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The impact of market-like arrangements on specialist services: a case study

Ian Tilley and Helen Tilley*

*University of Greenwich and *Bexley and Greenwich Health Authority, UK*

This article considers how specialist hospital services in the UK fared under Conservative health policy, with its emphasis on market-like arrangements, and what looks likely under the New Labour era, where new shibboleths (cooperation, quality, etc.) supposedly are in place. There appeared inherent in the Conservative health policy threats to specialist services from local competition, and purchaser agendas for local health needs of equity and prioritization. Moreover, small providers grappled with costs and the bureaucracy engendered by market-like arrangements and with their inability to make economies of scale. From the policy rhetoric since the New Labour election victory of May 1997, one might expect such specialist services to be 'coming in from the cold', but the reality seems quite different. In particular, this paper will outline the policy context for specialist providers for the period in the 1990s when the Conservative government undertook to reform the NHS. We also, through the Unit that is the subject of the case study, examine the actual effects of those reforms on this specialist service. Finally, we reflect further upon the resonances for specialist services in the New Labour era that can be gleaned from the case study.

Introduction

Specialist services may be defined as those whose volume is not sufficient for provision in district general hospitals (DGHs). Additionally, some may view them as those specialties that cannot be clinically effective without the critical mass of patients that no single health authority can provide (Mullen, 1995). Together, these definitions lead to specialist services being those requiring concentrated expertise and a wider commissioning remit than that afforded at district health authority (DHA) level. However, specialist services comprise services that although of relatively low volume can be located almost anywhere on the continuum of costs for health services. High cost can therefore be seen as an inadequate marker for defining specialist services. Indeed, intensive therapy services have very high cost, but are considered essential to both teaching and DGHs.

If such services are provided, therefore—either to more than one DHA, or concentrated in teaching hospitals for reasons of clinical effectiveness—questions arise as to how they should be funded. Historically, since 1983 (NHS Executive, 1996a) some specialist services have been purchased/commissioned nationally (e.g. complex liver services) by the Supra Regional Services Advisory Group (SRSAG) and

Ian Tilley PhD, Reader in Health Finance and Policy, University of Greenwich, Old Royal Naval College, Park Row, Greenwich, London SE10 9LS, UK, and **Helen Tilley B Soc Sc (Hons)**, Specialized Services Developmental Manager, Bexley, Bromley and Greenwich Health Authority, Marlowe House, 109 Station Road, Sidcup, Kent DA15 7EU, UK
Correspondence to: I. Tilley, i.g.tilley@greenwich.ac.uk

some have received centrally allocated ring fenced funds (e.g. the early days of HIV funding). Notably, the SRSAG and its successor National Specialist Commissioning Advisory Group (NSCAG) controlled the numbers of designated centres and services.

In their 1995/96 report (NHS Executive, 1996a) NSCAG recommended the removal of heart/lung transplantation services from central commissioning to a national consortia purchasing arrangement, on the grounds that the eight centres designated at that time already constituted regional provision (NHS Executive, 1996b). Obviously, such services can grow over time, to the extent that local or national consortia become more practical than central funding. The nationally top-sliced services do therefore tend to be services of very low volume and potentially high cost.

The service that forms the basis of this case study is a low-volume low-cost service conducted from two centres within the UK. One is in a city in Northern England, where a few beds are allocated in a general medical ward in a large teaching hospital. The other, situated in London, is the focus of this case study. The clinical service in this centre throughout the 1990s was contained within one small building, but was institutionally part of a very large central London teaching hospital. This specialty is very small, including even the treatment of a medical condition with a national register of about 100 patients only. The London Unit, as it will be called here, held its own outpatient clinics (one to three clinics every session) and contained, throughout the period under scrutiny, a 22-bed inpatient facility. Most importantly both centres are supported by unique and highly specialized laboratory services and by a major internationally renowned research institute integrated within a major UK university.

The purpose of this paper is to consider how specialist services fared under the Conservative government, with its health policy emphasizing market-like arrangements, and what appears to be happening in the New Labour era. From the policy rhetoric one might expect such specialist services to be 'coming in from the cold', but reality seems quite different.

In particular this paper will:

- outline the policy context for specialist providers for the period in 1990s when the Conservative government undertook to reform the NHS
- through the Unit that is the subject of this case study, examine the actual effects of those reforms on this specialist service
- reflect further upon the resonances for specialist services in the New Labour era that can be gleaned from the case study.

Market-like arrangements in the UK NHS in the 1990s

The reforms to the UK NHS, initiated by the Conservative government in 1991, followed on from a wide ranging review of the Health Service chaired personally by the then Prime Minister, Margaret Thatcher. The White Paper *Working for Patients* was published in January 1989 (Department of Health, 1989). Alternatives to financing healthcare were rejected on the grounds that other systems in place in other Western nations had as many problems as the British system. The basic values inherent in the setting up of the NHS in 1948 were to remain — namely that 'the care and treatment that the service provides should be available to any man, woman and child, on the basis of clinical need, regardless of the ability to pay' (Department of Health, 1993b).

The White Paper was concerned with the delivery of health services through an 'internal market'. The internal market idea arose from a report published in 1985 by the American economist Alan Enthoven (1985). The fundamental principle was that the money would follow the patient via contracts between purchasers and providers. Thus was born NHS Trusts as providers, no longer managed by DHAs. The DHAs themselves became primarily responsible for purchasing the services needed by their resident populations. There was also enshrined in these policies the opportunity for some GPs to become purchasers of hospital treatments as GP fundholders (GPFHs). If money followed the patients, the assumption was that hospitals would improve their performance through this stronger incentive than that of the global budgets which had prevailed up until that time. Such global budgets had fixed financial limits, and this led hospitals to cancel operations and procedures once allocations had run out. There was no incentive in such a system for hospitals not under financial pressure to see more patients, and those that became efficient

treated more people but were penalized by the fixed income levels as more patients inevitably incurred more variable costs.

How were specialist services, especially low-volume services with little room for economies of scale, supposed to fit into the new market-like arrangements? As many of these services took in patients from throughout the UK (the Turnberg Report [1998] pointed out that contrary to the prediction of the Tomlinson Report [1992], the use of beds in London by non-Londoners has not fallen), the advent of extra-contractual referrals (ECRs) within the contracting system was predicted to be of enormous importance in areas of care where the likelihood of host and local purchasing contracts being sufficient was low.

The main objectives of the internal market were to rationalize healthcare and improve its efficiency of delivery, rewarding well-run units and penalising those whose financial integrity was poor and/or whose demand input was low owing to the effects of inefficiency and low-quality services. This can be demonstrated by the gradual withdrawal of the privileges of what had been designated Special Health Authorities (SHAs). These particular specialist hospitals and units either became integrated into existing Trusts over time or became Trusts in their own right and were subject to the same rigours of the market place as others (Department of Health, 1993a). Only those nationally designated under SRSAG and NSCAG continued to be centrally planned and funded with adequate block contracts. Like the SHAs, specialist units often became swallowed up in larger units to ensure their survival and were quite attractive to large teaching hospital Trusts in terms of their international and academic prestige. To some degree, absorption could cushion such specialities in that internal allocations of financial resources by no means followed the contracts various specialties were awarded (Baeza *et al.*, 1993; Tilley, 1995; Tilley, 1996; Tilley and Salt, 1994).

Without national recognition, however, specialist services might feel under threat from the Conservative reforms. They could become subsumed under all-encompassing categories within Trusts, particularly general medicine, which could in turn affect their clinical freedoms, pricing structures and resource allocations. The internal market also held the danger for specialist services of being purchased by Health Authorities that could/did not give them 'high priority or fully understand their requirements' (Bunch, 1998).

In one of the more important papers on specialist services in the Conservative era, Langham and Black (1995), researched the experience of both provider and purchaser in a relatively high-cost specialist service — tertiary cardiac revascularization — during the early period of the market-like arrangements (1991–1995). They have concluded that purchasers were overcome with increasing demand for the services in question and the difficulties of having to make decisions about the cost and quality of services with a paucity of accurate comparable data. However, the providers were troubled about the future, about increases in demand for services and about a lack of resources to deal with such increases. Although conducted early after the implementation of the Conservative NHS reforms, this study remains relevant for specialist services in outlining the major perceived threats to such services operating under market-like arrangements.

In another important study of the same period, Mullen (1995) summarized very comprehensively the debate over the most appropriate and effective models for the purchasing of specialist services. The author points out that, having looked at supra-authority services in terms of planning and central funding (Mullen, 1986), ten years on and in the midst of the Conservative health reforms such services were facing increasing problems. One important aspect of the reforms was the move to capitation funding, the effect of which was to remove funds from London where many specialist services are based.

Most specialist work is based on tertiary referrals, where a patient is referred to a specialist service by a consultant and not a GP. This implies that the patients, by the very nature of their mode of referral, can be assumed to be already receiving treatment, and therefore that they have a legitimate expectation that their treatment will be completed, regardless of cost. Purchasers were perceived to be attempting inappropriately to place contracts locally in order to avoid the costs of specialist services. Mullen (1995) concludes that problems remain because of conflicting objectives such as equity versus local priorities.

Mullen's conclusions are particularly pertinent for specialist services like the one studied here, which were national in remit, in that they were a service needed by a rare type of patient,

but which often became undifferentiated from more general services within the large teaching hospitals in which they resided. Often, as in the case study presented here, they had been separate small postgraduate teaching hospitals. Very few now remain outside a large teaching hospital Trust. In fact, one of those hanging on grimly in the outside world has just approached its regional office in crisis because of its underperformance during 1999/2000 and the subsequent threatened withdrawal of DHA/Primary Care Group (PCG) funding in the coming year. Often their separate identity is maintained for a few years in the name of the combined Trust and/or through retaining their own medical committee and control of historically amassed designated special trustees funds, but this separate identity is then quietly dropped. An example of the latter can be found with the four specialist urology hospitals in Central London that were commonly known collectively in the 1980s as the three Ps. They were incorporated into University College London Hospitals early in the 1990s yet no longer figure on the institution's headed notepaper. Such units offer for study a microcosm of the problems of specialist commissioning—being national in remit, they are even more vulnerable to all the problems discussed in this section. Most importantly, their survival depends on the recognition of their national remit and the ability to convince politically purchasers and strategists that local services are not concentrated enough in practice terms to be clinically effective.

The case study that follows will look at various financial indicators for the chosen specialty and, in particular, how it fared in terms of variable income. It might have been supposed with the advent of the internal market that the unpredictability of ECRs would be destabilizing to Health Authorities, and indeed the difficulties of administering such a system were a matter of concern for purchasers. At a conference held in South London in early 2000, the commissioners of bone-marrow transplant services were enthusiastic for consortia arrangements as an 'antidote' to the fluctuations and headaches ECRs had caused. An eminent haematologist, however, publicly lamented to the same forum that the loss of ECRs was partially responsible for the financial instability of his nationally renowned clinical haematology service.

With the advent of contracting, however, mechanisms had to be found for resources to pass from purchasers to providers through contracts. Commonly, block contracts were agreed between DHAs and Trusts, where a set financial envelope was agreed for the contracting year irrespective of the actual volumes of health interventions processed by the providers. An over-performance on such a contract left the provider working harder for no extra gain and an under-performance penalized the DHA who had then spent non-utilized resources in one area that could have been used to purchase extra services elsewhere. Such inflexible mechanisms of contracting were to some extent vired when viewed by DHAs from a whole-Trust perspective, but were vital for specialties in terms of internal resource allocation. For specialist units, these 'bread and butter' block contracts enhanced the value of successfully attracting variable income, especially in a climate where only a tiny proportion of specialist services are nationally top-sliced by expert bodies such as the NSCAG.

The case study

The material for the case study is derived from unit monitoring data of financial performance over the study period. The data derive from the period when the umbrella hospital became a Trust (on 1 April 1994) and covers the period until the disestablishment of the internal market at the end of the 1998/1999 financial year. The data can be seen summarized in Tables 1 and 2. A number of indicators and their trends over the study period will now be represented graphically and then discussed.

As shown in Figure 1, the level of overspending remained fairly constant for each financial year studied; this suggests consistent underfunding of the service. The percentage increase in base budget figures for 1994/95 is unavailable because the values for 1993/94 (on which

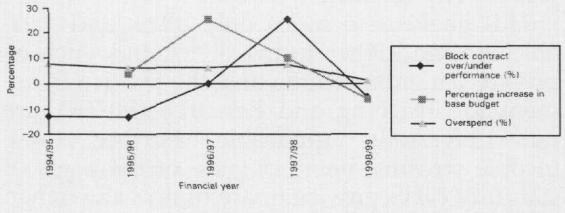

Fig. 1 *Percentage changes under market-like arrangements.*

the 1994/95 values are based) are unknown. Interestingly, 1996/97 saw a substantial increase in the base budget over the previous year, and there was no over- or underperformance on block contracts. This would suggest that planned expenditure matched actual activity. It would seem logical to assume that this followed underperformance on block activity where the base budget was unable to resource the contracted work. In 1996/97, when there was a substantial base budget rise, block contracts were matched by actual activity (overperformance was only 0.1%). This would imply that raising the base budget was a rational strategy in that it afforded matching of block contracts to activity achieved.

In 1997/98, there was a 25% overperformance on block contracts, leading to a downturn in activity growth in 1998/99. Units often overperform in one year and then attempt to contract the following year at outturn. An exceptionally good year may be followed by a year in which false expectations are raised in terms of the market, and an under-performance occurs. The growth in the base budget in 1998/99 was less than for the previous year, however, and this may also account for the inability to achieve contracted activity levels. It must also be remembered that over-performance on block contracts means that the work is done, but not resourced by the contracting Health Authority.

Notably, in the early years of the internal market, the unit underperformed against block contracts, which may have been owing to the difficulties in predicting activity once subject to the process of contracting. It is possible that for small-scale specialist units this was particularly a problem, as inaccurate overassessments would have greater impact on smaller specialist services compared with large generalist services such as general medicine. However, this was only to the disadvantage of the purchasing Health Authority, who would be obliged to fulfil the contractual payments whilst having lost activity for their residents.

This analysis includes only block and variable income. Other forms of income, such as private patients' income and the Service Increment for Teaching and Research (SIFTR), are not universally applicable. Further, these income streams, being outside of the aegis of statutory NHS provision, are of no value when examining the fate of specialist services under market-like arrangements.

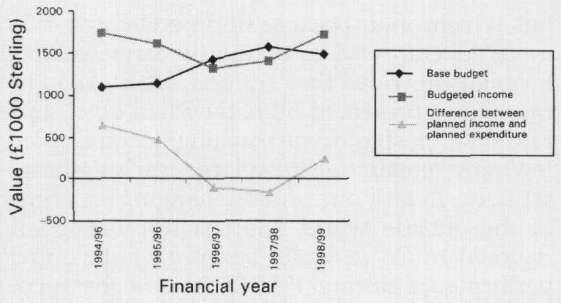

Fig. 2 *Budgeted income and expenditure.*

Figure 2 illustrates that base budgets rose in absolute terms year-on-year throughout the study period, with the exception of 1998/99. As stated earlier, 1996/97 saw the greatest percentage increase on the previous year, despite this being the first year in which budgeted income was projected to fall below the actual costs of running the service. This year, and the following one, appear particularly interesting in this respect as they were both years in which the base budgets were raised considerably above inflation, but in which it appears the 'market' was 'beginning to bite' in terms of the anticipated income streams. Again, it appears that slowing the base budget growth was problematic in terms of attracting contracts and maintaining the ability to provide the service. Local contracting by purchasers choosing to downplay the specialist nature of the service may have played a part in this.

Although block contracts formed the 'bread and butter' income for any unit under market-like arrangements, it was variable income and its percentage of a unit's income that curried favour with umbrella Trusts and justified supporting specialist services in the difficult

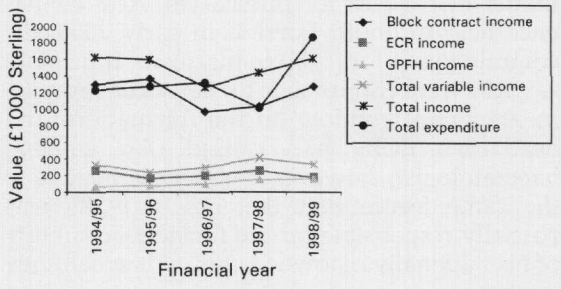

Fig. 3 *Income and expenditure values for the Specialist Unit, 1994–1999.*

environment described above. Variable income, in the context of the NHS from 1991 to 1999, includes GPFH and ECR income. Figure 3 illustrates the relationships between income from different contracting sources (block, GPFH or ECR) and total income and expenditure. Again, the table supporting the graphic representation is to be found in Table 2.

Most notably, there were only two years in which total income for the specialist unit fell below total expenditure. In 1996/97 this under-recovery of income was £57 320 (4.5% of total income). This was the year in which the base budget rose substantially and there was an absolute drop in total income. The base budget was subsequently reigned in with decelerated growth, until 1998/1999, when there was negative growth. However, in 1998/99, the situation was more serious than in 1996/97, with a deficit of £255 505 (16% of total income). Having been a net contributor to the organization throughout the period when market-like arrangements were government policy, the year before the internal market was disbanded was financially disastrous. However, in that year the unit relocated to new premises and in the process merged with another inpatient service. The costs of the relocation, not included in the capital costs of the new premises, were borne within the normal expenditure budgets and had not been sufficiently planned for.

It is of note that throughout the period in question, total income fell from £1 621 700 in 1994/95 to £1 606 895 in 1998/99. Variable income remained fairly constant, but rose slightly from £328 200 in 1994/95 to £334 000 in 1998/99. Figure 4 shows that as a percentage of total income, its contribution ranged from 15 to 28%. Variable income was thus not insignificant in keeping this particular specialist unit afloat. Notably such values are well above those

Table 1 *Planning indicators for the Specialist Unit, 1994–1999*

	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999
Base budget	1 088 000	1 130 900	1 413 600	1 560 000	1 472 000
Percentage increase in base budget		4	25	10	−6
Overspend (%)	7.66	6.19	6.24	7.44	1.25
Budgeted income*	1 729 900	1 600 000	1 309 000	1 393 300	1 712 000
Difference between planned income and planned expenditure	641 900	469 100	−104 600	−166 700	1 358 000
Budgeted GPFH income	7200	70 700	112 900	172 000	163 000
Actual GPFH income	68 400	73 100	99 400	149 000	160 000
GPFH income variance	61 200	2400	−13 500	−23 000	−3000
Budgeted ECR income	262 000	170 400	230 000	191 000	240 000
Actual ECR income	259 800	159 800	195 600	256 600	174 000
ECR income variance	−2235	−20 600	−34 400	65 600	−66 000
Block contract over/under-performance (%)	−12.63	−12.86	0.10	25.11	−5.24

**This sum covers only block and variable income. It excludes SIFTR or its equivalent, transitional relief and any private income. GPFH = GP fundholder.*

Table 2 *Actual financial values for the Specialist Unit, 1994–1999*

	1994/1995	1995/1996	1996/1997	1997/1998	1998/1999
Block contract income	1 293 500	1 358 980	967 100	1 030 065	1 272 895
ECR income	259 800	159 800	195 600	256 600	174 000
GPFH income	68 400	73 100	99 400	149 000	160 000
Total variable income	328 200	232 900	296 000	405 600	334 000
Total income	1 621 700	1 591 880	1 262 100	1 435 665	1 606 895
Total expenditure	1 224 465	1 270 780	1 319 420	1 011 000*	1 862 400*

**This expenditure includes contribution to overheads and an internal recharge for usage of ITU.*

for large teaching hospital Trusts in general, which averaged around 7.1% in 1994/95 (Fitzhugh, 1995).

As shown in Figure 5, overall the unit was a net contributor to its umbrella Trust. Despite the difficulties inherent in contracting throughout the United Kingdom and relying disproportionately more than the average on variable income, the Unit survived the period of market-like arrangements.

1998/99 appeared to herald disaster, but the relocation was designed to achieve economies of scale with the merger partner and the absolute value of variable income and its proportionate value in terms of total income remained respectable at 21% (Figure 4). Had the relocation costs not been attributed against income, income would most probably, as in most other years, at least have been sufficient for the running costs of the service.

The future of specialist services in the UK National Health Service

In May 1997, a Labour government was elected in the UK with a large majority. The key White Paper setting out Labour's overall stance on the NHS, *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997) clearly stated that policy was aimed at retaining good aspects of Conservative policy and reintroducing elements of the founding principles of the NHS, which mainly involved a return to equality of access through the abolition of GP fundholding and the introduction of mechanisms to ensure uniform quality of service provision throughout the whole NHS. The overall banner under which this was to be achieved was through clinical governance, and chief executives were

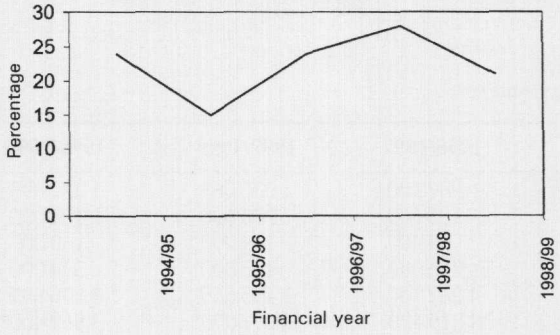

Fig. 4 *Variable income as a percentage of total income.*

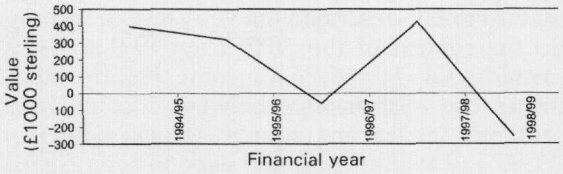

Fig. 5 *Surplus income over expenditure.*

to be responsible for this, as well as the financial probity of their organizations.

In their Green Paper on public health (Secretary of State for Health, 1998), emphasis was placed on partnership and cooperation: 'the Government, local communities and individuals will join in partnership to improve all our health'. Both papers give Health Authorities the role of 'leading local alliances to develop Health Improvement Programmes, which will identify local needs' (Secretary of State for Health, 1998).

As Griffiths (1998) pointed out in his summary of *The New NHS: Modern, Dependable* (Secretary of State for Health, 1997), performance 'will, in future, be measured not on the discredited efficiency index, which rewarded admission to hospital and throughput, but on indicators which include health improvement and the health outcome of NHS care'. The new National Performance Framework is to have six dimensions: health improvement, fair access, effective delivery of appropriate healthcare, efficiency, patient/carer experience, and health outcomes of NHS care.

The New Labour government has laid emphasis on partnership and cooperation, as opposed to the adversarial nature of Conservative policy where Trusts that failed to attract sufficient contracted income for their services were expected to 'go to the wall'. In place of the annual contracting round and the variable incomes that could be earned through GPFH and ECR income, local commissioning mechanisms, which vary from country to country within the UK, have been set the agenda of agreeing three-yearly service agreements with providers in response to local needs (NHS Executive, 1998a).

Publication of *The New NHS* (Secretary of State for Health, 1997) followed on very shortly from the publication of a report on the commissioning of specialist services by the Audit Commission (1997). It was clear from this report that special mechanisms were required

for the commissioning of supra-DHA services (i.e. specialist services). Thus, draft guidance on commissioning specialized services was sent out to consultation in May 1998 (NHS Executive, 1998b) and this guidance recommended that:

- services be defined by annual review
- regional specialized commissioning groups (RSCGs) be established by April 1999
- RSCGs determine the best model for commissioning in their region
- regional offices approve RSCG action programmes
- Health Authorities should usually pool resources.

The changes outlined in commissioning in general in HSC(98)198 (NHS Executive, 1998a) were not implemented until April 1999, and so specialist services have only experienced a short period without variable income. GP fundholder and ECR resources were, wherever possible, incorporated into service agreements at the Trusts where such activity had historically taken place. Anecdotally, however, this has left small specialist services exposed. If unable to achieve previous activity levels, there is none of the valued variable income to make this up. If working within a system of service agreements identified by a financial envelope, high-cost emergency procedures may only be undertaken above agreed activity levels, and others omitted, thus keeping the contract performing within the set value. However, the costs of providing the service may not have been planned for such an activity profile or be large enough to absorb such differing costs, and may therefore become adversely skewed. Before the publication of the year-end financial statements for 1999/2000, the unit in question was underperforming at all levels, and, as already stated, other such specialist units were in fear of destabilization because underperformance encouraged commissioners to threaten withdrawal of activity and therefore funding.

Conclusion

The case study described here must be viewed in the light of the methodological problems that all case studies present. Can the unit studied be thought to be representative of other provider units? Case studies are often useful in areas currently under-researched, as specialist services certainly are. At this stage a single, intensive case study seems entirely appropriate. Furthermore, case studies provide the necessary foundations for subsequent surveys of the whole sector. Nonetheless, the preponderance of specialist services in London makes it a suitable location for the current case study.

As outlined by Mullen (1995) and Langham and Black (1995), throughout the 1980s and 1990s specialist services have remained anxious in the face of various protocols for cutting the NHS cake. The demand for specialist services is less easy to identify with and understand than for generalist services.

The advent of the Conservative NHS reforms of the 1990s and market-like arrangements caused problems for specialist providers. Many disappeared into other larger organizations to increase their viability and subsequently lost much of their independence. However, they were often valued for their highly prestigious academic reputations and, much to the surprise of many, for their ability to attract variable income that often made them significant, if fluctuating, net contributors to the umbrella organization. In the Conservative era, variable income was significant but highly volatile, and block contract activity appeared able to increase in response to investment of resources in the base budget, but this proved difficult to sustain. It is possible that the move to longer-term service agreements may iron out some of the difficulties inherent in a system that almost invariably contracted every year at outturn and therefore experienced such swings.

The New Labour agenda has emphasized a return to a *National* Health Service, and moves are being made towards this through regional planning and direction from RSCGs, which have been operational since April 1999. However, as those specialist services — particularly the small, low-volume, low-cost national services not designated as major priorities in the modernization agenda (unlike cancer and cardiac services) — or those subject to quasi-regional commissioning consortia (e.g. high-cost low-volume services like those for haemophiliacs) experience the loss of activity resulting from loss of variable income, they will become increasingly at risk. As commissioning becomes increasingly devolved down to Primary Care Trusts (PCTs), this risk could rise. Such threats require, at the very least, monitoring of vulnerable services and further national action within the New Labour rallying cry of a return to a

National Health Service, with equality of access to all services depending on clinical need alone.

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