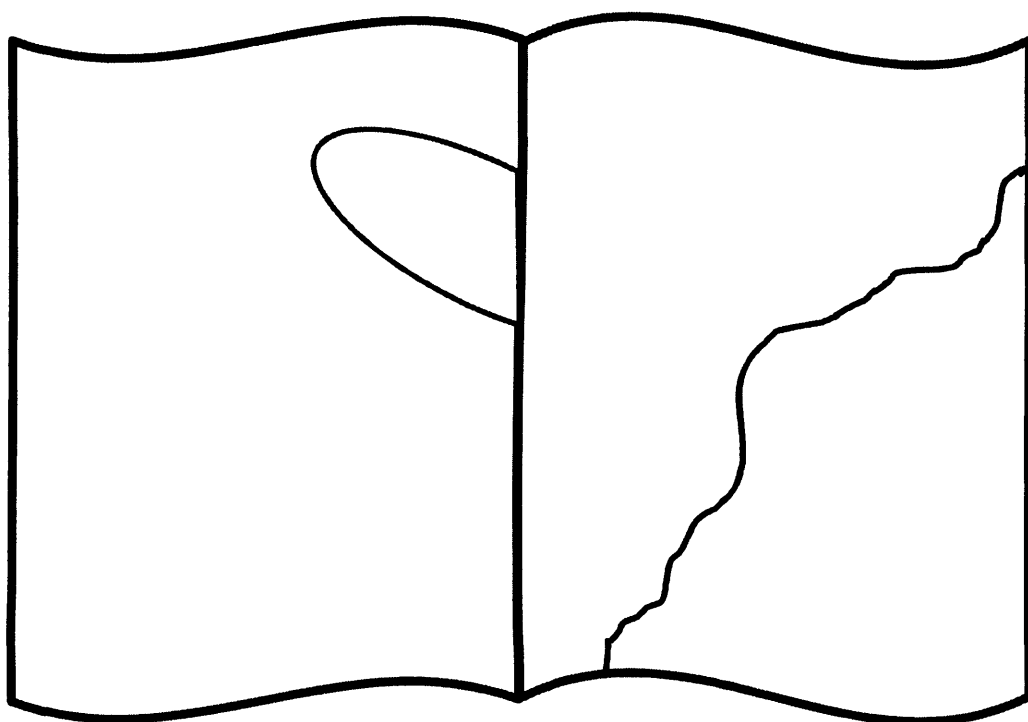
(Please tick box)

- 3 (e) Please estimate the percentage of all contracts offering

- Loyalty discounts
- Volume discounts
- Other, please specify

% of all contracts
<input type="text"/>
<input type="text"/>
<input type="text"/>

SPECIAL NOTICE



DAMAGED TEXT - INCOMPLETE IMAGE

4 (a) Does your Trust monitor the contracting process?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

Is the monitoring of contracts standardised across all types of purchasers?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

If no, please specify

Type of Purchaser (eg GPFH; non-GPFH; Health Authority)	Key elements of contract monitoring
GPFH	
Non - GPFH	
Health Authority	
Other (Please specify)	

4 (b) In drawing up contracts with purchasers, did your Trust:

- Include default measures
- Enable termination of contracts where mis-specification of contracts occurs
- Operate cost-sharing agreements to aid contract re-alignment?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

4 (c) To what extent do you agree that monitoring/auditing of contracts has impaired providers ability to innovate patient services?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

4 (d) To what extent do you agree that auditing/monitoring of contracts has affected managers' perception of their control over the contracting process?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please tick box)

- 4 (e) Do you perceive differences in contract requirements made of you by the Health Authority compared to other local Trusts? Please specify in respect of.

- General Monitoring/Auditing systems
- Outcome Assessment
- Output (ie volume) assessment
- Realignment or re-specification of contracts not complied with
- Default measures

Yes	No

(Please tick relevant box)

- 5 (a) Do you perceive that the relevant Health Authority has a 'preference' for specific Trusts in its area?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

 (Please tick box)

- 5 (b) Does the Trust typically offer additional services and benefits over and above that necessary for contract fulfillment.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

 (Please tick box)

- 5 (c) If yes, how important is this service augmentation in strengthening relationships with purchasers.

Very Important	Important	Neutral	Unimportant	Insignificant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 (Please tick box)

- 5 (d) Please give brief details of service augmentation you offer purchasers.

Type of additional service/benefit offered to purchasers

- 5 (e) Does the hospital 'customise' generic patient services to meet the specific needs of particular purchasers, eg GPFH's.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

 (Please tick box)

If yes, please give brief details.

Type of Service 'Customisation' Offered

5 (f) How important is this customisation of services in building relationships with purchasers?

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

5 (g) Was feedback sought about purchasers satisfaction with your services?

Yes	No

(Please tick box)

5 (h) If yes, how important was their feedback in building relationships with purchasers?

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

5 (i) How important were the following in deciding whether purchasers contracted with you?

Pricing of contracts
Non-price aspects of
contracts (eg customisation)

Very Important	Important	Neutral	Not Important	Insignificant

(Please tick box)

5 (j) To what extent would you agree that purchasers were seen as the “customer” after 1991?

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

6 Which of the following were the most important benefits of the internal market. Please rank them 1-5, ie 1 - Most Important, 5 - Least Important.

- More competition between providers
- Increased hospital efficiency
- Greater responsiveness to local purchaser needs
- Wider patient choice + access to services
- Increasing the power of service users

Ranking (1-5)

THANK YOU FOR YOUR COOPERATION

APPENDIX 2

NATIONAL PURCHASER - PROVIDER SURVEY

Health Authority Questionnaire

- 1(a) How important was the definition of output measures (ie volume of treatments) in negotiating contracts with local Trust hospitals?

Very Important	Important	Neutral	Unimportant	Insignificant

(Please tick box)

- 1(b) How important was the definition of health outcome measures in negotiating contracts with local Trust hospitals?

Very Important	Important	Neutral	Unimportant	Insignificant

(Please tick box)

- 1(c) Did Trust hospitals offer your Health Authority any of the following as part of the contracting process?

- Loyalty discounts
- Volume discounts
- Other, please specify

Yes	No

(Please tick box)

- 1(d) Please estimate how often the above were offered.

	Always	Frequently	Sometimes	Seldomly	Never
Loyalty Discount					
Volume Discount					
Other					

(Please tick box)

- 1(e) Did Trust hospitals place emphasis on building close **personal** relationships as part of the contracting process?

Yes	No

(Please tick box)

- 2(a) Did your Health Authority jointly gather, collate, share information relating to the contracting process with other interested parties?

- GP Practices
- GP Fundholders
- Health Authorities
- Trust Hospitals
- Local Social/Welfare services

Yes	No

(Please tick box)

Please state briefly the type of joint information exercises carried out in the box provided.

--

- 2(b) How often did Trust hospitals seek feedback on your Health Authority's satisfaction with the quality of their service delivery?

Always	Very Frequently	Frequently	Infrequently	Never

(Please tick box)

- 3(a) Did your Health Authority monitor the progress of contracts towards contract fulfillment?

Yes	No

(Please tick box)

- 3(b) Was the monitoring of the contracting process standardised for all types of providers?

Yes	No

(Please tick box)

IF YOU ANSWER NO to the above please specify

Type of Provider	Key elements of monitoring of contracts

- 4 (a) Did your Health Authority have a system to deal with providers who did not meet the requirements of your contract(s) ?

Yes	No

(Please tick box)

- 4 (b) Please specify those methods used to **AVOID** non-compliance with contract agreements .

	Key element to avoid non-compliance with contract agreements
1	
2	
3	

- 4 (c) Did your Health Authority have any of the following built into the contracting process at the initial negotiation stage?

- Default measures, ie a penalty clause
- Possibility for contract termination
- A cost sharing agreement to enable contract specifications to be re-drawn

Yes	No

(Please tick box)

- Other (Please specify brief details)

.....

.....

- 5 Please specify the key methods used to **CORRECT** for contractual non-compliance if this had occurred.

	Key element to correct for non-compliance with contract agreements
1	
2	
3	

- 6 (a) Did Trust hospitals offer extra services/benefits over and above that necessary for contract fulfillment?

Yes No

--	--

(Please tick box)

- 6 (b) If yes, please specify briefly the nature of these extra services/benefits offered by providers.

	Nature of extra services/benefits offered
1	
2	
3	

- 6 (c) Please estimate how often these extra services/benefits were offered as part of the contracting process.

Always	Frequently	Sometimes	Seldomly	Never

(Please tick box)

- 6 (d) Did providing units 'customise' standard services to meet your specific requirements.

Always	Frequently	Sometimes	Seldomly	Never

(Please tick box)

6 (e) Please state briefly the nature of 'customised' services offered to you by providers.

--

7 (a) To what extent would you agree the relative 'cost' of contracts was important in choosing between alternative providers of patient services.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	(Please tick box)

7 (b) To what extent would you agree that non-cost aspects were important in choosing between different providing units.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	(Please tick box)

7(c) Was your Health Authority aware of the drawbacks of switching between different providers (eg additional time spent negotiating, and gathering information).

Yes	No
<div style="border: 1px solid black; width: 80px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 80px; height: 20px; display: inline-block;"></div>

(Please tick box)

If yes how important was this awareness in determining whether switching between providers did occur?

Very Important	Important	Neutral	Not Very Important	Insignificant	(Please tick box)

7 (d) Did your Health Authority seek information regarding the service capacity of potential providing units.

Yes	No
<div style="border: 1px solid black; width: 80px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 80px; height: 20px; display: inline-block;"></div>

(Please tick box)

7 (e) If yes, how important was this information in determining which providers would be chosen?

Very Important	Important	Neutral	Not Very Important	Insignificant	(Please tick box)

THANK YOU FOR YOUR COOPERATION

APPENDIX 3

NATIONAL PURCHASER - PROVIDER SURVEY

GP Fundholder Questionnaire

- 1(a) How important was the definition of output measures (ie volume of treatments) in negotiating contracts with local Trust hospitals?

Very Important	Important	Neutral	Unimportant	Insignificant

(Please tick box)

- 1(b) How important was the definition of health outcome measures in negotiating contracts with local Trust hospitals?

Very Important	Important	Neutral	Unimportant	Insignificant

(Please tick box)

- 1(c) Did Trust hospitals offer your Practice any of the following as part of the contracting process?

- Loyalty discounts
- Volume discounts
- Other, please specify

Yes	No

(Please tick box)

- 1(d) Please estimate how often the above were offered.

	Always	Frequently	Sometimes	Seldomly	Never
Loyalty Discount					
Volume Discount					
Other					

(Please tick box)

- 1(e) Did Trust hospitals place emphasis on building close **personal** relationships as part of the contracting process?

Yes	No

(Please tick box)

- 2(a) Did your Practice jointly gather, collate, share information relating to the contracting process with other interested parties?

- GP Practices
- GP Fundholders
- Health Authorities
- Trust Hospitals
- Local Social/Welfare services

Yes	No

(Please tick box)

Please state briefly the type of joint information exercises carried out in the box provided.

--

- 2(b) How often did Trust hospitals seek feedback on your Practices satisfaction with the quality of their service delivery?

Always	Very Frequently	Frequently	Infrequently	Never

(Please tick box)

- 3(a) Did your Practice monitor the progress of contracts towards contract fulfillment?

Yes	No

(Please tick box)

- 3(b) Was the monitoring of the contracting process standardised for all types of providers?

Yes	No

(Please tick box)

IF YOU ANSWER NO to the above please specify

Type of Provider	Key elements of monitoring of contracts

- 4 (a) Did your Practice have a system to deal with providers who did not meet the requirements of your contract(s) ?

Yes	No

(Please tick box)

4 (b) Please specify those methods used to **AVOID** non-compliance with contract agreements .

	Key element to avoid non-compliance with contract agreements
1	
2	
3	

4 (c) Did your Practice have any of the following built into the contracting process at the initial negotiation stage?

- Default measures, ie a penalty clause
- Possibility for contract termination
- A cost sharing agreement to enable contract specifications to be re-drawn

Yes	No

(Please tick box)

- Other (Please specify brief details
.....
.....

5 Please specify the key methods used to **CORRECT** for contractual non-compliance if this had occurred.

	Key element to correct for non-compliance with contract agreements
1	
2	
3	

6 (a) Did Trust hospitals offer extra services/benefits over and above that necessary for contract fulfillment?

Yes	No

(Please tick box)

6 (b) If yes, please specify briefly the nature of these extra services/benefits offered by providers.

	Nature of extra services/benefits offered
1	
2	
3	

6 (c) Please estimate how often these extra services/benefits were offered as part of the contracting process.

Always	Frequently	Sometimes	Seldomly	Never

(Please tick box)

6 (d) Did providing units 'customise' standard services to meet your specific requirements.

Always	Frequently	Sometimes	Seldomly	Never

(Please tick box)

- 6 (e) Please state briefly the nature of 'customised' services offered to you by providers.

--

- 7 (a) To what extent would you agree the relative 'cost' of contracts was important in choosing between alternative providers of patient services.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

- 7 (b) To what extent would you agree that non-cost aspects were important in choosing between different providing units.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree

(Please tick box)

- 7(c) Was your Practice aware of the drawbacks of switching between different providers (eg additional time spent negotiating, and gathering information).

Yes	No

(Please tick box)

If yes how important was this awareness in determining whether switching between providers did occur?

Very Important	Important	Neutral	Not Very Important	Insignificant

(Please tick box)

- 7 (d) Did your Practice seek information regarding the service capacity of potential providing units.

Yes	No

(Please tick box)

- 7 (e) If yes, how important was this information in determining which providers would be chosen?

Very Important	Important	Neutral	Not Very Important	Insignificant

(Please tick box)

THANK YOU FOR YOUR COOPERATION

Appendix 4

Semi - Structured Interview: Discussion Agenda:

1. The Contracting Relationship (Trust/opportunism)

- *how important was trust/ possibility for opportunism between purchasers and providers?*

Trust defined as “confidence in an exchange partners reliability and integrity”.

- a. In what ways did this affect the negotiations process?
- b. Did it result in more efforts to accurately define contracts at the initial stage? (“contractual trust”)
- c. How did trust influence monitoring of contracts? (“competence trust”)
- d. Did pre-market NHS culture affect the extent of trust in contracting?
- e. In what ways did the market culture affect trust?
- f. Others?

2. Incentives: Why did providers augment or customise contracts? (“goodwill trust”)

- How important was the opportunity to meet latent demand?
- How important was it as a source of new funding?
- How important was managerial professionalism? (i.e. opportunities raised by the new market culture)
- * others?

3. What were the costs of relationship marketing by Trusts? (consider the downside)

- were there changes to management structures? (systems/staffing)
- Were there additional costs? (information;time; policing etc)
- * others?

4. What will be the effect of the new White Paper’s reforms on relationship building between purchasers and providers?

Appendix 5

	coefficient	St.error	b/St. error	P[Z >z]	Mean of X	Coefficients Marginal effects on Prob[y=1]
Constant	-.8650639933	1.0835996	-.798	.4247		-.1572703412
X3	.1181831020	.61979496 E-01	1.907	.0565	4.1609195	.2148592118E-01
X19	.7602957083	.51661169	1.472	.1411	.89080460	.1382232602
X42	.4376486500	.36540212	1.198	.2310	.60919540	.7956538829E-01
X51	.1454299453	.23810233	.611	.5413	4.0459770	.2643945107E-01
Chi-squared	9.314643					
Log U.r.	-.93.73448					
Restricted Log Likelihood	-.98.39180					
Degrees f.	4					
Signif. Level	.5369847E-01					

Model A: Contract Augmentation

X3 = Numbers of competitors

X19 = Long term relationship building

X42 = Preferred – providers

X51 = Competitive culture

variable	coefficient	St. Error	b/St.er	P[Z >z]	Mean of X	Marginal Effects Coefficient
constant	-2.471957056	.93402581	-2.647	.0081		-.6166219738
X42	.6441972334	.32196997	2.001	.0454	.60919540	.1606929896
X51	.5372394820	.21566767	2.491	.0127	4.0459770	.1340127123
Chi-squared	9.6887					
Log U.r.	-115.5793					
Restricted Log Likelihood	-120.4236					
Degrees f.	2					
Signif. level	.007872733					

Model B: Contract Customisation

X42 = preferred – providers

X51 = competitive culture

variable	coefficient	St. er.	b/St. er.	P[Z >z]	Mean of X	Marginal Effects Coefficient
constant	617.0697765	368.48022	1.675	.0940		80.84712271
X2	-.3111335795	.18494096	-1.682	.0925	1992.9	-.4076403616E-01
X3	.937841968E-01	.51922890 E - 01	1.806	.0709	4.1609195	.1228739886E - 01
X43	1.209143267	.64461175	1.876	.0607	.74712644	.1584192870
Chi-squared	11.23532					
Log U.r.	-75.91758					
Restricted Log Likelihood	-81.53524					
Degrees f.	3					
Signif. Level	.1051915E - 01					

Model C: Loyalty Discounting

X2 = First – mover variable

X3 = Numbers of competitors

X43 = Service augmentation strategy

variable	coefficient	St. er.	b/St. er.	P[Z >z]	Mean of X	Marginal Effects Coefficients
constant	599.1241690	306.28607	1.956	.0505		149.5291025
X2	-.3018083995	.15370936	-1.964	.0496	1992.9	-.753251854E -01
X3	-.6133551315E - 01	.51354643 E - 01	-1.194	.2323	4.1609195	-.1530808588E - 01
X22	1.817102906	.71385504	2.545	.0109	.86206897 E -01	.4535116104
X32	1.243431542	.35845553	3.469	.0005	.58045977	.3103350059
X44	.3735564657	.22202947	1.682	.0925	3.7126437	.9323203091E – 01
X57	.5549392067	.34633774	1.602	.1091	.46551724	.1385014423
Chi – squared	34.62099					
Log U.r.	-103.1936					
Restricted Log Likelihood	-120.5041					
Degrees f.	6					
Signif. level	.5102184E - 01					

Model D: Cost – sharing Contracts

X2 = First – mover variable

X3 = Number of competitors

X22 = Outcome measurement

X32 = Default clauses

X44 = Emphasis on contract augmentation

X57 = Trust Type

variable	coefficient	St. er.	b/St. er.	P[Z >z]	Mean of X	Marginal Effects Coefficient
Constant	-4.798340596	1.3213688	-3.631	.0003		-1.1599699286
X5	.7057339570	.22252321	3.172	.0015	3.9022989	.1706068375
X9	.7152877102	.45735928	1.564	.1178	.83908046	.1729163985
X34	.9693692705	.34251745	2.830	.0047	.48275862	.2343390508
X44	.3619351593	.22541269	1.606	.1083	3.7126437	.8749559559E - 01
Chi-squared	30.45800					
Log U.r.	-103.1159					
Restricted log Likelihood	-118.3449					
Degrees f.	4					
Signif. level	.3947758E - 05					

Model E: Default Contracting

X5 = awareness of local surplus capacity

X9 = joint venture strategies with other NHS trusts locally

X34 = Cost-sharing contracts

X 44 = Emphasis on service augmentation

Appendix 6

Technical Proof: Marginal Effects

To find the marginal effects for the functional form of $y = \frac{e^{\beta'x}}{1 + e^{\beta'x}}$ we need to make use of the

quotient rule, which is $\frac{d}{dx}\left(\frac{u}{v}\right) = \frac{v \frac{du}{dx} - u \frac{dv}{dx}}{v^2}$

Here $u = e^{\beta'x}$ and $v = 1 + e^{\beta'x}$, consequently $\frac{du}{dx} = \frac{dv}{dx} = \beta e^{\beta'x}$

Thus

$$\frac{d}{dx}\left(\frac{e^{\beta'x}}{1 + e^{\beta'x}}\right) = \frac{(1 + e^{\beta'x})\beta e^{\beta'x} - (e^{\beta'x})\beta e^{\beta'x}}{(1 + e^{\beta'x})^2}$$

$$= \frac{\beta e^{\beta'x} (1 + e^{\beta'x} - e^{\beta'x})}{(1 + e^{\beta'x})^2}$$

$$= \frac{\beta e^{\beta'x}}{(1 + e^{\beta'x})^2}$$

$$= \beta \times \frac{e^{\beta'x}}{1 + e^{\beta'x}} \times \frac{1}{1 + e^{\beta'x}}$$

$$= \beta \times P[y_i = 1] \times P[y_i = 0]$$

Appendix 7

Pilot Survey Interviewees:

Position:

Chief Executive

Chief Executive

Chief Executive

Chief Executive

GP Fundholder Managers

Organisation:

St. Cross Hospital NHS Trust, Rugby

George Elliot Hospital NHS Trust, Nuneaton

Dudley Group of Hospitals NHS Trust

Warwickshire Health Authority

4 interviewed from Bedford Health Authority area

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