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Longer-term Agreements for Health Care Services: What Will They Achieve?

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DISCUSSION PAPER 157

LONGER-TERM AGREEMENTS FOR HEALTH CARE SERVICES: WHAT WILL THEY ACHIEVE?

By

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ABSTRACT

Government policy announced in the White Paper is to require purchasers and providers in the NHS to move from annual contracting cycles to longer-term contracts (agreements). It would appear the original arguments for this change came from the economics literature, suggesting longer-term contracts would help deal with problems of asset specificity, promotion of new entry and transactions cost. The Labour government emphasises longer-term contracting as a means of shifting the focus of purchaser provider relations from price and activity to quality of service and strategic planning.

This Discussion Paper reports the results of research into the extent and nature of long-term contracting in the NHS. It is based on examination of contracts from a sample of six health authorities and their GP Fundholders, supplemented by interviews with individuals from these Health Authorities and Trusts who were involved in the contracting process. The paper considers the extent to which the problems identified in the theoretical literature on duration of contract are likely to be observed in the NHS and the extent to which it is likely a movement to longer-term contracting will achieve the benefits expected.

(I) INTRODUCTION

Longer-term contracts or agreements[1] for health care services were highlighted in the White Paper as a way of creating a more stable environment, compared with the "short-termism" of the internal market (Department of Health 1997). The advantages of a shift towards agreements lasting between 3-5 years (or even up to 10 years in some instances) were outlined in the White Paper and subsequently elaborated upon in the 1998/99 Planning and Priorities Guidance (NHS Executive 1997). Particular attention has been given to using longer-term contracts as a tool for encouraging collaboration between purchasers and providers and as a means of achieving stability and long-term planning in the NHS.

There is no technical definition of a "long-term contract" but, in the economics literature, the term tends to be used to refer to an agreement that covers a sequence of repeat transactions or a single transaction that requires a multi-period production process. It is the opposite of a spot contract. While duration of contract is the key characteristic, there is no theoretical basis for saying how long a contract must be before it is considered "long-term". The Department of Health has adopted the convention of treating a contract of one year duration as "short-term" and one of three or more years as "long-term". We follow this convention as a working definition but note that most examples of "long-term" contracts in the economics literature are of 15-25 years in duration.

In this paper we discuss whether the benefits perceived by the government are likely to be delivered by a shift towards longer-term contracting in the NHS. We consider some of the economic issues relating to contract duration in order to draw out the implications of longer-term contracts in the NHS context. In doing so, we draw upon some of the findings of a recently completed study commissioned by the Department of Health. This involved examination of almost 300 health authority and GP fundholder contracts and semi-structured interviews with a sample of Health Authority and Trust staff involved with contracting.

We conclude that although longer-term agreements are more consistent with the general policy drift of encouraging collaboration and joint planning, they do not address any of the economic problems for which longer-term contracts are normally proposed. They may not deliver automatically the range of perceived benefits expected by the government and we suggest that if these issues are seen as important, effort is targeted directly towards achieving them through other means, rather than relying on longer-term contracts as a tool.

The paper is organised as follows: section II outlines the benefits expected by the government from the current policy developments in contracting. Section III considers some of the economic issues relating to the duration, form and nature of contracts, focusing on the importance of long-term *relationships.* The implications of the theoretical issues for the NHS are considered in section IV. Section V presents our conclusions and summarises the implications for policy.

[1] The Department of Health uses the term "agreement" rather than contract in most recent guidance. However, in this paper we use them interchangeably. NHS contracts are not legal documents, so substituting the terms makes little difference.

(II) EXPECTED BENEFITS OF LONGER-TERM CONTRACTS

The issue of duration of contracts in the NHS is not new. The guidance accompanying the 1989 NHS reforms stated that the previous government expected many block contracts to be 3 year rolling contracts with extensions negotiated annually (Department of Health, 1989). In almost every year since, central guidance on contracting has encouraged purchasers and providers to consider the use of rolling or fixed longer-term contracts in "appropriate" circumstances, whilst noting that annual contracts were the norm (NHS Executive, 1992, 1993, 1994, 1996a). Both the previous and the current government have defined the perceived benefits of moving towards longer-term contracts. Whilst the previous government emphasised some of the competitive advantages associated with longer-term contracts (eg encouraging market entry by making it more attractive for Trusts to offer new services), the present government has focused on using them as a way of promoting purchaser/provider collaboration. Despite the shift in emphasis, both expect a similar range of benefits to flow from longer-term contracts. The advantages of longer-term contracts outlined in the White Paper were:

- allowing for longer-term planning for improvements, service changes and investment
- shifting focus away from cost and volume considerations, towards other aspects of performance such as outcomes and quality
- involving clinicians in agreeing programmes of care
- reducing the time, effort and resources expended in the annual contracting cycle

This was reinforced in the 1998/99 Priorities and Planning Guidance in which the messages concerning greater involvement of clinicians, better planning and a focus on outcomes and quality were repeated. The guidance also defined the features the Department of Health expect to see incorporated into longer-term contracts, which include:

- Methods for dealing with uncertainty
- Methods for sharing risk
- Methods for dealing with inflation
- Incentives for achieving quality improvements over time

In particular, central guidance has suggested that the *funding* agreements within longer-term contracts should span more than one year, either being fixed for the contract duration or "related to a mechanism which can be referred to at agreed intervals during the contract" (NHS Executive 1997).

(III) ECONOMIC ISSUES RELATING TO CONTRACT DURATION

Although there is a substantial body of economics and law literature which considers the circumstances under which longer-term contracts improve efficiency, it is not immediately clear whether institutional conditions are such that longer-term contracts represent an efficient solution to contracting for health care services. In this section, we discuss just *one* strand of the literature on contract duration, focusing on the nature of contractual relationships and the subsequent implications for the form of contract. [2]

(i) From "Classical" to "Relational" Contracting

Much of the Law and Economics/Sociology literature has focused attention on the apparent irrelevance of classical contract law for the form and content of the contracts actually executed by firms. McNeil (1978) used the term "relational contract" to underline the argument that modern contracts are designed to maintain good working relationships through periods of uncertainty, rather than for the adversarial task of assigning liability for failure to perform. "Classical" contract law is based on full legal protection for the parties and is relevant only in circumstances when the frequency of exchange is low and all rights and future obligations can be specified in the contract. Non-classical contracts however have three broad distinguishing features as summarised by Campbell and Clay (1992):

- *Flexibility*: rather than stipulate price and quantity in each period, the contract contains rules/procedures for adjusting price and quantity over time as circumstances change;

- *Open-Endedness*: where circumstances change beyond the limits allowed for in predetermined rules for "flexibility", the partners agree to what in effect will be re-negotiation of the contract;

- *Extra-Legal Dispute Resolution:* maintaining a good working relationship between the parties is essential to efficient production. Procedures involving legal action, designed to identify blame and assign liability are more likely to harm than to help the relationship.

"Neo-classical" contracts would incorporate a degree of flexibility where both parties acknowledge the contract to be incomplete. The rules/procedures used to adapt to changing circumstances would minimise the likelihood of opportunistic behaviour. This is necessary as although parties recognise they both have a degree of commitment to the exchange, their co-operation is strictly self-interested and trust is limited. Opportunistic behaviour is more likely to occur when one party becomes relatively disadvantaged over time.

"Relational " contracts incorporate the features of open-endedness and extra-legal dispute resolution as they focus on the trust needed for the parties to commit to an open-ended

[2] There are many other themes and issues which arise in relation to the economics of contracting which are not discussed here. Our research covered a number of topics and the results will be published elsewhere in future.

agreement, an acknowledgement that co-operation between the parties is essential to efficient production and the commitment to finding solutions to problems that permit the relationship to continue over time. These contracts would not contain detailed rules for adjusting automatically price or quantity but would contain provision for re-negotiation of the contract when appropriate.

The economic models underlying the alternative forms of contract associate the classical contract law with the complete information spot exchange of general equilibrium models where anonymity of the parties to the exchange is a critical characteristic of efficiency ("arms-length transactions"). Neo-classical and relational contracts would reflect the economic structure of small numbers (strategic interdependence) production and exchange under conditions of incomplete information. However, theory yields no prediction about whether the latter categories of contracts will be long-term or short-term, only that the economic *relationship* between the parties will be long-term. Hence the importance of considering relationships in the analysis of contracts and we return in section (iii) to consider this issue further.

(ii) Risk Sharing and Price/Activity Adjustment Mechanisms

The few longer-term contracts observed in other sectors are not fixed price contracts, as costs and nominal prices are normally expected to change over time and in response to unanticipated events. Under a fixed price regime, initial prices would need to be high as they would be front-loaded to reflect potential increases in costs. If this was done imprecisely there would be a strong incentive for one party to breach the contract rather than continue at a disadvantage. At the other end of the spectrum, pure cost-plus contracts allow any increased costs of the provider to be passed directly onto the purchaser in the form of increased prices. The disincentives for efficiency produced by such agreements are well known (Vickers and Yarrow 1989) and the use of cost-plus contracts has declined rapidly in industries such as defence where they were common years ago (De Fraja and Hartley 1996).

Contracts that do not fall into either the fixed price or cost-plus categories can incorporate risk-sharing mechanisms which provide incentives for agents to co-operate in adapting to changes in circumstances which were not fully anticipated when the contract was negotiated. The longer the duration of contract though, the higher the likelihood that conditions will change and unanticipated events will occur before the contract has ended. Such events may alter the return to each party and reallocation of that risk may be achieved through the use of price or quantity adjustment rules which automatically adjust the value of the contract to each party. The economics literature suggests two distinct roles for these risk-sharing mechanisms:

- The bilateral monopoly literature focuses on minimising the use of resources to re-negotiate contracts when events outwith the control of the parties to the contract change the value of the contract. Examples include changes in the price of raw material or changes in consumer demand. In the absence of risk sharing, these events would open the window for opportunistic behaviour. The risk-sharing arrangement would be reflected in a price or quantity adjustment rule that adjusted the financial value of the contract to each

party in a way which reflected a jointly recognised "fair share" of the new contract value (see Blair 1987 for an example).

- The principal-agent literature stresses the role of risk sharing as producing incentives for each party to act in ways that will minimise the deviation of cost and demand conditions from those the parties would have agreed to had they known of future conditions at the time the contract was originally agreed. The emphasis here is on giving each party the incentives to manage risk efficiently. This implies a pricing structure that "rewards" efficient risk management and "penalises" inefficient management (see Chalkley 1996 for examples).

In the short-run this distinction may be obvious--an increase in raw material prices is exogenous, while a rise in unit costs due to poor inventory control is endogenous. In the long-run the distinction is blurred as one wants firms faced with a rise in raw material prices to have an incentive to change production processes and thus minimise the effect of the price change on profits. The reason for maintaining the distinction when discussing risk sharing is that it relates to the distinction between "fairness" and "efficiency", both of which can be important in sustaining the relationship between buyer and seller in bilateral monopoly. The rise in raw material prices will reduce the profitability of the joint enterprise of the two parties even if the producer responds in an efficient manner. Is it "fair" for that loss to be borne solely by the reduced profits of the producer as in a fixed price contract or should the buyer share the loss by accepting a larger fall in profits than would have occurred with the fixed price contract?

This traditional view of risk sharing raises three issues that we return to later in discussing the NHS. First, when the adjustment of contract value is via a semi-automatic price or quantity adjustment, there is an implication that the financial value of the contract becomes open-ended. The value of the contract for date t+1 is unknown at the time of agreement because it depends on whether events activate the risk-sharing rule that automatically adjusts contract values or if the "rewards" for successful risk management are greater or less than any "penalties". Ceilings can be used to limit the extent of upward movement in contract price but if the ceiling is so low it is always likely to be hit, it will be in effect a fixed price contract with negligible automatic risk sharing properties. If there is to be genuine automatic risk sharing and if these agreements are to become binding on the budgets of the purchasers and providers that are signatory to the contracts, then both parties need access to capital markets, equity capital or financial reserves of sufficient size to absorb changes in contract values that result in expenditure exceeding current income.

Second, it is not always obvious which party is in the best position to manage particular risks. Returning to the example above, it may be that in the face of the higher raw material prices the strategy to minimise the loss of profitability of the joint enterprise would be for the buyer to change marketing activity and promote a redesigned product that used fewer of the more expensive raw materials. Where this situation is likely to arise, ex ante allocation of risk may be inefficient and what is needed is a means of encouraging co-operative behaviour.

Third, if theory suggests that risk-sharing adjustments to contract values may contribute to efficient performance, would we expect to observe these principles being applied in the public sector? To apply these risk-sharing rules *across the years* may not be consistent with annual, cash limited budget allocations where the real change from one year to the next is unpredictable and failure to balance the budget may be penalised. In other words, the public sector[3]. The historic argument against allowing public sector organisations malleable budgets centred on a perception of the incentive structure of the public sector. It has been argued that because public sector organisations cannot go bankrupt, individuals have an incentive to be "over optimistic" in forecasting the future outcome of present plans. A budgetary regime that does not allow a unit to obtain funds now against some future expected outcome is designed to minimise the social cost of this behaviour. These rules can appear silly when say, a school cannot obtain additional capital for new central heating boilers and offset the capital cost against future saving on heating bills. However, the Treasury does not tend to believe a public sector organisation when managers say that if only they are allowed to spend more now, they will find savings in the future. One therefore observes that virtually all budgets for production of public sector goods and services are for one year only and cash limited, with very little temporal virement. This reflects the presumption that on average such limited budgetary flexibility will produce more efficient outcomes than would be the case in the absence of such a rule.

In June of this year the Chancellor announced that, following the Comprehensive Spending Review, government Departments would have budgets set for each of the next three years (HM Treasury 1998). The intention is to break with the tradition of an annual public expenditure round where Departments bid against each other (and against the Treasury) for incremental resources. There has been no suggestion that the statutory requirement for Trusts to break-even on an annual basis is to be changed though there has been a marginal increase in the amount of any "underspend" that can be carried forward into the next financial year. There has been no mention of granting a power to spend in excess of the budget for the current financial year in anticipation of funding to be made available in the following financial year. The degree to which a three year public expenditure cycle will genuinely reduce uncertainty for Health Authorities and Trusts about their income over a 3-5 year period will only be apparent after the system has operated for several years. However, it is difficult to believe that budgets will not continue to be affected by the same sort of policy initiatives that we currently see announced during each financial year which are often accompanied by changes in finance. Examples from the past year would include initiatives to deal with winter pressures, waiting lists and breast cancer.

The approach to risk sharing agreed by the parties to a contract will be reflected in the price/quantity adjustment mechanisms they adopt. Adjustment mechanisms which tackle the issue of changing the financial value of a contract over time can be classified as re-determination or re-negotiation provisions (Crocker and Masten 1991). The former

[3] This is not to imply that the financial regime of the private sector will always accommodate variable priced contracts. Firms reliant on bank finance with little equity capital would not be able to enter into such contracts. The rarity of examples of private sector contracts with long-term price-adjustment rules suggests the problem may simply be relatively more serious in the public sector.

establishes prices by a formula which takes the form of either a "definite" or "indefinite" price escalator. Definite price escalators allow for predetermined increases in price and are fairly uncommon in longer-term contracts as they do not allow consideration of changes in factors thought to influence price and they therefore do not incorporate much flexibility. Indefinite escalators specify the process by which price changes are to be agreed, usually linking contract prices to changes in the price of variables which are agreed to be indicative of general changes in market conditions. At the simplest level, contract value could be linked to the market price of the good, but this assumes the good is homogenous and that there is a spot market with which to make price comparisons. Another variation would link contract price to changes in the price of substitute goods, hence reflecting opportunity cost (eg the price of gas linked to the price of oil). Finally, "cost-plus" mechanisms adjust the contract value to reflect changes in the costs facing the supplier, but may not provide good incentives for efficiency. As the contractual environment becomes more complex or uncertain and thus it gets difficult or costly to obtain and certify information about the future environment, *re-determination* clauses will become difficult to design and enforce. *Re-negotiation* then becomes the norm and parties will not set out in advance how agreements on prices will be reached but, they will negotiate mutually acceptable terms each time a change in circumstances arises.

This analysis suggests that when examining contracts in the NHS we want to know if there are differences in the mechanisms used to allocate risks in long and short-term contracts, whether some mechanisms appear to be more successful than others and whether the financial regime of the public sector affects the approach to risk sharing.

(iii) Contracts and relationships in the private sector

There has been a tendency to identify "relational contracts" with long-term contracts on the grounds that in a world of incomplete information, long-term relationships are likely to be more profitable than "arms-length" transacting. Trust and reputation play a greater role in contractual arrangements that are repeated over time and thus the hypothesis that long-term relationships are likely to be more efficient is probably correct. However, it is not the case that long-term relationships *necessarily* involve longer-term contracts. In the economic analysis of contract the critical distinction is whether anonymous/ arms-length transactions are likely to produce outcomes as efficient as co-operation between transactors who recognise their mutual dependence. If co-operation is expected to be more efficient, we would predict its emergence irrespective of duration of contract: we are as likely to see the relevant behaviour where the world is one without formal contract, with short-term contracts or with long-term contracts.

In much of the private sector, the duration of contracts seems to be less of an issue than the duration of *relationships*. The most recent published study of contract duration in the private sector examined contracts amongst firms in the engineering and kitchen furniture industries in three countries (Arighetti et al 1997). The majority of all firms had long-term relationships with their largest customers - 80% of British firms had been dealing with their largest customer for more than five years and almost 40% for more than twenty years. However, rather than having long-term contracts with guarantees of future price and quantity built in, most firms tended to contract on a short-term basis either order by order or through a

"framework" or "requirements" contract under which buyers place orders as required. The British firms in particular, placed a high degree of emphasis on personal contacts and informal understandings of the basis on which they conduct their business. The authors state that:

"a commonly expressed view was that the success of the relationship depended on how well the exchange proceeded from the point of view of the parties, not on the form of the agreement".

They quote a UK supplier as saying:

"we don't have long-term contracts. We do have long-term relationships" and
"long-term relationships have very little to do with pieces of paper".

Many firms saw advantages in retaining the flexibility of short-term contracts and stressed some of the difficulties of making firm guarantees in the longer-term (eg changing demand, price fluctuations, one-off projects). However, although the majority were happy to have shorter contracts within the framework of a long-term relationship, a small number did see some advantages in having long-term contracts with guaranteed volume, mainly in terms of allowing them to make firm commitments in buying supplies. This was seen as particularly important when the supplier operated in a volatile and competitive market. In the context of the NHS, this is unlikely to apply to many Trusts in terms of their relationships with their main purchaser as the majority of their income will be more or less guaranteed. However, of more relevance was the view that long-term *relationships* were important as a means of focusing on product quality, innovation and development. Longer-term framework agreements (which do not commit finance) were seen as one way of developing such a focus.

Research on private sector contracting has shown that the nature of contracts and of contractual relationships is influenced heavily by the social and institutional environment. Many studies have shown how extra-legal sanctions, unwritten rules, social pressures and norms are used to manage relationships based on trust and reputation, rather than reliance on rigid contract terms (eg Macaulay 1963, Beale and Dugdale 1975; Burchell and Wilkinson 1996, Arighetti et al 1997).

This strand of analysis suggests that rather than being considered in isolation, the issue of contract duration in the NHS should be viewed within the context of the relationships between purchasers and providers. In the NHS, does the form and content of the contract reflect the reality of the relationship? Do short-term contracts reflect short-term relationships?

(IV) IMPLICATIONS FOR LONGER-TERM CONTRACTS IN THE NHS

(i) Duration of NHS contracts

There appears to be some confusion about the prevalence of longer-term contracts in the NHS. The Department of Health has reported that despite the absence of official obstacles to prevent parties entering into longer-term contracts, the annual contracting cycle has been dominant and the "vast majority of contracts are for one year" (NHS Executive 1996). Hence the central guidance aimed at encouraging purchasers and providers to use longer-term contracts more frequently. However, some survey evidence has suggested that purchasers and providers were already using longer-term contracts (Raftery et al 1996). We offer an explanation for this apparent confusion in section V. As stated in the introductory section of this paper, there is no technical definition of a long-term contract. For our empirical work we adopted the Department of Health convention of treating a contract of three or more years as "long-term".

In our sample of 106 contracts from six Health Authorities,[4] we found that the majority of contracted activity in five of the Health Authorities is currently organised under agreements spanning three years. In these Health Authorities, where annual contracts are used, they tend to be for small sums and with providers outside the authority boundary. All the Health Authorities with longer-term contracts stated that they had been using them for some time and not as a response to the more recent policy announcements. The other Health Authority currently uses annual contracts with all providers but expects to be moving towards three year agreements the following year. In the sample of five contracts supplied by the NHS Executive, three covered a three year period, one a two year period and one a five year period. The latter was written to ring fence resources at a mental health Trust to affect the transfer of patients with learning difficulties into the community over this period. Tables 1 and 2 summarise the findings. Of the 177 contracts from GP fundholders, only one specified a duration of more than one year.

(ii) Risk Handling in the NHS and Price/Adjustment Mechanisms

Despite the fact that the majority of patient activity was included in three year contracts, the *financial value* of these contracts was almost always re-negotiated annually. The legal obligation of Trusts to break even each financial year is reflected in the contracts in the form of highly detailed rules for adjusting and re-negotiating activity in-year and for adjusting contract values. These clauses are designed to help both the purchasers and providers stay within their annual budget constraints. They inform the parties of the adjustments that are acceptable when conditions change (e.g. reduce elective work if an increase in emergency work would otherwise threaten to breach total cost agreements). While these triggers for adjustment of contract value within year were common for acute services, within our sample of contracts there were few examples of rules for automatic adjustment of contract price between years. Table 3 summarises the details of just 3 longer-term contracts (all from the sample of 5 provided by the NHS Executive) which contained rules for adjusting contract value across years.

[4] See annex 1 for description of the sample

The NHS Priorities and Planning Guidance 1998/99 makes it clear that the Department wants to see contracts moving away from providing for annual negotiation of finance and activity to 3-5 year agreements on finance. It does not say how this is to be done, only that:

"*the funding agreement is either fixed or related to a mechanism which can be referred to at agreed intervals during the contract.*"

A fixed price agreement would not be consistent with the argument in the same Guidance for more risk sharing. It therefore appears that the guidance is referring to re-determination mechanisms like those found in some of the long-term contracts in the energy sector that have been reported in the research literature - for example:

"the purchaser agrees to automatically adjust payment in line with changes in spot gas prices within the limits of +/-4% of prices at the date of signing the contract; if prices go outside the limits, the terms of the contract are to be re-negotiated."

This is very similar to the wording of existing NHS contracts where floors, ceilings and triggers operate within year to manage annual contract value. Extending this type of "automatic" price adjustment mechanism between years would only contribute to the objective of "reducing time spent" each year negotiating finance if the ceilings and floors were rarely reached and the likelihood that the parties would have to meet to re-negotiate was thus reduced.

At present the annual re-negotiation of contract finance centres on:

- The change in the purchaser's budget which will be composed of any change in the formula allocation from the region, any inflation allowance, any real growth and any additional funding for specific services (all determined on an annual basis by the Treasury, Department of Health and Region);

- "Cost pressures" of providers which can be (roughly) decomposed into (i) legislation/government policy changes (ii) changes in costs of usual activities and (iii) new developments favoured by providers;

- Purchaser priorities for new developments.

In almost all cases one is looking at quite small changes in year on year expenditure for a main contract. Except where there has been prior agreement to move a block of services, the annual local negotiations between a purchaser and each of their providers centre on how to divide the change in revenue between providers to deal with cost changes of existing services (which are likely to differ by provider) and how much can be invested in new developments with different providers. Trying to distinguish between changes in the cost of existing services and new developments in the acute sector was the most frequently cited problem of the annual financial negotiation.

The annual financial margins of change are so small they create apparently contradictory messages for those who want longer-term financial agreements. First, for all main contracts, it

would be easy to draft contracts that guaranteed, say, 95% of the current budget of £Xm for each of the next five years. This might look more like a longer-term financial agreement than the present contracts but would in fact represent no change. The annual negotiations are not about moving large parts of contracts but about the allocation of any *extra* money allowed by the Treasury each year. The second implication of the annual negotiations being over marginal resources is that small numbers are of disproportionate importance - the ability to redirect 0.5% of the budget is the only way a purchaser may have of beginning to alter the pattern of service development and delivery. A Trust deficit of 0.5% of the budget is treated as evidence of serious financial difficulty unless a feasible recovery plan is in place. With margins this tight, neither party is usually willing to commit themselves to pricing rules that would remove the discretion to negotiate marginal expenditure and revenue each year.

All purchasers said they could live with a pricing rule that automatically gave providers the national inflation adjustment but only one purchaser was willing to go further and offer all providers an increase equal to the total increase in the Health Authority budget. This is the only contract pricing rule that would serve the purpose of eliminating annual re-negotiation of contract prices. All the other purchasers felt strongly that growth money was there to implement purchaser priorities and not to simply be handed over to finance provider priorities. It is worth noting that the purchasers with the strongest commitment to strategic planning and those involved with Trusts in metropolitan service "reconfigurations" were the most likely to oppose a pricing rule that automatically gave providers a percentage of any growth money.

From interviews it was clear that contracting parties have developed some mechanisms to improve the management of the risks they face and thus reduce the "hassle" of annual financial agreement but none saw the possibility of reducing them to pricing rules that could be incorporated into 3-5 year financial agreements. In one Health Authority they had worked out a matrix of relevant costs that allowed a provider to alter within year case-mix without coming back for additional funding. Another Health Authority is trying to develop more robust definitions of cost pressures in order to further separate discussion of cost changes from new developments. For that authority, a cost pressure is a change in the cost of a service that is not associated with a change in quality or quantity. This would make a pay increase or a change in junior doctor hours a cost pressure but the introduction of a new drug with improved therapeutic properties for treating an already treated condition, a new development. In these circumstances it is not clear what the Planning and Priorities Guidance means by "risk sharing" and "managing risks". In the academic literature, the first term is used to indicate that the Health Authority would pay for part of the change in cost and the Trust would pay for the other part. Incentives are strengthened as neither party's budget would bear the full burden of the change in staff costs or the cost of introducing the new treatment. However, Health Authorities are cash limited public sector organisations. The only way they can "share" the cost with a Trust is to reduce their reserves or forego preferred service developments elsewhere. In the US literature on risk sharing, the assumption is that the payer (the employer or government) agrees to depart from strict capitation payment and adjusts payment to partly reflect actual costs (see Frank et al 1995) for an example of "soft capitation"). A Health Authority is not in a position to do this across all providers.

Public sector budgets, cash limited for each financial year, ordinarily contain a "contingency reserve". The contingency reserve is an important mechanism for managing within year financial risk so as not to breach the annual cash limit but such reserves are not useful for carrying risk between years. The tradition within the public sector has been to approach risk sharing in a

discretionary, rather than a rule based, way. Each tier holds back part of its fixed budget as a contingency reserve before passing the remainder on to the next tier. When unforeseen events arise, the higher tier decides, often on an ad hoc basis, whether and on what terms to contribute to the financial problems of the unit below. In several interviews, individuals pointed out that each year there was not only uncertainty about their formal allocation of funds between years but even more uncertainty about the various forms of non-recurrent funding that might be made available during the year by regional offices--in effect, their receipts from the Regional, Departmental, and Treasury contingency reserves.

(iii) Contractual Relationships in the NHS

Contracts between NHS purchasers and providers are not legally binding and are legally enforceable only if they involve a private sector provider (Allen, 1995). Disputes are dealt with not through the courts but rather through internal arbitration or conciliation processes at a regional level, with the Secretary of State acting as final conciliator in pre or post contract disputes (NHS Executive 1991). The latter option has rarely been used in practice (Mchale et al 1995). On the surface, they thus appear to bear similarities to the form of relational contracts outlined earlier. However, there may be some question about the degree to which the form of the contract corresponds to the reality of the nature of the relationships between parties in the NHS as the latter may not necessarily be based on goodwill and trust between parties.

Each individual interviewed was asked what they understood by the term long-term contract. While two people said anything longer than one year was a long-term contract, the overwhelming majority said that as long as finance was negotiated on an annual basis, their contracts were short-term. One Trust executive (who had previously worked in the Health Authority) referred to their three year contracts as "*a sham*". He argued that the three year contracts were there to show commitment but both parties already know they must continue to work together. Others felt there was some value in "showing commitment" but agreed that the annual cycle of agreeing finance and activity was what most parties considered the core of contracting. When asked whether her contracts were long or short-term, one contract manager replied she thought it an irrelevant question as the *relationship* with her main purchaser was obviously long-term. "*Where else can they go?*". The duration of the contract did not matter.

It is not clear that acknowledging the relationship as long-term was likely to engender the co-operative relationship discussed in the relational contracting literature. The perception of those negotiating on behalf of the Health Authority often saw Trusts as trying on everything to increase their share of resources; Trusts often felt they had a right to a "fair-share" of any growth money received by the Health Authority irrespective of whether the Health Authority's priorities differed from those of the Trust. There was a total absence of agreement as to what constituted "fair shares" of the resources annually made available by the Department of Health.

It has been argued that long-term contracts would reduce uncertainty where services were to be restructured. Our research suggested that Health Authorities and Trusts often develop

non-contractual frameworks to agree and implement policies of service development and structural change. It would appear a matter of indifference, or more likely of local convenience, whether these arrangements were referred to or included in contract documentation. Taking the contracts of the six Health Authorities as a whole, there was considerable variation in what people in different Health Authorities considered relevant to include in the paperwork of the contract as opposed to appearing in other documents. For example, one Health Authority had a five year rolling strategic plan and each year particular points for action were agreed with each of their contracting Trusts. Neither the strategy nor the points for action during the current year appeared in contracts. Another Health Authority included the equivalent strategic points for action within the contract documentation. In both cases the parties to the contracts had planning periods longer than the duration of their contracts and significantly longer than the annual re-negotiation of the financial value of the contracts.

Several interviewees said they did not see contracts as the appropriate place for detail of their strategic plans. In future they expect to put this information in the local Health Improvement plan, not in a longer-term contract/agreement. This view of the rather limited role of contract occasionally emerged when discussing service specifications. In some contracts service specifications were no more than lists of procedures, in others one found detailed clinical protocols included as service specifications. The same contract would have highly detailed service specifications for some services but not for others. A number of those interviewed treated service specifications as marginal or irrelevant to contracting. In one Health Authority where effort went into producing a complete set of service specifications three years ago, they are now ignored. If a problem arises, the clinicians sort it out with the Health Authority. It was considered that achieving change in clinical practice was an ongoing process of dialogue - "*an organic process*". The important thing was to work out care pathways and protocols with clinicians:

"*pulling all this together in a service specification is bureaucratic*."

The contracting process was seen as peripheral to the process of raising clinical standards and moving to longer-term contracts would make no difference. The Government would appear to share this view as they are proposing to establish national institutions such as the National Institute for Clinical Excellence (NICE) and Commission for Health Improvement (CHIMP) as the key instruments for bringing about changes in clinical standards.

(V) CONCLUSIONS AND POLICY IMPLICATIONS

The lack of longer-term *financial* agreements coupled with frequent use of longer-term frameworks for planning investment and service developments is probably at the root of the confusion about the extent to which long-term contracts are used in the NHS. It was clear from our interviews with Health Authority and Trust staff that contracting was seen as a very narrow financial activity. To them a longer-term contract is one that settles financial arrangements for a period of three years of more. Long-term planning and strategy are not necessarily carried out within this narrow contracting framework and our research indicated that in most cases parties to NHS contracts had planning periods longer than the duration of their contracts and significantly longer than the annual round of financial re-negotiation. Four to five year financial frameworks were used to explore the financial implications of service development strategies. Five year, and in one case a ten year, investment planning horizon was used where purchasers and providers were negotiating changes in infrastructure. Use of longer-term plans for investment and service development was not inconsistent with annual re-negotiation of prices and activity. Most of the expected benefits of a move to longer-term contracts (summarised on p.5) are at present being realised by use of arrangements other contracts. We found no evidence to support the view that a movement to longer-term contracts with financial re-determination clauses, the proposed change that *would* be significantly different from present practice, would contribute to the objectives of better planning, more clinician involvement and improved clinical standards.

Economic theory and the evidence from the NHS suggest there is limited scope for revising the current longer-term agreements to incorporate re-determination clauses which adjust price and activity automatically over time. Changes in contract value are currently achieved via annual re-negotiation and this is appropriate within the current financial system with its stress on annually balanced budgets and cash limits. A three year expenditure cycle for central government departments may reduce some uncertainty for Health Authorities as to their budgets for the next three years but a firm three year budget for the Department of Health does not mean a firm three year budget for a Health Authority. The most obvious sources of change would be changes to the capitation formula, changes in the proportion of funds distributed by criteria other than capitation and new policy initiatives from the Department of Health. Trusts face even more sources of income variation as purchasing budgets are devolved to Primary Care Groups.

When trying to assess the impact of moving to a three year public expenditure round it is useful to distinguish between the effect on forward planning and the effect on managing financial risk across years. The three year cycle may well enable public sector organisations to make better guesses as to the real value of expected budgets in each of the next three years than is the case with an annual expenditure round. However that information does not make them better able to absorb the financial risk of committing in year one to pay a predetermined share of a contingent cost that may arise in year three due to change in the price of a drug, introduction of a new therapy, a change in demand or any other "unplanned" event that affects cost. Because of the relatively smaller size of Primary Care Group budgets, we would

expect the between years financial risk of re-determination clauses to be even greater for PCGs than it is perceived to be for Health Authorities.[5]

We conclude that the present system has already evolved to encompass many of the activities which the Department of Health wishes to encourage through their policy shift (eg joint longer-term planning and strategy) and in this sense the impact of the policy of requiring longer-term agreements will be neutral. However, we would advise a cautious approach to the implementation of rigid rules for longer-term financial agreements as this would deliver few benefits while forcing purchasers and providers into an activity which may have substantial resource implications as they try to cope with the increase in financial risk.

[5] See Carr-Hill, Rice and Smith (forthcoming) for a discussion of funding Primary Care Groups

Table 1 Contract Duration - number/proportion of contracts of different duration from 106 Health Authority contracts

Health Authority	3 year	3 year rolling	1 year	Other	Notes
1 **n=50**	All bar one main contract	None	Most small contracts	2 year rolling for one main contract	2 year rolling was with a main provider but year 2 was to be reviewed following results of acute services review
2 **n=29**	(see note)	All 9 main contracts with the exception of some specific named services within the 3 year contract with the provider	All small contracts with the exception of 3 small acute contracts which were 3 year rolling. One year contract for some specialist health promotion and for open access occupational therapy within a 3 year contract with Trust	2 year rolling for "mainstream" health promotion	The terms 3 year and 3 year rolling appear to be used interchangeably. The core contract terms refer to all contracts as 3 year rolling but some of the contract documentation has 3 year written on it. The services for which there were 1 year contracts within a 3 year general Trust contract were either due to be reviewed, put out to tender or retracted.
3 **n=9 (not a full set of small contracts)**	All 4 main contracts	See next column	Four contracts stated they were 1 year "within the context of a 3 year rolling contract" 1 annual contract with provider outside Health Authority		One example of small contract with provider outside Health Authority was supplied but all others follow the same format ie annual
4 **n=5** **(examples only)**	All 4 main contracts 1 small contract with provider outside Health Authority		None		One example of small contract with provider outside Health Authority was supplied but all others follow the same format ie 3 year
5 **(example only)**		All main contracts			One example only was provided but all other contracts are in the same format
6 **(n=13)**	None	None, but see note	All contracts		All contracts were annual in this Health Authority, but 2 with community Trusts stated that there was an intention to move towards a 3 year rolling contract with annual review.

Table 2 Contract Duration in isolated sample of Longer-term contracts.

Contract Description	Duration	Notes
A. Health Authority and mental health Trust	5 year	Refers to a single contract with a mental health Trust which ran from 1992 to 1997 in order to affect a transfer of patients with learning difficulties to the community
B. Consortium of purchasers and acute Trust	3 year	For provision of cardiac services only.
C. Health Authority and community Trust	2 year rolling	For provision of community health services excluding specific parts of service covered by different contracts
D. 3 Health Authorities and acute Trust	3 year	For provision of all acute services.
E. Health Authority and Community Trust	3 year	For provision of mental health services. Draft of general terms only

Table 3 "Rules" and Principles for adjusting Price and Activity over Time in 93 Longer-Term contracts

Health Authority	Price "Rules"?	Activity "Rules"?	Notes
1	Annual re-negotiation One contract states the "anticipated" cash limit for following year and lists factors to be considered when setting it next year (inflation, changes to non-recurrent funding in Health Authority). All other contracts say this year's activity and price to be used as a "baseline" for future negotiations.	Core contracting terms state that 75% and 50% of year 1 activity is guaranteed as a minimum in years 2 and 3 respectively. These terms apply to most main providers.	
2.	Annual re-negotiation Contracts with main providers state that both parties recognise the "preferred status" of the other and thus expect the provider to ensure the prices it offers are as least as favourable as to others who may wish to purchase the same services (ie other Health Authorities, GPFHs etc). If during the contract the provider offers or sells the services to a third party at prices lower than those in the contract, the Health Authority expects to be notified and normally offered the same terms	Annual	The price clause is similar to the "most favoured nation" clauses contained in longer-term contracts in the private sector in some industries (eg gas). They have been viewed by some as potentially anti-competitive devices, but by others as an efficient means by which price adjustments can be made to reflect changing economic circumstances as it is assumed that new prices relate to changes in costs or demand which would otherwise be difficult to track. It is not clear that this is the reasoning behind the Health Authority clause.
3.	Annual re-negotiation One contract with a main provider states that funding for the following will include consideration of additional posts and extra theatre lists, and the recurrent nature of unfunded inflation. However, it states that this is "unlikely" to involve any additional cash increase over current year.	Annual	

Health Authority	Price "Rules"?	Activity "Rules"?	Notes
4.	Annual re-negotiation. States that this will reflect the recurring financial baseline with amendments made for inflation, costs of additional activity and "agreed" in-year cost pressures	Annual	Contracts with non-local providers state that the annual re-negotiation will reflect service changes which may arise as a result of acute services reviews taking place in those areas. This presumably reflects the difficulty of devising even a general indicator of the factors likely to impact on price and activity during a period involving substantial service shifts. Additionally, the Health Authority is likely to have far less control over the shifts occurring in distant areas than it does within it's own boundaries.
5.	Annual re-negotiation to reflect agreed changes in quantity, quality and finance	Annual	

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ANNEX 1: Selection of Health Authorities, GP Fundholders and Interviewees

A. Selection of Health Authorities/GP Fundholders

The duration and scope of the project did not allow for the collection of all contracts from all Health Authorities. We therefore decided to limit our sample to two regions outside London from which we would choose a number of Health Authorities and GPFHs. As all regions were likely to provide a good cross-section of Health Authorities with different characteristics, we chose two regions whose proximity would limit cost and time involved in fieldwork associated with project. The following criteria were used to select Health Authorities within these regions:

- Population: an indicator of size;
- Revenue budget: an indicator of size/purchasing power;
- Number of main provider contractors: an indication of the number of contracts to be examined;
- Number of general practices (fundholding practices): examining the ratio would give an indication of the relative purchasing power of Health Authorities and GP fundholders;
- % acute/community expenditure split: included partly because the nature of the contract may vary depending upon whether the main provider is largely acute or community service-based.

There were twenty-four Health Authorities in the two regions.

Eight Health Authorities were initially selected (allowing for a 25% non-response/non-compliance rate) and approached to participate in the study. All of the GP fundholding practices within each selected Health Authority area were also approached to participate in the study.

We requested copies of *all* contracts from the Health authorities and GPFHs in the study, explaining that although the project focused on longer-term contracts, part of the scope was to assess the extent to which longer-term contracts were used and that we required annual contracts for comparative purposes.

B. Response

Although six Health Authorities agreed to send us their contract documentation, there was substantial variation in the documents which were seen as being part of the actual contract. For example, some Health Authorities sent us every service specification to which they refer in contracts, whilst others sent us only the contract schedules or one or two specifications as examples. Some Health Authorities had "core" documents which contained details of their financial and contracting requirements which applied to all contracts; others had separate details for each provider. Although this may reflect nothing more interesting than the amount of photocopying that the Health Authorities were willing to undertake on our behalf, we believe some of it represents a genuine variation in what is understood by "contracting" at

both the Health Authority and Trust level in terms of the range and nature of the activities that are included as part of this process.

Two Health Authorities sent us "representative" examples of their standard contract documents, rather than all the contracts as they stated that the format and all the terms and conditions were identical in every contract with their main providers. One Health Authority supplied us with examples of main contracts and examples of those with distant or marginal providers.

In total, we received 106 separate Health Authority contracts. Additionally, the NHS Executive supplied us with some examples of longer-term contracts they had collected via a trawl around regional offices, which added 5 more to our sample.

The response from GPFHs was less favourable. This may have in part been due to the cost of photocopying (although we did offer to reimburse practices for this) but also because they believed the Health Authority held copies of all their contracts and would send them to us in one batch. Although we did follow this up, it became clear that if the contracts were indeed held at Health Authority level, they were not all located in one place and we were unable to find anyone who could supply copies at the Health Authority level. Thus we had to rely on the responses from the GPFHs. In total, 47 practices responded and sent 177 contracts. Again, many of them said all their contracts followed an identical format, so sent only a single example. A preliminary analysis of the fundholding contracts led us to expect that gathering further examples would not add substantially to the project and thus we did not attempt to send reminders.

C. **Interviews**

Interviews were held with staff from each Health Authority in our sample (we included the Health Authority with one year contracts for comparative purposes) and from a Trust with which the Health Authority contracted. The Trusts were selected as being a main provider of services to the Health Authority and also as representing a spectrum of experiences. Two were mental health Trusts, two were non-teaching acute and two were teaching acute. The individuals interviewed varied in terms of their position as we asked for someone who was involved in the contracting process with the specific Health Authority/Trust in question. In general, the individuals in both Trusts and Health Authorities tended to be Directors/Assistant Directors of Planning, Commissioning or Contracting.