The Marketisation of Health Services; A case study of the UK General Practitioner Fundholding "Experiment".

Professor Geoff Easton*
Department of Marketing
The Management School
Lancaster University
Lancaster, Lancs LA1 4YX

Tel (44) 1524 593917
Fax (44) 1524 593928
Email G.Easton@lancaster.ac.uk

Malcolm Poad
Director of Planning and Performance
Bradford Hospitals Trust

*Corresponding author

Abstract

In 1991 the UK government of the day changed the way in which some of the funding for the National Health Service was administered. They introduced a measure of marketisation into the process. Prior to 1991 the funding of both primary and secondary health care had been on a distributed allocation basis. After 1991 a partial purchaser - provider split was created. In 1998 the new Labour government fulfilled their election pledge and abolished what came to be known as GP fundholding. Thus this period from 1991 to 1995 in the UK can be regarded as an experiment in using market processes to manage health care. The case study reported in this paper is based upon the Bradford Hospitals Trust. It draws on a wealth of very detailed hospital data on admissions etc as well as formal qualitative interviews and continuing day to day contacts between one of the authors and the GP Fundholding practices within the area.

There were 4 main types of change in the relationships between GP fundholders and the Bradford Hospital Trust during the marketisation experiment. GP fundholders moved referrals to competitor hospitals, reduced demand on the Bradford Hospital trust, persuaded the hospital to run outreach clinics and used contract mechanisms to reduce prices and improve services.

In order to explain these changes a three component model, dyad, network and contingencies, was developed. The paper concludes by arguing that regulation of the marketisation process meant that GP – hospital relationships were largely transactional but within a highly regulated hierarchy.

1.Introduction

In the autumn of 1987, the UK National Health Service (NHS) was seen to be in crisis, with reports of financial problems and hospitals closing beds and wards against a background of ever-increasing waits for treatment. The Prime Minister, Margaret Thatcher announced that her government was conducting a major review into the way that the Health Service was organised and funded.

This review resulted in the publication of a white paper entitled "Working for Patients" in early 1989. Although the review team had looked at the possibility of introducing more private healthcare insurance, this proposal was rejected because of fears about increasing the administrative costs of providing healthcare, without necessarily improving the quality or the efficiency. A healthcare system largely funded through taxation was still felt to be the most appropriate system.

The Conservative government led by Margaret Thatcher from 1979 to 1990 believed that market forces were powerful drivers for change. Whilst wanting to retain a NHS funded largely through taxation, there was a belief that the monolithic public sector organisation was inefficient and wasteful. The 1991 changes therefore attempted to introduce market forces labelled, rather inelegantly, marketisation into the NHS by creating an internal market.

Prior to 1991, District Health Authorities (DHAs) and hospitals were part of the same statutory organisation. Money flowed through the NHS by an annual allocation process. DHAs received an annual allocation from Regional Health Authorities (RHAs) who in turn received an allocation from central government. DHAs then simply used this money to pay the staff and non-staff costs to run the hospitals and community health services. There was no real link between the money paid out and the amount of work actually undertaken. Ironically, in any one year, if a health care unit treated more patients, it received no extra income and so there was no incentive to do more work. Conversely if less work than predicted in that year was done payment was not reduced.

In the UK the NHS, as in most health care systems, there is split of responsibility between primary and secondary care. Primary care doctors, known as General Practitioners (GPs), deal with non-urgent cases and diagnose and refer all other cases to secondary care, usually in hospitals. GPs were administered by Family Practitioner Committees (FPCs) until 1990 and by Family Health Service Authorities (FHSAs) until 1994/1995. GPs have never been NHS employees but contractors for services and they were paid literally per item of service. GPs were not involved in decisions about how the Hospital and Community Health Services (HCHS) budget was spent. The resources that GPs used were funded from a separate allocation called the General Medical Services (GMS) Budget.

Before 1991, GPs referred patients to secondary care hospitals for a range of tests, diagnoses, outpatient consultations and operations, but they did not have to be concerned about the cost of this or for paying for decisions that they made. Equally, there was no incentive for GPs to control their demands on acute hospitals because there was no real benefit to them or their patients in doing this. In addition, there was no incentive or finance to develop services within primary care to diagnose and treat patient as an alternative to referral to hospital

The 1991 Health Care Funding reforms resulted in a split between those purchasing healthcare (District Health Authorities and GPs) and those providing healthcare services (NHS Trusts providing a range of hospital and/or community health services). NHS Trust hospitals became independent of Local Health Authority control and were able to compete for work from Health Authorities and GPs anywhere in the UK. For the trusts income was no longer secure and was not fixed at the start of the financial year. Hospitals were required to cost and price their services, publish price lists and negotiate contracts with purchasers.

GPs were given the choice of becoming fundholders or remaining within the previous system. GP practices or groups of practices serving populations of over 10,000 patients could apply to their Health Authority to hold the budget to purchase a range of secondary care procedures. These procedures were specified by the Department of Health and in the main concentrated on a range of elective surgical work. Whilst the scheme covered outpatient and inpatient elective work it did not cover emergency activity and individual procedures that cost over £5,000, raised to £6,000 from 1st April 1994.

Thus there were safeguards to protect GPs from the fluctuations in emergency activity and the volatility that can occur with high cost, low volume procedures that have potential to run up bills of thousands of pounds. These sorts of fluctuations are much more easily managed on a larger population i.e. a Health Authority population of ½ million as compared with a practice population of 10,000.

As GP fundholders (GPFHs) primary care doctors were able to contract for secondary care services from any hospital, public or private. As a result an element of competition, albeit limited, was introduced into the UK health care system. Money only passed from purchasers to providers on the basis of contracts. These contracts specified what the purchasers wanted for that money, e.g. the number of patient treatments, access times etc.

The Fundholding Scheme worked by analysing a GP practice's historic costs attributable to use of hospitals (inpatients and outpatients), drugs and appliances and community nursing. These costs were then deducted from the Health Authority activity and spend with hospital and community trusts and given to fundholders who purchased services direct. If GPs made changes in any of these areas that reduced their spending then they could use the money saved to reinvest in other services in primary or secondary care. This change wasn't designed just to reduce demand, but was also about using GPFH purchasing power to get a better price from the local provider trust or moving the work and negotiating a deal with another NHS Trust or private hospital or even starting alternative primary care services at less cost.

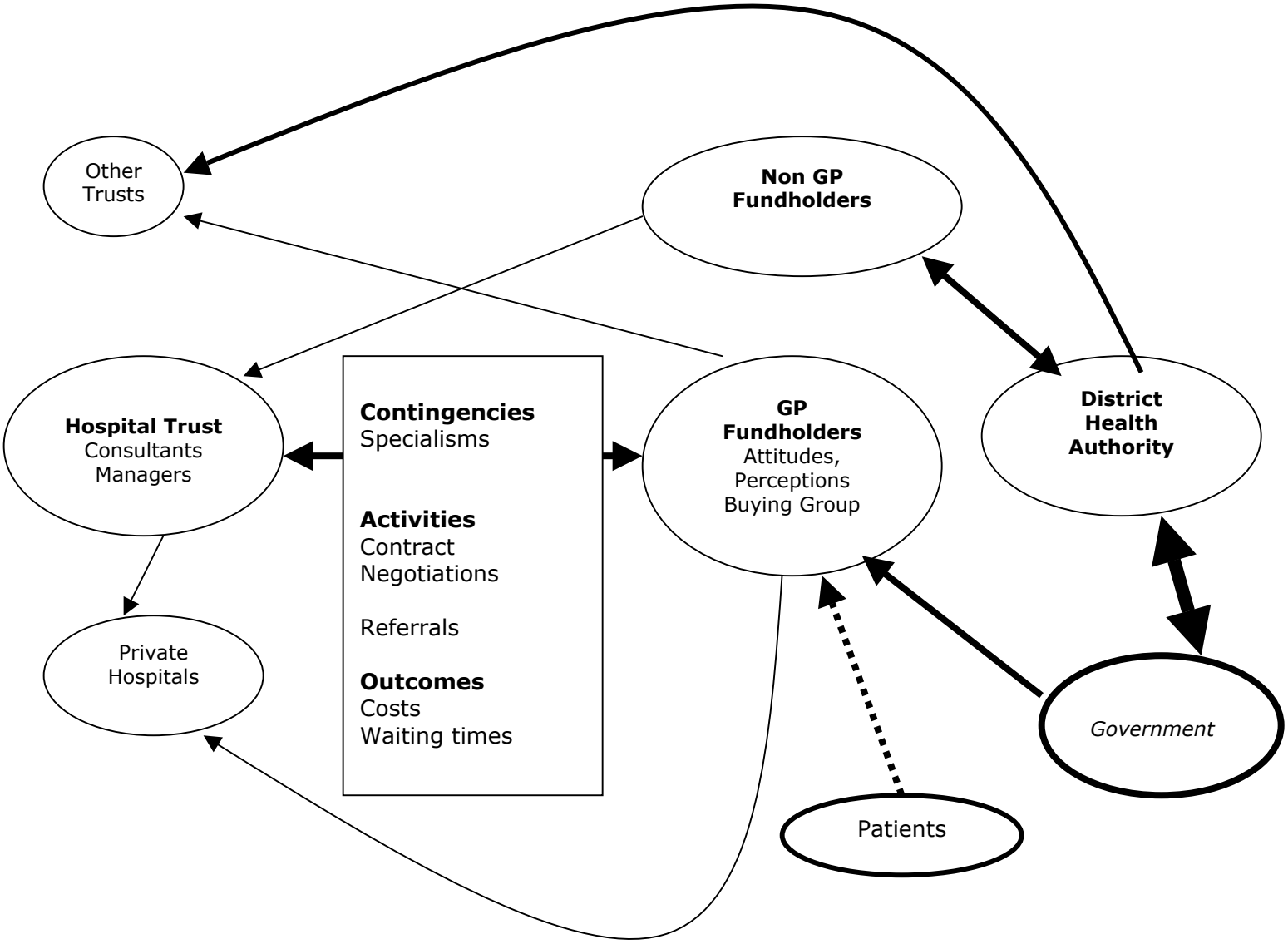
The incoming Labour government had campaigned on a platform of abolishing GP fundholding and in March 1999 the practice ceased. The 8 years of GP fundholding therefore provides an interesting opportunity to study the marketisation of healthcare services during what had come to be known as the "fundholding experiment". In particular it offers a chance to research the movement of an economic system from a direct control hierarchy to some other form of interorganisational system. In this paper we frame the analysis of marketisation as an industrial network phenomenon and in doing so have to address the issue of how industrial network theory can be helpful in understanding hierarchy.

2. Analytical Framework

Much has written about the theoretical bases for marketisation. Lunt et al (1996) provide one of the most comprehensive reviews. They suggest that four schools of thought can make contributions to our understanding of the process; neoclassical economics, (Culyer, Maynard and Posnett (1990), transaction cost theory, (Propper (1993a), Austrian economics and the new economic sociology (Ferlie and Pettigrew (1996)). Of these only the last lies close to the industrial network perspective. Lunt et al suggest that two key issues from this literature are particularly relevant to marketisation; social network relations and non price competition both of which resonate with an industrial Networks point of view.
However in terms of making theoretical advances it would seem to be important to ask the question "What can the industrial network perspective do to explain the ways in which marketisation changes the behaviour of the actors in this heath care system?" We therefore propose a three component model of marketisation which is illustrated in figure 1 below.

2.1 Dyadic Relationships
The first and central component is the dyadic relationship between individual GPFHs and individual hospital trusts. The process of marketisation changed this relationship from one of hierarchy, where local hospitals largely accepted local patients referred by local GPs based on perceived need, to one where GPs could choose among different hospitals and perhaps form new kinds of relationships albeit ones constrained by written contracts and under a fairly tight government controlled regulatory regime. It is the changes to these relationships that we seek to explain.

Figure 1 An Industrial Networks Model of Marketisation



While recognising that the simple tripartite division of organisation to organisation exchange phenomena into market, network and hierarchy is a gross simplification it will be helpful to use these labels for the time being. However we do acknowledge that they are unlikely to be understood as positions on a single dimension continuum. As has already been pointed out the marketisation literature largely accepts that the move from hierarchy via marketisation implies that the end result will be a market form. "The NHS Reforms were presented as replacing a hierarchical command and control organisation with one driven purely by market signals". Mohan, J. However an alternative view is that hierarchies might become more like relational markets embedded within an industrial network. In order to test out these ideas it is necessary to set out the conditions and driving forces that lead to the occurrence of relational markets.

Buyer – seller relationships are more likely to occur than transactions because, under the right conditions, they can outperform them. They can do so because of greater volume of exchanges leading to economies of scale and scope, decreased uncertainly leading to increased long term investment, higher levels of specialisation and better planning. In addition joint actions with partners help to create novel and more effective ways of doing business. Most of these outcomes rely on investment and adaptations as the basis for better performance. However relationships can also be driven by non economic factors including the existence of few or no options (Microsoft), reciprocity, high relationship exit costs, social binding and inertia.

Transactions are more likely to occur where the short term benefits of competition, playing one supplier off against another, outweigh those of forming relationships. In these cases the long term returns to investment in a relationship are perceived to be small. Exchange contingencies which might promote this situation include may be infrequent or low value purchases, standardised or unimportant product. There are also a variety of situational contingencies that make relationships difficult to form including cultural constraints and distances, competition regulation of various kinds, fear of the power of potential partners and speed of change in markets or technologies. None of these contingencies would appear to be in place during the GPFH experiment and so one might expect that a change from a hierarchal to relational situation to occur.

US experience provides support for this idea. "It is clear that the contracting process as used in the US health and social care markets has been characterised by less competition than originally envisaged. Competition in bidding has been limited. Contractual relationships have been lengthened, provider and purchaser have developed close relationships and the incumbent has come to dominate the market". Propper (1993)

In summary, what we are looking to find is whether the actions of GPFHs and the hospital trust were closer to relational or transactional form and what reasons could be adduced for their occurrences.

2.2 Network Effects

The second component of the model is the close environment i.e. the network of relationships within which GPFH / hospital trust dyads existed. The most important difference at the network level was the increase in choice offered to the GPFHs, of which the introduction of new actors in the role of competitors for the local hospital trust was probably the most important. Thus while the change in the nature of the relationship between GPFHs and the local trust is important it takes place in the context of possible new relationships which can introduce the role of competition as an indirect network effect (Easton et al (1996)).

However there are other actors in the system e.g. private hospitals, non fundholding GPs, District Heath Authorities and patients who were involved in the extended market and who may have had important impacts on the focal relationships.

2.3 Contingencies

The third component is the set of contingencies that affected actors, dyads and networks. "The evidence from the emerging UK quasi-markets

is indicates that there is considerable variation across these markets. Key differences exist in the technology of production, the relative size of provider and purchaser, information, extent of risk aversion and objectives of provider purchaser" Propper (1993a). In this case there were three entities that had internal contingencies (Sayer (2000)). Hospital trusts varied in terms of their capacities, capabilities, performance and cultures. GP fundholders varied as to their size, sophistication, patient profile and the existence of fundholding champions within. Exchange activities such as referrals differed in respect of the forms of illness presented and the ways and means of treating them. Any or all of these could have affected the newly marketised situation. However it is not enough to simply note that a contingency has an effect. It is crucial to discover what it is about each contingency that created the effect.

3. The Bradford Hospital Trust Case Study

In order to explain the general changes in the relationships between GPFHs and BHT it is essential to describe in some detail the situation prior to 1991.

3.1 Pre 1991 GP and BHT Relationships

Prior to the 1991 reforms, if GPs required hospital services, their only option was to refer the patient to the appropriate hospital. In the main, a referral meant a referral to a consultant in a hospital, who would then see, examine, diagnose and if necessary, treat the patient. Consultants decided whether this was an urgent or a routine condition. Urgent patients were given a date for an outpatient appointment and depending on the specialty and the condition. Routine patients could wait up to 12 months for an outpatient appointment. If, having been seen in outpatients, the patient required inpatient / day-case treatment the Consultant would either place the patient on a theatre list for an operation in the next 2 to 3 weeks, or put them on an inpatient day-case waiting list. Patients would be called off the waiting list in clinical priority order and then by length of wait. The length of wait could vary from 3 months up to 12 to 18 months in some cases, although 75% of patients on a waiting list would typically be treated within 6 months. Hospitals were under severe demand pressure as evidenced by long waiting lists.

GPs played little or no part in this process nor did financial considerations, unless a hospital started to over-spend the annual budget that had been allocated. In this case managers would hold discussions with Consultant Medical Staff about ward, theatres and possibly outpatient closures to reduce the numbers of patients being treated and to try and bring expenditure back in line with budget.

Consultants frequently criticised GPs for making excessive and sometimes inappropriate demands on their services and for not doing more to manage their patients in primary care. Hospitals would argue that, unless they used consultants to filter out patient requests for services, then they would be swamped by excessive and inappropriate demands from primary care providers.

Hospitals would contend that they had to provide a service to the whole of primary care and there was a massive variation in the quality of referrals from GPs. Some GPs either didn't have the ability to decide what was an appropriate use of hospital departments or referred patients into

secondary care to get them out of their surgeries. If they were making excessive and inappropriate demands on the hospital, then why worry about it, because it wasn't costing them financially and there was no real incentive in the system to change the behaviour of those who were making greater demands on secondary care than their colleagues. Hospital doctors were seen to be clinically autonomous and accountable only to their patients.
GPs on the other hand complained that hospital services were slow and unresponsive and that the only way they could get access to diagnostic and therapeutic services like X-ray and physiotherapy was by referring patients to a consultant. Some GPs would also claim that when you made a referral to a hospital, consultants sometimes simply took over complete management of the patient's diagnosis and treatment and GPs were not informed or involved in any of this care. GPs were often frustrated by this approach and wanted to do more to manage patients in primary care, if only they could get hospitals to be more responsive and just give an opinion when that was all that was required and to allow more direct access to services.

3.2 Post 1991 Changes in GPs and Bradford Hospitals Trust

Following the introduction of the internal market into the NHS in April 1991, Bradford Hospitals, the main provider of acute medical services in the city of Bradford and surrounding areas, became a first wave trust (BHT) and the first wave of 10 GP practices became GP fundholders. By 1997/1998 56% of GP practices and 68% of GPs were involved in fundholding in Bradford. Within the space of 6 years, the responsibility for the hospital's funding had gone from a single source to a large number of GP practices.
In 1991/1992, the Bradford Hospital Trust income derived over 80% from Bradford Health Authority, whilst Bradford Fundholders accounted for only 3% of the total. By 1997/1998, this had changed to an income from Bradford Health Authority of approximately 70% of the total, whilst Bradford Fundholders were now spending just over 22% of the total income with BHT.
Fundholding practices now had budgets to purchase services in secondary care and with it came responsibility and incentives. GP fundholders realised that they could use their purchasing power to change practices in both primary care and their relationships with BHT and to change them in ways that benefited their patients, either by obtaining quicker access, or by getting more service at less cost.
Within Bradford, GPFHs made changes in 4 broad areas: managing overall demand and service, moving work to other providers – either NHS or private sector, starting alternative services in primary care, and using the contract mechanisms to manage their purchases with BHT.

Managing Overall Demand and Service
With the exception of 4 specialties (Oral Surgery, Thoracics, Pain Management and Gastroenterology) there were big reductions in the total elective and day-case activity purchased by Bradford Health Authority and Bradford Fundholders. In addition, the fundholders managed to get more of their patients seen quicker than non GPFH patients in this period.

Fundholders had fewer patients listed per 1000 population on BHT waiting lists by February 1999. In 1993/1994, the spend by Fundholders with the BHT as a % of total healthcare spend was 58% and by 1997/1998, this had reduced to 55%.

Moving work to other providers

There is evidence to suggest that fundholding practices moved work to other providers between 1991 and 1998 although quantifying the change and the impact on BHT is difficult to estimate. It is difficult separating how much was work being moved and how much of their spend was reduced due to better demand management.

The real evidence that starts to quantify the use of other providers is not so much in the activity and finance data as in the exchange of letters between BHT and fundholding groups and in the contract documentation. This clearly shows that the some of the earlier fundholding groups moved work to other providers.

Other evidence of work being moved to other providers was seen in a 1995-1996 Fundholder Purchasing Intentions survey commissioned by BHT. Other providers used by fundholding practices in this period were a mixture of Airedale, Dewsbury, Halifax and Leeds hospital trusts and agreements with the local private hospital, The Yorkshire Clinic. In 1989 fundholding practices spent nearly £2m in the private sector some based on long term contracts.

In addition BHT used a private firm to undertake a Market Position Analysis in 1995. Overall, there was very little change in the 1991 to 1995 period. Across all specialties for all admission types, the BHT share of the Bradford activity stayed the same at 68% to 69%. The only real shift in activity was a move of work to Airedale associated with the development of a local service for ENT and Ophthalmology and a shift of Ophthalmology and ENT work by South and West to Halifax. The conclusion therefore is that with these two exceptions, relatively small amounts of work were moved away from BHT and the majority of this was then brought back to BHT.

Alternative services in primary care

One of the ways in which GPFHs reduced their reliance on BHT was to demand that consultants come out from the hospital and begin to see outpatient referrals in their surgeries. By 1998 18 hospital consultants were working in 10 different locations across Bradford, providing 334 clinic sessions and seeing 5222 new outpatients.

Using the Contract Mechanisms to Manage Purchases from BHT

Most fundholding groups either operated a cost and volume contract or a cost per case contract for outpatients and inpatients/day-case activity.

Typically, a cost and volume contract would work in the following way: BHT and the fundholding practice would agree a volume of activity (numbers of patients to be treated) and a concomitant cash value by medical / surgical speciality. The patient activity would be multiplied by the Trust's price tariff to give a cash value, which was then deducted from the Health Authority allocation to give to the GPFH practice a fundholding budget to purchase services from secondary care. If a GP practice used more than one hospital, then this exercise would have had to take place

between each hospital and the Health Authority to compile a total budget for the fundholding practice.
The financial arrangements for the NHS internal market made it clear that there was an expectation that all purchasers paid their fair share of a Trust's fixed and semi-fixed cost and that marginal rates, based on the variable cost element, typically 25% of full cost, should only apply to unplanned variations that occurred in year and be for one year only.
Marginal rates were the subject of much discussion and negotiation as fundholders tried to use this device to maximise the financial advantage to themselves, i.e. to get as much activity as possible done for 25% of full cost. Trusts obviously tried to prevent potential abuse, which could leave them with a financial problem if fixed and semi-fixed costs were left uncovered.
Typically, astute fundholders would try negotiating down the contract volume at the start of the year arguing that they were intending to make changes that would reduce their demand on the Trust. But then during the year they would try and claim marginal rates for any referrals made over the planned number in the original impact statement.
Some fundholding groups would reduce activity at one hospital and do this at full cost, but then refer it into another hospital and pay for this work at a marginal rate as an overtrade on an existing contract. Again, under the financial rules covering contracting, this should not have happened and should have been dealt with as a planned change and properly paid for at full cost.
Financial rules set down by the Department of Health that were aimed at trying to prevent perverse behaviour and to prevent financial destabilisation of the hospital or other organisations, were inadequate to cope with this strategy.
It is also ironic that, at the start of the internal market, Government pronouncements were made about the need to introduce competition to improve efficiency and then central guidance put in place mechanisms aimed at controlling competitive behaviour and stopping the development of a health care market.

Other attempts to control demand and spend at BHT can be seen in the TCI systems (to come in), which fundholders introduced into contract agreements. BHT could go ahead and treat urgent patients and those who had waited a long time. All other elective admissions for treatment would not be paid for by the practice unless they were included in the To Come In list of patients given to the Trust by the GPFH practice on the first of the month, to be treated in the following month. BHT had enormous difficulty working with these systems. For example GPFHs refused to pay for patients who were treated but were not on their TCI list.

4. Analysis - Model Components

The four main changes in GPFH / BHT relationships have been described above. In the next 2 sections explanations for those changes will be offered using the 3 component model described earlier. First of all the key factors which changed in each component are summarised.

4.1. Dyad

GPFHs

GPFHs could have simply chosen to remain within the existing system and many did. While most GP practices became fundholding only a minority of GPFHs embraced all the fundholding changes described above. For those that did there were a number of factors that explain their changes in behaviour. GPFHs wanted to improve the quality of service they received from BHT, have more control over the treatment of their patients, increase their discretionary income (which could be used for outreach clinics for example) and to rebalance the power / status relationships with BHT consultants.

BHT

A crucial point for BHT was that during this period they were in a parlous financial situation. Whilst Bradford Health Authority remained the single biggest purchaser, the size of the Fundholding income and changes in the contracts could make the difference between the Trust meeting financial targets and ending the year in balance or overspent. Trusts were not allowed to overspend and a deficit could have serious implications for the Chief Executive, other senior managers and the Trust Board.

For the consultants there were two key factors that influenced their relationships with GPFHs. The first was their attitude that Consultants were providing the specialist and more complex forms of medical care and so were superior to GPs. The second was their concern to protect their private work, which was often a major additional source of income.

4.2. Network Relationships

Clearly the ability of GPFHs to move business from their local trust was a major network factor and demonstrates the notion of competition as an indirect network relationship. Non GPFH practices provided a stable alternative to the GPFHs certainly in the early years of the experiment and a standard by which the BHT could judge the behaviour of GPFHs. Government continued to impact indirectly on the dyad through a set of draconian regulations which limited the impact of any market like behaviour on the behaviour of the GPFHs.

A crucial indirect relationship was that between Consultants and GPFHs via the medium of services commissioned by GPFHs through the private non NHS system which included the use of private hospitals. The most market oriented GPFHs were also likely to be those who referred more of their patients privately and so controlled to a great extent the private income of some consultants. As a result this provided them with leverage over these Consultants in the NHS system.

Generally patients appeared to have little influence on the referral process. They normally accepted the advice of the GPFHs who acted as gatekeepers in the system.

4.3. Contingencies

Contingencies did not in general change dramatically during this period but nevertheless affected the outcomes of the experiment. An important contingency in understanding the changes is that of the medical conditions presented and the forms of treatment available. Major procedures are normally treated in local hospitals since this means that patients know something about them and can be visited more easily. However different hospitals have different specialisations and capacities and so there may be

no other choice but to treat at a distant site. At the other end of the scale there are conditions that could equally well be treated by GPs or in GPFH premises.
GPFHs vary enormously from the single handed inner city GP to the large well endowed multi partner practice in affluent suburbs. In addition the existence in a GPFH of what might be called an entrepreneurial GP, who was keen to exploit the new opportunities, was a key factor in determining the approach the practice took towards BHT.
Hospitals trusts varied in terms of their size, specialisms, capacities, capabilities and cultures

5. Analysis – Explanations

5.1 Managing Overall Demand and Service

In general GPFHs were able to reduce their demands on BHT and the more aggressive GPFHs did so. The primary reason was almost certainly that this allowed them to save money from their budget that they could use at their own discretion and for purposes that they felt were important for patient care. Most of the savings went on new buildings. They may have also wished to use the threat of reduced demand to help in their contract negotiations with BHT. In addition history may have played a part. In some cases a history of perceived poor treatment by Consultants could have led them to wish to punish the perpetrators
They could only have been able to do so by being more thorough about assessing patient referrals, treating more patients in surgery or by degrading the service they offered.
In network terms they were able to do so because of the power they wielded over their own patients who, in general, had neither the knowledge nor inclination to question GPs judgements.
A key contingency is that of the medical condition presented. Only a subset of all conditions, mainly involving elective procedures, was referred via the fundholding system. Expensive and acute conditions were treated as previously. This restriction reduced the power of the GPFHs. As mentioned previously only those GPFHs who had a marketisation champion were likely to reduce demand to any great extent.

5.2. Moving work to other providers

Moving work to other providers is a network effect. The most obvious reason for GPFHs moving referrals to competitor trusts was service quality, in particular waiting times, at BHT. They did so eventually because BHT was not treating the number of patients that fundholding practices had contracted and agreed to pay for. BHT simply did not have enough capacity.
For example, at the start of the 1993-1994 financial year the GPFHs moved their Ophthalmology work to Leeds hospital trust. BHT and the Consultant Ophthalmologists faced a real dilemma in trying to meet the demands of the fundholders to treat all their patients and reduce the waiting times. The District Health Authority did not have money to invest. Nor could BHT take a financial risk and invest in its own right since they had no surplus and any other resource would have had to come from the non market allocation system.
The resulting loss of £0.16m was a real for BHT, but was a smaller financial loss than investing £0.5m in an expansion of service. Similar

problems occurred with other fundholding groups and in other specialties such as general surgery, Orthopaedics, Ear Nose and Throat. In this case the contingency of type of illness and medical specialisation is crucial.
In terms of the total income and budget for BHT, the sums of money involved were small, but made it far more difficult for the Trust to achieve financial balance in year.
A second reason for moving work, however little, to another provider was probably as a lever to change the attitudes of Managers and Consultant Medical Staff. There is no doubt that the loss of work shook BHT staff and made them realise that they no longer had a monopoly as the only provider of care to Bradford patients. This was a demonstration that unless Bradford Consultants were prepared to take the GPs seriously and meet their requirements, then the GPs would move work to other providers. This was particularly wounding for Consultants who believed that Bradford patients should be treated in Bradford and it was a criticism of their service if patients had to be treated by other providers or seen by other consultants. As in the previous case it is also likely that there was an element of getting ones own back.
Nor did BHT have the skills or appetite for the market place. In early 1996, a GPFH group invited representatives of the Trust Management and the Ophthalmologists to present competitive proposals about how they would deliver reduced waiting times for their patients. The fundholding practices reported that the Trust performance at this meeting was poor. There was no formal presentation and no worked out or costed proposal to deliver the fundholders requirements for that specialty. This contrasted with a local competitor trust, whose Chief Executive, together with a Consultant Ophthalmologist, did a formal presentation and produced a glossy document setting out a costed proposal setting out their activity and waiting time offering in Ophthalmology. As a result, they were awarded a contract for this work.
This example provides a good illustration of one of the problems of the internal market. If an NHS Trust attracted new work at full cost, then this was additional income and could be use it to staff up specifically to do that volume of work. If the Trust had an existing workload and existing income stream, then staffing up to provide an improved service was difficult to do, in a cost-effective way, within an existing income stream. The GPFHs were only moving a proportion of the work to a competitor who BHT surgeons argued was mainly day-cases and the simpler work. BHT on the other hand, was left with the acute work and the more complex cases.

5.3 Alternative services in primary care
Outreach clinics were a case of changing the relationship between GPs and BHT from one of hierarchy to one of partnership. It also started to develop individual relationship between hospital consultants and GPs and enabled GPs to be more involved, particularly where this was linked to the development of GPs with a specialist interest.
GP fundholders declared reasons for making this change were because it provided a local and more personal service (the hospital outpatients department dealt with 5000-6000 patients per week), and a low-tech familiar environment, which was less intimidating for patients. It was easier to get to, and to park at, the surgery than the hospital.

Moreover this practice offered the chance for GPs to provide a more complete service for some of their patients and wrested some of the control of treatments from Consultants.
It also allowed GP fundholders to save money. Ironically, whilst the Trust was left with a potential problem of uncovered overheads, the GP fundholding practices were using the savings and resources transferred to meet overheads on their premises, which were being extended and better equipped out of GP fundholder savings from the hospital and community health services budget.
From the point of view of BHT, introduction of outreach clinics meant lost income. However the trust didn't really have a choice but to make this change. If BHT consultants and services were not involved in outreach clinics, then an even bigger loss could have been incurred through the loss of the resultant inpatient day-case work which would have gone to other providers, a network competition effect.
The really significant change that had occurred in this period was a big change in the culture and secondary care attitudes in BHT towards primary care staff. This was a change that was initially resisted by many older consultants. One BHT Consultant described outreach clinics as akin to prostitution, made it clear that he would not become involved and put severe pressure on his consultant colleagues not to take part. A number of younger consultants could see why the GP fundholders wanted to make this change and were prepared to experiment with it. Some younger consultants were genuinely enthusiastic about the change.
Consultant opposition, particularly from older Consultants, also stemmed from a traditional view that Consultants were superior to GPs. They were the experts in their fields and did not like the idea that they were somehow going to be employed by a group of GPs who would be controlling where they worked, when they worked, which patients they saw and what they could do with them. Consultants saw themselves as clinically autonomous accountable to their patients.
However Consultants were concerned that private referrals followed NHS referrals and they did not want a loss of private income, an important network effect. Hospital managers were also concerned about the loss of income and if you lost the outpatient income, then the chances were that you would lose the inpatient income as well. Meeting financial targets was not optional and hospital managers had to persuade consultant medical staff to undertake outreach clinics and to change an attitude that went back 50 years to the start of the NHS.
There was a similarity in the specialties chosen by fundholders and this was either because of the nature of the specialty or because of particular problems with waiting times at BHT, both important contingencies. In the former case this was because only certain illnesses can be treated in outreach clinics. In the latter case because demand exceeded supply as a result of increased incidence of the illness or a failure by the system to invest in the necessary resources.

5.4 Using the Contract Mechanisms to Manage Purchases from BHT
In terms of the contracts process it is clear that a small minority of GPFHs played the system for all it was worth. Many entrepreneurial GPs who

entered the first wave of fundholding had done so because they were attracted by the prospect of being able to use the new market freedoms. The evidence suggests that the GP Fundholders were trying to use contract mechanisms to change and improve BHT services for themselves and their patients and make them more responsive. Some of this was also aimed at trying to secure a financial advantage and get more services at less cost for their patients. However some more enterprising GPFHs found the central rules restricting marketisation to be typically bureaucratic and seeming to prevent them from making the improvements that the reforms were supposed to bring about. Contract negotiation was also about control. GPs did not like to think of themselves as failed consultants and so when the opportunity came to assert their new found authority they did not hesitate to do so.

For BHT getting the contracts signed was crucial since their financial survival depended upon it. However while a single GPFH only had to negotiate with on or two trusts BHT had to do so with dozens and had to learn how this process could be managed. In addition where the GPFHs were bending the rules BHT didn't really have the systems or the manpower to police the contracts and so lost out in that way too.

Throughout the 1990's there was mistrust and tension between Fundholders and Trusts, as each tried to understand the limits of the system they found themselves in. Each was concerned about the other's ability and potential to cause damage and harm to the other. Each organisation was also concerned about success and failure and the need to manage within financial allocations.

Whilst there is evidence that the use of contract mechanisms to improve financial penalties did make the Trust more responsive, this probably did little to improve relationships between primary and secondary care. There is plenty of evidence to support the view that use of the contract mechanisms caused a lot of irritation and as well as an increase in bureaucracy, which secondary care consultants saw as getting in the way of treating patients and for this they blamed the GP Fundholders.

The "To Come In System" also created massive tensions and was another source of control for the GPFHs. They wished to ensure that the patients they wanted treating got treated and in the timescale that they wanted. They also wanted to be able to control their level of spend at BHT. In addition to this, they wanted to move away from a situation where a referral to hospital meant that you had no further involvement in the management of the patient. They did not want the Consultant to be the sole arbiter over when somebody got treated. They wanted to take on the responsibility to explain to patients why some treatments were inappropriate and suggest the alternatives available. It was argued that GPs who had far more contact with the patients, and therefore, knew about and understood crucial socio-economic factors that affected patients and were better placed to make these decisions than Hospital Consultants. In any case, if they were now paying to have their patients treated, they wanted to manage this process.

BHT managers took these issues up with the Consultants concerned. Their written responses to Trust Managers give an indication of the problems in trying to run a hospital and treat patients in the changed environment of an internal market.

When I saw this patient in November, she was quite remarkably over-weight. I made a deal with her that, if she was less than 10 stones when I reviewed her in 3 months time, then I would give her a date for admission. In view of the fact that she met with this deadline through a great effort, I decided to bring her in for an operation.
If I had not given her a date for her operation, it is highly likely that she would have gained her weight again, which, at some stage, approached nearly 15 stones and she would then have been a considerable anaesthetic risk. I feel this is sufficient to warrant me operating on her.
Consultant Gynaecologist

While the letter from the Consultant Gynaecologist set out good reasons to operate on the patient, he had failed to grasp the change in the service and the need to get prior approval from the GP.
The TCI system required consultants to work in ways that they had not been trained for and which, to them, seemed to add to bureaucracy and get in the way of treating patients. It was a painful process that sometimes resulted in acrimonious telephone conversations between Consultants and GPs, but the loss of income proved to be a powerful lever in bringing about a change in culture.

6. Conclusions

This is a complex case study and one for which there is an unusually large amount of data available. There were many subtle and interrelated changes that occurred and there were many influences and causal factors involved. In the previous section an attempt has been made to explain the driving forces and contingencies that help create 4 types of change that occurred in GPFH / BHT relationships. Some drivers and contingencies were present in all cases but no two change situations could be explained by the same mechanisms, which is to be expected. However there are some general conclusions that can be tentatively offered.
The first point to make is that the effect of marketisation in the BHT area was actually quite small. It was limited in the sense that not all GPs became fundholders, only elective procedures were included, many GPFHs behaved as if the system had not changed and extent of the changes in practice by even those GPFHs who did go to market was quite small. Even in the last case, overall demand on BHT was reduced but not by very much, a small amount of work was transferred to other trusts, a few outreach clinics were set up and a small number of GPFHs played hard ball in the contracting process. It would not have been very surprising then if the overall impact on the BHT had been minimal.
But it was not. The impact upon BHT was substantial in terms of improved, albeit targeted, services at lower prices, changes in practices with regard to GPFHs and changes in BHT culture. It should also be pointed out that not all of these changes were made with good grace and the BHT was delighted when the experiment came to an end.
The key contingency in this situation was the parlous financial state of BHT at this time. Had they had spare resources of money and service and administrative capacity they could have stood their ground and refused to be influenced as much by the GPFHs. But since the factors that constrained Bradford GPFHs from moving work to other hospitals also

worked in the case of BHT gaining business from adjacent areas its options were limited if it was to survive. It had to be responsive to GPFHs demands.

However the GPFHs marketisation enthusiasts complained that their actions in the market place were heavily constrained by a set of market rules and regulations that were put in place by a prescient, and cautious government, to ensure the survival of the trusts. Mohan for example argues that "concerns as to the combined effect of the switch of purchasing power and competition between hospitals led to several measures designed to minimise the likely impacts". "The language of the reforms therefore softened over time". Mohan (2000).

The government realised that had the GPFHs had total power to buy what they wanted from where they wanted the result could have been catastrophic. While the purchasers had plenty of funded demand to be met the suppliers could not respond to their demands in the time frame involved.

As a result of these constraints aggressive GPFHs behaved in a more transactional and opportunistic way than they might otherwise have done. They realised that there were safeguards in the system and so they could push the boundaries knowing that they would not cause the system to crash. There was no need to form relationships, except for the rather personal and limited ones created as a result of outreach clinics, since they were by and large forced to relate whether they wanted to or not. The metaphor of a couple stuck in a loveless relationship, behaving badly towards each other but remaining together, "for the sake of the children", comes to mind.

If this interpretation is accepted then one implication might be that that little bit of marketisation simply doesn't work. It has to be all or nothing. "The principal problems *(with marketisation in the NHS)* are associated with an absence of a competitive market structure. The simple separation of purchaser and provider role has done little to disturb the monolithic approach to health service delivery on a local level…" Bartlett and Harrison (1993).

In practice of course no market is totally unregulated and free. There is a measure of government regulation in all cases. However, by and large, such regulation tends to be rather light. Markets generally self regulate in two ways. Market actors adopt minimum norms of behaviour that allow any market to work. More subtly, market actors, given the right conditions, choose to "regulate" themselves and certain chosen partners by entering into relationships where benefits of various kinds are perceived to outweigh the loss of freedom that results. This is not a call for or a justification of the extreme free market model. It may actually be an argument for why it doesn't occur in practice. And in any case the way of judging the worth of any healthcare system must recognise that there are other kinds of objectives than purely economic ones.

References

Bartlett, W. and Harrison, L. (1993), Quasi-Markets and National Health Service Reforms, in (eds) LeGrand, J. and Bartlett, W. Quasi-Markets and Social Policy, Macmillan; Basingstoke

Culyer,A.J., Maynard, A. and Posnett, J. (1990), Competition in Health Care, Macmillan; London.

Ferlie, E. and Pettigrew, A (1996), Managing through Networks; Some Issues and implications for the National Health Service
Lunt, N, Mannion, R. and Smith, OP. (1996), Economic Discourse and the Market; The Case of Community Care, Public Administration, 74, 369-391.
Mohan, J. (2002), Planning Market and Hospitals, Routledge; London
Propper, C. (1993a) Quasi-markets and Regulation in (eds) LeGrand, J. and Bartlett, W. Quasi-Markets and Social Policy, Macmillan; Basingstoke.
Propper, C. (1993b) Quasi-markets, Contracts and Quality on Health and Social Care: The US experience, in (eds) LeGrand, J. and Bartlett, W. Quasi-Markets and Social Policy, Macmillan; Basingstoke.
Sayer, A. (2000), Realism and Social Science, Sage, London.