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Contracting in the UK NHS : Purpose, Process and Policy

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CONTRACTING IN THE UK NHS: PURPOSE, PROCESS AND POLICY

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ABSTRACT

Contracting has played a central role in the NHS reforms as the principal mechanism by which resources are transferred from purchasers to providers. The nature, process and role of contracting are traced by examining the development of government policy on this issue since the inception of the reforms. Much of the emphasis in the early years of the reforms was on getting the detail of contracting ‘right’, with attention becoming focused more recently on wider commissioning issues and the nature of the purchaser-provider relationship.

The contracting environment is described and consideration is given to the way in which changes in this environment have influenced the role and nature of contracting, particularly in terms of the tension between the role of the **market** and the role of **management** in the NHS. Contracts have been used partly as a management tool and partly as a means to promote competition, often through the *threat* of competition (‘contestability’) rather than actually switching contracts between providers. The present government’s stated intention to abolish the internal market will lessen the role of contracts as a mechanism to promote competition, but within a “*system of contestability to force improvements in standards*” (Labour Party 1996). If contestability is to be used more radically in the NHS, a clearer separation may be required between the ownership and operation of assets to address issues of poor provider performance.

Longer-term contracts (or agreements) then become the framework within which providers operate to meet purchaser service specifications, with an increasing emphasis on quality and effectiveness of services, and a decreasing emphasis on annual activity and price negotiations. The key challenge will lie in creating an appropriate set of incentives to reward efficient providers, and to ensure sufficient flexibility in longer-term agreements to challenge poor performance.

1. INTRODUCTION

The NHS reforms moved the provision of health care services away from a system based on hierarchical organisation to one based on contracting between purchasers and providers. It was made clear at the outset that the system was to be purchaser driven, as a former Secretary of State (SoS) for Health said, “*From first to last it is purchasers who should be in control. They pay the piper. They must call the tune*” (speech to NAHAT 1993). Purchasing was seen as the “*engine driving the reforms*” and contracting was seen as the “*engine house for effective purchasing*” (NHS Executive 1993).

The contracting process was originally intended to enable purchasers to secure high quality, value for money services for their local population, facilitating “change and choice”. For providers, contracts were to provide a stimulus to better performance as the most successful would receive a larger share of resources and would be able to invest in providing more and better services (Department of Health 1989a).

Despite the new government’s stated intention to replace the internal market with new structures which may alter the nature and role of contracting in the future, new policies will need to take account of the lessons learned from past experience. In this paper we consider the purpose of contracts in the NHS and the way in which the contracting process has changed over time, by tracing policy developments in contracting since the inception of the reforms. The form that contracts take and the nature of the process by which they are negotiated and monitored are influenced by the environment in which they operate. Contracting in the UK has taken place within a highly regulated environment which has permeated the contracting process. By exploring the main issues which have emerged over time, we show that whilst there has been a great deal of concern to get the detail of contracting ‘right’, attention has also turned to the wider issues concerning the contracting environment, particularly the nature of the relationships between purchasers and providers.

The question of whether contracting has been used as a means of promoting competition or as a management tool (replacing the hierarchical management processes of the pre-reform NHS) is discussed, since contracting is likely to play both these roles to varying degrees. This again reflects the environment in which contracting operates and the conflicts between the role of ‘market’ versus ‘management’ in the NHS ‘managed market’. Finally, we outline some of the tensions currently emerging in the contracting system which have implications for the future direction of contracting, as well as discussing the direction likely to be taken by the new government.

Sources of data include published empirical studies, documentation and information from the Department of Health and a small scale survey. The survey took the form of a convenience sample in which semi-structured interviews were undertaken with the director of contracting or commissioning in five health authorities in the north of England. The interviews covered a range of issues relating to their experience of contracting and their views about the operation of the internal market. The results are used in an illustrative manner rather than as a basis for generalisation to the rest of England.

2. WHAT IS AN NHS CONTRACT?

The Oxford Concise Dictionary defines a contract as “*a written or spoken agreement between two or more parties, intended to be enforceable by law*”. One would assume they are also voluntary agreements, as a party would not enter into the arrangement unless they thought they would be better off with, rather than without, the contract.

It is immediately obvious that NHS contracts do not conform to this simple dictionary definition (nor to the way in which contracts have been viewed in neo-classical economics). Indeed, contracts in what is often referred to as the NHS “quasi-market”, are best viewed as “quasi-contracts”. They are not legally enforceable unless they involve a private sector provider (Allen 1995) and disputes are not dealt with through the courts but rather through internal arbitration (or, more accurately, conciliation) processes at the regional level, with the SoS for Health acting as final conciliator in pre- or post-contract disputes.

They are not strictly voluntary, as the arbitration process allows for intervention in cases where it is perceived that one party may be taking advantage of an unequal bargaining position ie “*if either a purchaser threatened to cease securing services, or a provider threatened to cease supplying them, if its terms were not agreed, in circumstances where no alternative practical provider or purchaser was available*” (EL(91)11).

3. THE CONTRACTING ENVIRONMENT

It is not surprising that NHS contracts do not conform to the dictionary definition, as the environment into which they were introduced is not the stylised market of economic theory. The “*mental gymnastics*” required in order to sustain the metaphor of the market in the NHS has been noted since the outset of the reforms (Hughes and McGuire 1992). Purchasers and providers operate within a framework governed by a high degree of regulation, planning and public accountability. For example, there is a strong management relationship between purchasers and the NHS Executive; NHS Trusts have to adhere to public accountability and probity standards and their access to public funds for capital development is controlled centrally; and professional self-regulation is widespread. The pursuit of national policy objectives provides a framework within which the market operates and directs the behaviour of purchasers and providers.

A sense of the extent to which central direction influences local discretion is given by the annual “Priorities and Planning Guidance for the NHS” which sets out a national planning cycle in which the strategic purpose of the NHS, baseline requirements and objectives and medium term (3-5 years) priorities are described. These are presented in the context of four national policies¹ which affect the overall structure and direction of the NHS, but are aimed at defining more specific objectives which must be followed. For example, in the case of cancer services and intensive care services, the type of services to be delivered and the structure of the supplier market have been defined recently by the centre and the exercise of local choice and decision making in these areas is therefore constrained (EL(96)45).

Central regulation also permeates the contracting process in the NHS. At the outset of the reforms, the Department of Health clarified what contracts should include as a minimum.

¹ The Health of the Nation, Caring for People, The Patient’s Charter and A Primary Care Led NHS

Contracts were to “cover all aspects of the services to be provided and the expectations of both parties. A fundamental merit of the contract is that it will provide a vehicle to identify much more of what health service providers are expected to deliver” (Department of Health 1989b, page 16). At a minimum, the contract was expected to cover the following:

- ◆ nature and level of service provided
- ◆ price
- ◆ general or specific population characteristics
- ◆ facilities to be employed in so far as measures of outcome cannot be substituted
- ◆ criteria for admission and discharge and for referrals
- ◆ waiting times for access to service
- ◆ other measures of quality
- ◆ information the parties will make available to each other
- ◆ means of monitoring the contract
- ◆ mechanics of billing, authorisation and settlement

Particular aspects of the contracting process are governed by central regulations and these are detailed below.

3.1 Contract form

It was recognised that different forms of contract would be appropriate for different types of services and three types were originally envisaged as operating alongside each other (Department of Health 1989c):

Block: An annual fee is paid to the provider in return for access to a defined range of services. The contract is viewed as funding a given level of capacity, especially in relation to urgent cases and the level of capacity agreed reflects past and expected future number of referrals.

Cost and Volume: Hospitals receive a sum for a specified base-line level of activity (number of cases, treatments) and beyond that level, funding is on a cost per case basis where cost is agreed in advance. The base-line helps hospitals plan and the maximum volume helps Health Authorities retain control of expenditure.

Cost per Case: Used to fund referrals not covered by either of the other types of contract types, for instance where the GP or HA does not have a regular contract with the hospital or where additional treatments are required outside the contract. There is no prior commitment by either party to the volume of cases involved.

The block contract was intended to provide the starting point for most services in order to reduce the number of contracts which needed to be managed in the early stages and as a way of coping with the lack of information on activity and costs which was a feature of the pre-reform NHS. The block contract came very close to the pre-reform system of providing a sum of money for funding the activity of a hospital throughout a year. However, the guidance stressed that even the simplest of contracts would be more specific than the previous arrangements as they would specify how performance and quality was to be measured and set out criteria for admission and discharge. Over time, the block contract was expected to incorporate features of the cost and volume contracts, but it was acknowledged that some

services such as A&E may always need to be provided under a block contract (Department of Health 1989b).

The allocation of risk varies with each form of contract. A simple block contract with no volume threshold places the risk of unexpected surges in activity solely with the provider. Where volume thresholds are agreed, providers still bear the risk associated with case-mix as they are obliged to treat all patients regardless of the nature of treatment required. Cost and volume contracts pass the risks associated with unanticipated extra activity to the purchasers, as do cost per case contracts. In practice the preferred type of contract will reflect a trade-off between the risk-sharing arrangements and the perceived level of transaction costs associated with each type of contract. Other things being equal, the transaction costs are highest for cost per case contracts and lowest for block arrangements.

3.2 Pricing in contracts

The pricing regime has been determined centrally and the requirements were set out at the beginning of the reforms (EL(90)173). Contracts were to be generally priced at average cost, were to include all costs (overheads, an allowance for depreciation and a 6% return on capital) and planned cross-subsidisation between services was prohibited. Marginal cost pricing was allowed only if providers had unplanned spare capacity which purchasers were willing to buy.

This level of control on pricing was justified by the Department of Health in terms of the poor information base in the NHS. If providers were to make efficient choices about the nature and scale of their 'production' and purchasers were to make choices based on comparisons between providers, good information was required. If followed, the rules also ensure that providers do not make any profit as their income covers their costs (including the depreciation and 6% rate of return), there is no price discrimination between different purchasers and no subsidisation of particular services or departments by others. Under this system, it was thought that competition would be encouraged as price variations should reflect relative efficiency.

Concerns about the variation in costing methodology used by providers and the inconsistency in defining outputs and services, led to the introduction of minimum costing standards and also standardised definitions of procedures and services produced by the National Steering Group on Costing set up by the Department of Health in 1992 (see section 4.3 for a fuller exposition).

3.3 Quality

The initial guidance on contracting acknowledged that it would take time for a range of quality measures to be developed which would be comprehensive but not so "*exhaustive as to make the contract process unwieldy and the effective monitoring of their achievement impractical*" (Department of Health 1989b, page 17). It was envisaged that quality measures would fall into five broad categories: (1) guarantees related to legal requirements or national standards; (2) provision of systems to assure quality such as audit and surveys of patients opinions; (3) specific standards or key indicators of performance perhaps related to local concerns; (4) specific clinical outcome requirements; (5) "common law", a general assumption of standards which could reasonably be expected from a hospital.

Purchasers were warned against being “sucked by quality issues into the process of service provision” and were thus encouraged to focus on outcome rather than process. National quality standards (eg Patient’s Charter and waiting times targets) have been developed which provide a minimum quality requirement in contracts (largely process measures), although purchasers and providers are free to incorporate additional local targets.

3.4 Contract duration

The duration of contracts was assumed to vary according to the type of contract and the block contract was seen as most critical. The original guidance stated that, “*providers will need reasonable security before deploying the necessary resources; purchasers will want to ensure continuity of care. But, too lengthy contracts will ossify the system, depriving both purchasers and providers of the flexibility they need*” (Department of Health 1989b, page 16). Thus, the block contracts were expected to be 3 year rolling contracts with 12 month extensions negotiated annually to ensure that both parties always received at least 2 years notice of significant change.

Some idea of the extent of regulation and guidance on specific aspects of contracting can be gained by counting the number of pieces of guidance and executive and financial letters which have been issued on this topic since the reforms. Including only those which cover the main issues related to contracting, this amounted to six in 1989 and 1990; seven in 1991 and 1992; six in 1993; eight in 1994; nine in 1995; and seven in 1996 and early 1997. Although some of these consisted only of a few pages of instructions, others were rather more substantial and accompanied by more hefty manuals.

4. POLICY DEVELOPMENTS AND MAJOR ISSUES IN CONTRACTING

In each of the 4 years from 1992 to 1995, a major review of contracting has been undertaken by, or on behalf of, the Department of Health in order to reflect on the experiences of the previous contracting round and issue guidance for contracting in the forthcoming year.² Other reviews and surveys have been undertaken by national organisations representing purchasers and providers (eg National Association of Health Authorities and Trusts (NAHAT) and the Trust Federation). Specific guidance has been issued over time in relation to particular contracting issues which have arisen. These reviews and guidance are useful as they enable us to trace the main issues with which policy-makers have been concerned and, assuming the guidance for the forthcoming year reflects the issues raised by those in the service during the previous year, they also provide an insight into the concerns of those actually involved in the contracting process and the way in which contracting has evolved over time.

4.1 Contract type

Over time there has been a significant movement away from what was termed “simple” block contracts to “sophisticated block” contracts which contain target levels for minimum and

² The fourth review which was undertaken in 1995 was not published.

maximum levels of activity and trigger mechanisms which are used to initiate defined actions (eg re-negotiation procedures) when variances from target are experienced. These differ from cost and volume contracts in that extra payments are not automatically triggered by deviance from the threshold levels. These contracts have the effect of sharing the risk of unexpected activity levels between purchasers and providers.

The first national review (EL(92)79) undertaken in 1992 noted the movement towards the increasing use of cost and volume contracts and encouraged this for the forthcoming year. The Department of Health later stated that **no** simple block contracts (ie those without floors or ceilings) were to be used for the 1995/6 contracting round (Planning and Priorities Guidance 1994/5). It was acknowledged that block contracts may remain appropriate for non-acute and community services where information was poor and the contracting currency remained problematic, but these were at least to have some form of indicative volume. This was re-iterated in the 1993 and 1994 review (EL(93)103) and EL(94)88).

The latest information on contract type is for 1994/5 and deals only with the “top three” contracts from each HA (ie those accounting for large proportion of expenditure):

Simple Block:	5%
Sophisticated Block:	69%
Cost and Volume:	25%
Cost per Case:	1%

This shift has occurred fairly rapidly as an earlier survey in 1991/2 noted that 40% were simple block and 42% sophisticated block.

There is wide variation in the number of contracts held by Health Authorities. In 1996/7, there were 3973 contracts and each health authority held an average of 40 contracts, but this ranged from 12 in the Isle of Wight to 136 in West Sussex. Thirty-eight per cent of all contracts are held by purchasers within just two regions - in North and South Thames each (NHS Executive, personal communication). Information on GPFH contracts is scarce. It is estimated that there are 8,000 fundholder contracts in total and on average, each GP contracts with four acute providers, although they may have more than one contract in each (NHS Executive, personal communication). As fundholding expands and the range of services covered increases, NHS Trusts are dealing with more fundholder contracts. Between 1992/3 and 1994/5, the average number of fundholder contracts per Trust increased fourfold to reach 16, but again the variance is large as some Trusts hold over 100 GPFH contracts (Audit Commission 1996).

In addition, over time there has been a move away from contracts at the level of the “whole” hospital unit and towards specialty and sub-speciality based contracting (this was supported by developments in costing which are discussed below) and the 1994 review required purchasers and providers to further break down contracts in case mix by inpatient, outpatient, day patient and diagnostic services, with clear costs and volumes for each where possible.

4.2 Managing activity in contracts

There has been significant emphasis on the methods to be used for managing under or over performance in terms of the volume of contracted activity. This can be seen at least in part as a response to a spate of incidents (which received heavy media coverage) where hospitals

suddenly announced that they would not be treating any more patients for the remaining duration of the contract as they had already met or exceeded the contracted level of activity.

In 1993, guidance relating to the management of activity was issued (EL(93)10) and subsequent contracting guidance re-iterated this by stressing the need for contracted activity to reflect referral patterns and to be profiled to allow for seasonal variation. Contracts for non-emergency work were to contain thresholds and trigger mechanisms. Monitoring procedures and the actions to be taken to get activity back in line or to be re-negotiated were to be set out clearly in the contracts. Some purchasers and providers had agreed early warning systems for 'fast track' problem solving to deal with 'hot spots' of over-activity and these were recommended as good practice.

4.3 Pricing, costing and defining the product

As noted earlier, guidance on costing methodology was introduced in response to perceived inconsistency in costing and definitions of services. Concern over inconsistency was reported in the first annual survey as purchasers found it difficult to make comparisons and choices. Minimum standards for costing were produced in 1993 (FDL (93)59) and costing at the level of specialties was required, following a "top down" method of attributing costs. Indeed, the 1994 review reported that 16% of contracts amongst the main acute services were already being costed at sub-speciality level (eg using major/minor distinctions, procedure pricing or some form of banding)

The National Steering Group addressed the issue of consistency in definition by developing around 500 Health Resource Groups (HRGs) which allow case-mix differences to be taken into account in costing procedures. HRGs are now routinely recorded items of information on diagnoses and procedures and are used to allocate consultant episodes to groups of clinically similar conditions with similar costs. In 1994, guidance was issued which required all acute sector providers to cost at least one of three nationally selected acute surgical specialties (ophthalmology, gynaecology and orthopaedics) to the level of HRGs by 1995/6 (EL(94)51). The 1996/7 guidance extended this requirement to 6 specialties (adding urology, general surgery and ENT) and the recommendation for 1997/8 was that HRGs should be costed for all surgical specialties and that prices should be available for elective and non-elective work at the HRG level within these specialties. Purchasers and providers are not currently required to use costed HRGs as a contracting currency, but they are required to demonstrate that they are used to **inform** contracts by providing comparative cost data. The lack of standard contract currencies was highlighted recently as a cause of much of the extra paper-work and workload providers have to undertake in order to prepare for contracting (NHS Executive 1996a). As a result of this, there has been a recommendation that at least for acute services, all Trusts should move towards a standard basis for costing and that this should be used in all contracts and on the basis of current evidence, this should be HRGs. However, this is a recommendation only and many purchasers and providers will remain reluctant to use HRGs extensively as a contracting currency as there is a lack of clear direction about what future developments may be. At present, the development of Health Benefit Groups (HBGs) which group procedures on the basis of similar outcomes are receiving attention.

Whilst the rules relating to costing and pricing are very clear, there has been mounting anecdotal evidence that providers are able to disregard these rules, possibly in order to discriminate between purchasers or to cross-subsidise between services, especially where the provider has a monopoly in some services but faces competition in others. In addition, there

has been some pressure for relaxation of the rules on the grounds that information on costs and prices is much improved and providers no longer require detailed methodological procedures for allocation of costs. Moreover, there has been some criticism of the pricing rules, which in combination with rules relating to retention of surpluses, have been argued to be provide perverse incentives for efficient behaviour amongst Trusts (Dawson 1994, Propper 1995).

In response to many of these claims, the Department of Health recently commissioned a survey of the actual operation of costing and pricing amongst Trusts (KPMG 1996). Overall, the study indicated quite a high degree of compliance with the national guidance. More complex contracts (cost and volume and cost per case) often involved very sophisticated forms of costing and 73% of respondents indicated that their block contracts were costed at, or above the level, of sophistication required by the guidance. The extent to which prices were set to be equal to all purchasers and in all contracts was also examined in the survey and significant variation was found. Even where prices were originally set to be equal, they were often adjusted post-negotiation, especially in recognition of purchaser affordability and Trusts reported that only in around 44% of cases was there no variation between the prices paid by their main purchasers. This fell to 32% of cases for more minor purchasers and 35% for GPFHs.

In response to these findings and further consideration of the costs and benefits of the current pricing regime, the review group concluded that the cost=price relationship should be retained for the time being but dispensed with if a number of conditions could be met in respect of development of the internal market. The latter includes steps to increase price transparency and consistency in costing methods and the definition of products, on the grounds that this would facilitate the detection of attempts to exploit monopoly power through pricing (NHS Executive 1996b).

4.4 Duration of contracts

Each year, central guidance has “encouraged” purchasers and providers to consider the use of rolling block contracts and longer term fixed contracts with provisions for early termination where “appropriate”. GPFHs reported difficulties in committing resources for longer than one year as their budget-holding status is only confirmed on an annual basis, but they were encouraged to state their intentions within a longer timeframe, even if the contracts were always of one year duration.

The 1995 review reported that GPFHs and HAs saw the benefits of longer term contracts in certain circumstances, especially in relation to achieving strategic change over a period of time. Ten HAs had 2-3 year rolling contracts for all acute services and one had used a five year contract to facilitate acute sector reconfiguration. Some 10 year contracts existed for specific services such as nursing home care where continuity was important. Our survey ³ found that purchasers often have longer term contracts with voluntary organisations as these tend to be small organisations which depended almost solely on the contract as their main source of income and would find it impossible to employ all their staff on annual contracts.

Concern about the level of transaction costs prompted a recommendation that purchasers and providers move towards the wider use of longer contracts and a suggestion that the

³ Details of the survey are given in the introduction to this paper

Department might issue targets for purchasers to commit expenditures in this way. In reality, it is not clear how much the use of longer contracts would actually reduce transaction costs, especially if activity and price were re-negotiated each year in detail. One purchaser in our survey noted that whilst their 3 year contracts are not about saying "*here is the money, see you in 3 years*", they were sufficiently confident with good quality providers to make the commitment and flex activity and expenditure very slightly each year, thus avoiding intense annual re-negotiations. Other advantages of longer term contracts have been identified by both the Department of Health and those involved in contracting (eg longer term strategic developments, sharing risk), so this development may bring additional benefits.

In practice, some purchasers see the annual resource allocation cycle as an obstacle to the use of LTCs. For example, in our survey, purchasers reported that they may indeed commit to buying a range of services from a provider for more than one year, but that "*it doesn't avoid that annual round of what exactly do you buy, how much are you willing to pay for it and what changes do you want to negotiate*". The annual contracting timetable, annual pay awards and annual inflation allowances are seen as re-inforcing the shorter term outlook in many cases.

4.5 Involvement of health care professionals in contracting

The 1993 contracting survey revealed that despite earlier guidance emphasising the importance of involving health care professionals in contracting, clinicians still felt they were not fully involved in contracting. The following year, the involvement of clinicians was made a requirement in the annual planning and priorities guidance and the next contracting review reported that in 58% of main contracts, clinicians were involved at some stage in the contracting process. Of those that involved clinicians, 60% reported that the involvement had made a difference in some way. The message has been reinforced by special guidance on involving clinicians following a task force set up to address these issues (EL(90)221).

In common with the 1995 national review, our survey found that most purchasers recognised the importance of involving clinicians in particular aspects of contracting if they were to ensure that contracts were realistic and could be delivered by those actually responsible for providing the service. Some commented that it was a mistake to try to involve clinicians in the "*bureaucratic wrangling*", but that they should be heavily involved in the specification of services and the management of activity in-year. The importance of fostering a dialogue between GPs and the clinicians within Trusts was also seen as essential for managing the balance between elective and emergency work.

4.6 Working relationships and the balance of power

In the early stages of the reforms, the language surrounding contracting tended to depict purchasers and providers as being opponents battling through tough contract negotiations, each trying to score points at the expense of the other party. This may have been in part a result of the attempt by the government to separate the roles and to make it clear that the old-style provider no longer existed. The new purchaser was to be one step removed from the provision of health care and had a new role in identifying services required to meet the health needs of its resident population (Department of Health 1989c).

The NHS was reminded that an “*element of competition between providers and also between purchasers is vital for change*” and that purchasing is not about “*protecting the income of local providers*” (NHS Executive 1993). Many Trusts seem to have engaged in quite strong marketing exercises and purchasers in our survey noted that, “*some Trusts have been extremely macho. They have been looking to develop contracts all over the place, some many miles from their own patch.*”

Equally, on the purchasing side, the HAs felt the need to flex their muscles, especially as there was a perception that many of the key staff from the pre-reform NHS originally chose to work on the providing rather than the purchasing side, giving the providers the advantage in terms of information on services and the local area. Purchasers may have felt the need to signal that they were not prepared to be out-manoeuvred by the providers and would not be drawn into a provider-led, rather than a purchaser-led, NHS. The tendency for providers to drive service development and expect purchasers to pay was noted by most of the purchasers in our survey who felt this often was the cause of duplication and over-provision of services in the early days. For example, “*there was a culture of some providers initiating service developments and changes without purchaser approval on the basis of ‘you have got to pay for it or stop your patients coming’*” and, in relation to the duplication of cardiology services by two local Trusts, one purchaser remarked that “*..[the Trusts] are not funded for it, they just develop it. They are not based on a business plan, no clinical effectiveness has been satisfied, it is just ad hoc...It is marketed directly to GPs, it becomes out of control and what you then face is a bill for developments*”. It was clear that some purchasers felt that only now were they beginning to take control over the situation and become “*more systematic and assertive about [their] role and that has fundamentally shifted the balance of power*”.

However, almost simultaneously and certainly in more recent years, the need for collaboration and the development of longer term relationships has also been emphasised. The 1993 contracting review noted that purchasers and providers needed to work together and share risks and many examples of collaborative working were found by the 1995 review, although some respondents identified that “*power games*” still hindered collaborative work in some cases. In defining the elements of successful purchasing, ministers stated that “*mature relations with providers*” were essential and that although the reference to the purchaser/provider “split” was seen as useful in defining roles, the image of a stand-off relationship was unwanted (NHS Executive 1993). Ideally, they were looking for “*creative tension and robust negotiation*” whilst recognising that relations in the private sector are governed by partnership and longer term relationships. Instances of contracting characterised by “*posturing*” were frowned upon.

Whilst this shift may reflect changes in political context, it is likely to also be a consequence of the increasing familiarity of purchasers and providers with their new roles and acceptance of the need to work together in order to facilitate structural change and achieve national and local policy objectives. In our survey, all the purchasers agreed that relationships had matured and that the days of the “*macho-purchaser*” and independent provider were “*well past their sell-by date*”. The framework within which contracting is undertaken is characterised by the sort of relational contracting found in other sectors, “*It is about nurturing...if you have a good provider you want to work with them..it is a constant process..it is a dialogue based system*” and “*A key to anything happening is that relationships are sound...you don't have to like each other..... but the relationships have to recognise that we are all part of the same NHS*”. This is supported by the study of contracting undertaken by Flynn et al (1997) in which HAs said they favoured collaborative relationships and that trust

was central to these relationships. However, they also noted a certain tension between aspirations and the reality as the role of trust in the relationships was often “*precarious and volatile*”. This was also reflected by the purchasers in our study as they noted that some aspects of adversarial behaviour existed and that some Trusts still had a very “*predatory*” style, behaving opportunistically wherever possible.

In summary, many of the issues which have emerged over time have been related to clarifying the ‘rules of the game’ and have concerned the detailed mechanics of contracting such as what form of contract should be used, appropriate pricing and costing methods, standardisation of the definition of the product and managing activity within the contract. However, some attention has also been paid to the wider environment in which contracting takes place, who should be involved in contracting and the nature of the relationship between purchasers and providers.

5. COMPETING BY MANAGING OR MANAGING BY COMPETING?

The NHS reforms were one element in a much wider policy of ‘rolling back the State’ in order to contain rising public expenditure and to make public services more accountable to users. The introduction of elements of the private sector into public sector services was seen as a means of combining the disciplines of the market with the values of the welfare state (Flynn and Williams 1997). Different measures and degrees of “privatisation” were applied, ranging from the transformation of the nationalised utilities into regulated private profit-making enterprises to changes in the organisational structures of a number of public sectors including housing, education and social services. In common with other sectors, the method of allocating resources in health care was changed from a hierarchical bureaucracy within a vertically integrated “firm” to a quasi-competitive system of contractual arrangements between purchasers and providers within an internal market.

A strictly neo-classical view of markets and competition would perceive of NHS purchasers making fully informed purchasing decisions based on unrestricted choice between competing providers, taking into account the price and quality characteristics of the health care “product”. Some elements of this approach were apparent in the early stages of the reforms where the emphasis was on the importance of competition between hospitals, as a means to enhance responsiveness and efficiency eg “*...self-government for hospitals...supported by a funding system in which successful hospitals can flourish, will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered*” and “*competition with other hospitals, where it is effective, should also constrain costs*” (Department of Health 1989a, pages 22 and 24). Early policy statements at the start of the reforms stressed the potential for those hospitals which best meet the needs and wishes of patients to get the money to continue to do so and for hospitals which offer the best value for money to be rewarded (Department of Health 1989a). Purchasers were envisaged as defining what they required on the basis of comprehensive health needs assessments, and “*if the provider does not deliver satisfactory value for money for patients, consider moving your health care business elsewhere. The whole point of the internal market in the NHS is that purchasers should be able to use the threat of competition..*” (NHS Executive 1993).

However, conventional approaches to competition and the nature of contracting are restrictive and there has been a recent convergence from a number of different perspectives about the

role of collaboration, social networks and trust in understanding contractual relationships. Rather than being seen as mechanistically enforced documents, explained in terms of individual motives alone, contracts (and other forms of economic exchange) are seen as being embedded in ongoing networks of social relations (Granovetter 1992; Granovetter and Swedberg 1992). Thus contracts are seen as “relational” where parties recognise their mutual dependence and the contract is a method of adapting to changing circumstances over time. Empirical work in industries characterised by longer term relationships between purchasers and suppliers has illustrated the importance of extra-legal sanctions, unwritten rules, social pressures and norms as a basis for contractual relationships which are based on trust and reputation with repeat trading (eg Arighetti et al, 1996, Burchell and Wilkinson 1996, Macaulay 1963, Beale and Dougdale 1975). Similarly, research has shown that markets dominated by small numbers of large organisations, and where buyers and sellers have to make investments, the value of which depends upon a continued relationship, are likely to be characterised by long term social relationships and co-operative processes (eg Crocker and Masten 1988, Joskow 1987, Goldberg and Erickson 1987).

Additionally, some of the literature on organisational change suggests that reorganisations in the public sector may fail to deliver change in the long-term as once the immediate political pressures at the time of the change are relaxed, old-style behaviours will re-emerge. In the context of the NHS this might suggest that whilst the language and rhetoric of the market remains, the contracting process is used as a mask and merely serves to reinforce the pre-reform allocation and management processes (Bennet and Ferlie 1996).

Does this suggest that contracting has **not** been used in order to promote competition in the NHS? It has always been recognised that the scope for competition in the NHS is constrained by the fact that some of the conditions which facilitate competition in other markets, such as the existence of spare capacity, are difficult to maintain within a publicly funded system where duplication and spare capacity can be viewed as a sub-optimal use of resources. Additionally, for the most part, providers are working within a “zero-sum” game as the fixed budgets within which purchasing operates implies that for every “winner” there will be a “loser”⁴. The potential for economies of scale and scope in the provision of some health care services is also often put forward as a reason to expect the supply of many health care services to be dominated by monopoly providers, although the evidence for the existence of these economies is patchy (Effective Health Care Bulletin 1996). Empirical work which has attempted to measure the degree of competition on the supply-side in the UK has been very limited. A study of the degree of concentration in the ‘market’ for general surgery in 1991/2 in one region in England concluded that there were signs of competition emerging but highlighted the serious methodological difficulties associated with the study (Appleby et al 1994). Subsequent studies have attempted to explore the relationship between the degree of competition (using concentration indices) and prices and the expected negative relationship has been found to be rather weak in some cases (Propper 1996; Propper and Wilson 1996; Propper and Bartlett 1997) and more strongly in others (Csaba 1997).

Moreover, in a regulated market like the NHS it is clear that significant changes in the nature, location or scope of services will only be allowed to occur as part of a managed process, rather than purely as a result of the unconstrained operation of market forces. Although purchasers were expected to have the freedom to choose between providers and to direct their

⁴ Although there is some scope for expansion of the size of the “pie” through access to private rather than public funds

business only towards those who met their requirements and fulfilled their contracts, it became clear very quickly that the combined actions of a few purchasers or a significant contracting shift from a key purchaser could potentially “de-stabilise” a provider and threaten its long-term viability. The tension between encouraging change, which was one of the key purposes of the reforms, and ensuring that this change occurred within a managed framework to minimise unpredicted or “undesirable” results has permeated policy. Whilst purchasers were berated for “*cosy relationships*” aimed at maintaining the status quo, they were also exhorted to ensure that change should be planned and that there should be “*no surprises*” (NHS Executive 1993).

To this end, policy has emphasised the need for purchasers to give adequate notice to their providers (and also to purchasers who share the services of that provider), of “significant” changes in contracting intentions. In 1994, purchasers were required to produce five-year plans in addition to the usual annual plans and the former were aimed at developing strategic intentions over time. In the context of these, purchasers were required to signal major shifts at least eighteen months in advance and changes at the margin at least six months before the start of the contracting year. Similarly, providers were intended to signal changes in their costing methods well in advance so that purchasers did not face unexpected large price changes.

Empirical evidence based on studies of the contracting process is thin on the ground, but a few case studies of contracts for specific services have been undertaken. An examination of contracting for HIV/AIDS services from 1993-95 concluded that competition was rather patchy and that rather than picking and choosing between service options, purchasers seemed to prefer to encourage co-operation. However, purchasers did appear to be using the contract process to mould services in new directions and commission new services where necessary (Bennet and Ferlie 1996). In a study of contracting for community health services, the purchasers stressed the importance of the “localness” of services and thus concluded that it would be difficult to see any real competition, although they felt there was scope for competition “*at the edges*” of geographical areas (Flynn et al 1997). Purchasers in our survey saw that the ability to move contracts or to threaten to move them, had provided them with a powerful mechanism for change, especially in relation to services which were poor quality and for new services. For example, “[we have] *shifted providers in a positive way. You now have a formal mechanism whereas pre-reform there was not..if you were sat here and did not like the local services, there was no way of shifting the money.*” Similarly, “*the exercise of real choice about providers [is] when you are developing a new service or changing the pattern of use for a service.*” and “*you wouldn't think 5 years ago of moving services or telling people to lower costs or improve quality....[but now] we have moved services, costs have come down and quality has improved in some cases*”. However, this was tempered by the recognition that for some services, providers have local monopolies, “*there can be a lot of [talk] about shifting stuff around for which there is no reality....people want local services*”.

Data from the Department of Health estimating the proportion of purchaser expenditure contracted with providers from within the boundaries of the HA, illustrates in part the extent to which contracts are being moved around (NHS Executive, personal communication)⁵. Between 1991/2 and 1992/3, this ranged from an increase in “within-DHA” purchasing of

⁵ It is not possible to draw firm conclusions from these data as those purchasers with more than one local provider may shift contracts between providers whilst remaining within their DHA boundaries.

23% to a decrease of 38%, which suggests that at least some change is being made in terms of the providers with whom contracts are let. However, given that many purchasers will have little choice about where to place most contracts for non-elective services, it is not surprising that in 1994/5, 88% of **main** contracts were held by providers within the HA boundaries of the purchaser. Even if purchasers are not actually moving contracts around, this does not necessarily imply that competition or the **threat** of competition is not operating. Purchasers in our survey recognised this and often used the threat of switching as a way of forcing providers to improve quality. In one example, the local GPFHs had indicated that they were contemplating moving a chiropody contract from a poorly performing provider and the HA followed suit and said that if they did not improve by the following year, they would also move. The service had improved greatly by the end of the contractual period and the contract remained with the incumbent provider.

Market testing exercises where services are formally put out for tender by purchasers clearly involves an element of competitive bidding between alternative providers. Although most market testing activity has tended to be undertaken within Trusts in terms of the provision of non-clinical services, there has been experience in relation to the market testing of clinical services and some purchasers have found this to be a useful way of comparing the prices and quality of services offered by alternative providers in a more formal way before awarding a contract. A review of contracts in 1993/4 revealed that almost 40% of providers had been involved in tendering and another 20% expected to be in the following year (Appleby 1994). Experiences related in the annual contracting reviews suggest that most market testing activity has been focused on services with which purchasers were dissatisfied and this was confirmed by purchasers in our surveys who noted that "*we have tendered services that we have been concerned about*" and "*on the few occasions when competitive tendering has been used it has been used on services that really did need a kick up the backside. Emerging out of that has been a substantially improved service.*"

If contracts are used in conjunction with a non-competitive environment, this raises the problem of how they are made to be effective if they are used merely as a means of trying to manage providers. The use of sanctions and incentives in contracts has been fairly limited to date and largely confined to financial penalties on the provider for failure to provide the required data for contract monitoring purposes (Spurgeon et al 1997). Even if sanctions are used more widely, they will have very little teeth unless the purchaser can make a credible threat to switch the contract if providers fail to comply. Where purchasers are faced with monopoly providers of particular services and little chance of moving the contract elsewhere, the importance of **contestability** rather than competition can be seen. Whilst in some circumstances it may be feasible to have only a single provider of a service in the market at one time, perhaps because local access is key or because an efficient level of production can be achieved only through having one larger provider rather than several smaller ones, this does not imply that the provider automatically continues to receive the contract if performance has been unsatisfactory, as long as there can be competition **for** the market at this time.

If contestability is to be used more radically in the NHS, this might require clearer separation of the ownership and operation of assets. Trusts tend to behave **as if** they own the hospital assets whereas in reality they are owned by the SoS who has the power to divest a Trust of these assets and pass them into the control of alternative management. Thus, at least in theory, a poorly performing Trust could be made to relinquish the assets involved in the provision of a service and allow another management or clinical team to bid for the contract to operate the

services. This mirrors the situation in many of the regulated privatised utilities in the UK - for example, the privatisation of the railways has taken the form of monopoly ownership of the track whilst the franchises for running the service have been awarded in a competitive process.

Whilst there may be many practical problems in putting this into action into the NHS, not least the availability and willingness of alternative managers and clinicians to bid for such contracts⁶, it is a potential answer to the problem of using contracts effectively in circumstances where competition is limited. Indeed, despite the Labour Party's avowed intentions to "abolish" the competitive internal market, their pre-election speeches recognised the need to address poor provider performance and Chris Smith stated that purchasers could use a "*system of contestability to force improvements in standards*" (Labour Party 1996). As they also claim that this would address the deficit in the current system whereby a new purchaser could come in and use a sub-standard service even if it has been rejected by others, the **implication** is that contestability would be used to replace wholesale those responsible for the poor performance, be they managers or clinicians or at the very least to force them to come up to standard through the **threat** of replacement. However, we await clarification from the current SoS about the role of contestability.

Purchasers also recognise the value of having comparative information on price and quality of services from different providers, even where this does not change their purchasing pattern as they see it as a useful tool which can improve leverage. Purchasers in our survey noted that comparisons could be made within a city, a region or even nationally and that they had put considerable time and effort into bench-marking activities which they saw as improving their negotiating position with providers. Improvements in the availability and quality of comparative information was seen as a priority by some.

In conclusion, the evidence suggests that in **some** circumstances purchasers have used the contracting mechanism as a means through which they can stimulate competition and bring about change. This is seen most sharply where purchasers are developing new services or have identified that the service they are getting is very poor. In other circumstances, purchasers have used the threat of competition as a means of improving services, but this is not necessarily reflected in changes in their purchasing patterns as the incumbent providers are often able to meet the purchaser's requirements and the contract remains with them as a result. In the NHS there are limits on the extent to which it is possible to have competition **in** the market for some services, especially those where local access is essential and where economies of scale and scope exist and, in these cases, it is more difficult to make contracts effective. Making these services contestable at the time of contract renewal is one potential solution, but sharper separation of the ownership and operation of assets would be required if this method is to be used successfully. That contracting seems to be used to promote competition and achieve change in some circumstances and not others, is perhaps a reflection of the inherent conflict in a 'managed market' like the NHS where there is a balance to be struck between the relative roles to be played by the 'market' and by 'management'. This theme is also apparent in some of the current tensions in contracting.

⁶ There may be a severe supply constraint in terms of the numbers of clinicians within certain specialties who are available to take over the running of another service and, perhaps more importantly, the willingness of clinicians to venture into the territory of their colleagues given the close professional networks which exist.

6. CURRENT TENSIONS IN CONTRACTING AND IMPLICATIONS FOR THE FUTURE DIRECTION OF CONTRACTING

6.1 Equity

Around half the population is now covered by some form of fundholding which accounts for 15% of total expenditure in the hospital and community health services sector (Audit Commission 1996). Recent changes have moved primary care in a number of geographical areas towards total fundholding where GPs manage the budget for all services.

Although fundholding was viewed by the previous government as one of the successes of the NHS reforms, the potential impact on patients in terms of equity has been the subject of debate. Media reports and anecdotal evidence have suggested that some NHS Trusts offer preferential treatment to patients of GPFHs compared with patients funded through the HA, hence allegations of 'two-tierism' have arisen. The incentive for the Trusts to engage in such behaviour is to gain additional income by slowing down activity covered by block contracts with HAs (thus increasing waiting times for these patients), whilst increasing activity through cost per case contracts with GPFHs. Additionally, Trusts seem keen to retain the business of fundholders, perhaps as they are perceived as being willing and able to shift their contracts around if they are unhappy with the service provided. Early evidence did indeed suggest that GPFHs were willing to switch, generally on quality grounds (Glennerster et al 1994; Mahon et al 1994), but there also seems to have been a decrease over time in the extent to which GPFHs refer to hospitals outside their district (Coulter and Bradlaw 1993), although of course this could hide switching within-district for some services. A more recent survey confirmed that the majority of fundholders had made no major changes to where they referred (Audit Commission 1996).

Examples of Trusts cancelling outpatient appointments and routine surgery for patients of non-fundholding GPs have been cited as evidence that two-tierism is rife (Labour Party 1996). Examples and complaints of two-tier treatment have been widely reported (eg McCullough 1993; Samuel 1992; Luxton 1993; Association of Community Health Councils 1994), but systematic evidence is not available (Dixon and Glennerster 1995). Comparisons of access for fundholding and non-fundholding patients would have been needed for firm conclusions to be drawn. A study of outpatient and inpatient waiting times in one region found no differences in the length of wait for patients of fundholders and non-fundholders, casting doubt on the two-tier theory (Coulter 1995).

The perceived inequity of this system explains in part the pre-election proposals from the Labour Party to replace fundholding with GP-led local commissioning, involving **all** GPs. These groups would vary in size, so each HA would have between 5 and 15 groups which would receive a budget covering all aspects of care and would work with the HA to decide where contracts or "agreements" would be placed. The "health action zones" recently mentioned by the SoS fit this model. However, although entry to the eighth wave of GP fundholding has been deferred by the government, it is now not clear what direction purchasing will take in the future other than to retain the primary care focus and to be based on what works for particular local areas rather than on a single model across the country. Hence a number of primary care pilot site projects are being established in accordance with the Primary Care Act 1997, with an explicit evaluation framework (NHS Executive 1997).

6.2 Managing demand

Whilst HAs have the responsibility for placing contracts for services, they do not play a role in generating or managing demand for those services. GPs are the source of most referrals to the acute and the community sector and tertiary referrals to a Trust providing more specialist care are often initiated by the Trust currently dealing with the patient. Fundholders are responsible for paying for referrals they make for those services covered by their funds, whilst the HA is responsible for those services not included in the fund and for services for all non-fundholders. Non fundholders are expected to refer patients to hospitals with which the HA has a contract (so HAs are intended to set contracts by consulting local GPs and examining referral patterns), but in order to preserve the clinical freedom of doctors to decide if they require the services of a hospital with which the HA does not have a contract, the system of Extra-Contractual Referrals (ECRs) was created. Under this system, the HA in which the patient lives will reimburse the provider if a referral is made which is not covered in a contract. The need for prior notification of emergency and tertiary ECRs and more recently, of elective ECRs, has been removed with the intention of reducing bureaucracy [EL(96)56 and EL(96)94]. Although the costs of ECRs represent a small proportion of HA expenditure overall (just under 2%), this expenditure is unpredictable and HAs need to retain reserves in order to ensure they can meet their ECR bill.

Purchasers have tended to view the demand for health care services as an external hazard over which they have no control and have focused their attention on aspects of supply instead. Thus in many parts of the country, the impetus for merger and rationalisation of Trusts has come from purchasers who are keen to control supply in order to influence demand indirectly. However, recent policy developments are aimed at getting purchasers to take more control over demand. HAs have been urged to discuss ECR flows and referral patterns with local GPs in order to draw up local protocols clarifying the circumstances and the manner in which GPs should refer outside of contracts (EL(96)94). The purpose of this to create a greater understanding of the process between HAs and GPs in order to influence demand and facilitate efficient contracting. Similarly, innovative contractual arrangements which tie clinical and budgetary responsibility for tertiary referrals together have been encouraged. As well as ensuring seamless care across institutional boundaries, these sub-contracting models can also encourage efficient referral practices, as the Trusts in which the clinician making the referral is based are also responsible for payment for the referral.

Other developments aimed at controlling demand have been emphasised heavily both within and outside the contracting process. For example, prioritisation has been seen as a major role for purchasers, and in some cases this has led to the development of 'contract exclusions': procedures and treatments which HAs state they will not normally fund (eg gender realignment, cosmetic plastic surgery, pregnancy testing, some types of fertility treatment), although there is usually a caveat to cover cases where there are strong medical grounds (eg Redmayne et al 1993, Redmayne 1995). Some new and unevaluated treatments such as homeopathy have also been excluded by particular HAs.

Tight budget constraints for both purchasers and providers are unlikely to disappear in the future, thus policy aimed at increasing control over demand will probably continue. However, the Labour government may be less willing to allow explicit rationing to take place at the level of the HA as this has often led to geographical inequity in the range of treatments funded by the HA which are available to local populations. Instead they have suggested that there will be a clearer national framework for service priorities based on clinical evidence of effectiveness (Labour Party 1996).

6.3 Differentiation of roles

In defining the roles of the purchaser and provider in the new NHS, the Department of Health emphasised the importance of the distancing of the purchaser from decisions about the process of production of health care services: “*the changing role of DHAs from service managers to service purchasers will increasingly mean that they will concentrate on what services their residents need without specifying in detail how each service is to be provided*” (Department of Health 1989b). This simple model suggests that contracts specify precisely what is required and providers bid in order to win the contract and provide the service specified. However, the degree to which this is possible is governed by the ability of purchasers to specify their requirements in terms of health outcomes rather than process measures or intermediate outcomes. Although there has been some movement in this direction, purchasers are still not in a position to specify outcomes for the vast majority of services.

The need to continue, at least in the medium term, to focus on process measures has perhaps accentuated the difficulties experienced by some purchasers in becoming embroiled in the detail of **how** providers deliver the services required and the operational problems of their main providers. There is an important distinction to be made between purchasers’ concerns that providers take note of available evidence relating to clinical and cost-effectiveness (and there is increasing evidence that purchasers require providers to follow treatment protocols and best practice guidance), which may be viewed as a key part of the purchasing process; and the involvement in detailed discussions about how providers handle internal cost pressures.

Purchasers and providers frequently appear to be at odds in their approach to this dilemma, as providers often argue that purchasers fail to realise that they **must** be involved at this level, whilst some purchasers argue that they are involved inappropriately. For example, some purchasers in our survey noted that although in theory the contract allows them to agree a quantity of service for a given price and let the Trusts decide how to organise inputs as this is what they are paid to manage, “*....that theory is a long way from reality because each year we are faced with contract negotiations around the problems that Trusts have got in terms of delivering the service*” and “*in an ideal world we don’t buy any nurses or doctors or pieces of equipment - we buy a service - but we are nowhere near being able to hold that line and hand that problem back to them*”. The dilemma is also reflected in national policy which initially viewed purchasers as focusing on service specifications and letting Trusts manage their difficulties, but has later suggested that purchasers need to “share ownership” of provider difficulties, particularly the in-year pressures (EL(93)103).

There is a balance to be struck between on the one hand acknowledging that providers are faced with national and local pressures which may raise costs or make the current configuration of services inappropriate, thus requiring a degree of collaboration with purchasers and joint decision-making on service provision; and a need to ensure that purchasers do not get drawn back into a pre-reform system of involvement in issues which Trusts should be addressing themselves. This problem is clearly not new: indeed, it could be argued that as time passes purchasers are less likely to get involved in Trust issues as the old-style management involvement is replaced by new attitudes and approaches. However, it appears that current circumstances have highlighted the dilemma as there is a perception that the 1996/97 contracting year has been the toughest since the reforms (NAHAT 1996). This is being attributed to a growing financial gap between the funds available to purchasers and

the extra costs to providers of meeting purchaser demands for efficiency gains and improvements in quality, but more importantly, of meeting various national policies (such as limits on junior doctor hours) which have cost implications. Hence, Trusts may feel that they need to make purchasers aware of each cost pressure and management issue in order to justify requests for additional funding, although purchasers faced with limited funds themselves become frustrated that Trusts' income expectations far outweigh the available funds.

6.4 Contracting, purchasing and commissioning

It is now almost a stylised fact that the early days of contracting were dominated by what was seen by some to be an inappropriate level of attention to detail and content at the expense of an overall strategic outlook. The government at the time stated that the first two years of the reforms had been focused on safeguarding the provider base and achieving the separation of purchasers and providers. After that, attention turned to the importance of 'purchasing', with the emphasis on how purchasing was concerned with forcing the pace of change in the health service and moving away from services based on historical patterns, service inputs and institutions (NHS Executive 1993). The word '**purchasing**' seemed to be used to distinguish the wider responsibilities that HAs had for identifying the health needs of their population and specifying the services required to meet those needs, from '**contracting**' which was the vehicle to be used to achieve these changes - but focused somewhat narrowly on the activities related to writing and monitoring contracts (leading to criticisms that it has become a 'paper chase').

'Purchasing' now appears to have gone out of fashion as it tends to be associated with the process of buying in a market-place, and 'commissioning' is the focus. Whilst this may be seen merely as a change in language, it does seem to have been accompanied by a recognition that contracting - defined in terms of obtaining agreements about price, volume, quality and the flow of funds between purchasers and providers - is but one small part of the role of the commissioner or purchaser. At the outset of the reforms, the level and quality of information available to facilitate the contracting process was very poor, and a great deal of resources and effort went into ensuring that appropriate information systems were in place to rectify this. There have been numerous attempts to improve methods of costing, pricing and defining services to allow purchasers to make sense of comparative information. This has inevitably led to a focus on the detail of contracting, perhaps at the expense of the wider picture.

It is only now that purchasers appear to feel that they can start to move away from the detail of contracting and focus more on what they term "service-driven" contracting: as purchasers in our survey stated, "*contracts tend to be about columns of figures about activity and money and Patients' Charter standards.....service agreements describe the service and what it does for people*", and "*contracting has tended to concentrate on the exchange of money....commissioning is about re-shaping, modelling and planning changes in service provision*". Whilst this may have been the intention from the outset of the reforms, the amount of time purchasers have had to spend on developing the skills needed to ensure they can get contracts signed off each year appears to have dominated their activities for the past few years. Now purchasers are viewing contracts as a much less important part of their role and are emphasising the need to **use** contracts as a tool in order to achieve the models of service they require: "*I might want to contract to achieve certain things at the end of year one [in relation to service reconfiguration].... but I am less and less interested in the amount of people going through the service*".

If this trend is continued into the future, we can expect to see more emphasis on defining the characteristics of the services required by local populations and less on “bean-counting”, and a continued shift to service-based commissioning rather than concentrating on the detail of “*counting and defining things to the ultimate degree*”. In pre-election speeches, the Labour Party also emphasised its wish to focus on commissioning rather than purchasing, which included moving to 3-5 year ‘agreements’ between primary care commissioning groups and mainly local hospitals, based on definitions of the services required by patients and relating them to programmes of care. Although it is not clear whether the current SoS will stand by the pre-election promises to reduce the number of contracts to one-tenth of the current level, if achieved, this might also support a shift away from the detail of the contracting process if it were to involve more standardised contract documentation. Additionally, the use of longer-term agreements may be one way of facilitating strategic change which requires several years to achieve.

Clearly it is essential that the contracting process is recognised as a means to an end rather than an end in itself, but it may be unwise to go too far in the other direction and dismiss contracts as unimportant. In addition to requiring some sort of mechanism to manage the flow of resources between purchasers and providers, contracts have served a useful purpose in focusing attention on the need to define and measure quality, understand prices and think about the service rather than about institutions. As one purchaser put it, “*Most services have improved since contracting came in: not necessarily because of the process of contracting but because we have focused on the service delivery and it has become part of the dialogue.... about setting specifications and monitoring [and] assessing delivery. Purely and simply, the focus on services has led to improvements.*”

7. CONCLUSION

Contracting in the NHS has undergone significant development since the outset of the NHS reforms and we have shown how the features of the broader environment of the NHS managed market have influenced both the detailed procedural aspects of contracting and the nature of the relationships governing contracting. Contracting can be viewed as fulfilling both the ‘competing by managing’ **and** the ‘managing by competing’ functions in the NHS, to varying degrees and in different circumstances.

The future direction of contracting will of course depend on how (or if) the current government intends to implement its pre-election commitment to longer-term agreements with local providers. Whatever happens to the process of contracting *per se*, the movement towards a more strategic approach to commissioning is perhaps inevitable and long overdue. As this develops, contracting will still play an important role in mediating the flow of resources, but it will be just one component of a wider picture. As one purchaser noted: “*for too long [contracting] has been out on its own. It should be the back end of a process and the front end should be the strategy*”. Additionally, the more recent emphasis on co-operative and collaborative relationships is likely to be reinforced by the present government, whilst the role of contracting as a means of promoting competition will be played down. The challenge for the new government does not lie in re-inventing contracting, not least because the process of evolution towards longer-term collaborative arrangements had started long before the new government came into power. What will have to be tackled, however, is how poor provider performance can be addressed in the context of such agreements.

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