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INSTITUTIONAL CHANGE AND TRUST IN THE NATIONAL HEALTH SERVICE.

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SUMMARY.

Dominated by the National Health Service, health care organisation in the U.K. has been subject to considerable institutional change, especially since 1990. This paper aims to explore how the 1990 and 1997 legislation affected the value structure underlying the pre-1990 NHS and to analyse the impact of institutional change on trust relationships between stakeholders of the NHS. To this effect, economic, sociological and institutional approaches to trust are reviewed and criticised. Three specific instances where the 1990 and 1997 NHS reforms may have altered the nature of interaction between parties are considered: the relationship between purchasers and providers, between clinicians and patients, and between clinicians and NHS management.

The paper conjectures that the pre-1990 NHS was built on trust. The creation of an "internal market" has led to some erosion of trust between the stakeholders of the NHS. A more market aligned incentive structure has been superimposed on, and to some degree co-exists with, the Hippocratic ethos that governed the pre-1990 NHS. Economic relationships in the post-1997 NHS are likely to be characterised by a mixture of the socially-embedded trust of the pre-1990 NHS and the calculative, self-interested trust associated with a more market-oriented value structure.

1. INTRODUCTION.

Since its inception, the U.K.'s National Health Service has gone through prolonged periods of institutional change. Most recently, the 1990 and 1997 reforms (Secretary of State for Health, 1989 and 1997a,b) have introduced a variety of new organisational structures in the health service. To date, the majority of evaluatory studies have focused on the consequences of the 1990 and 1997 reform packages for efficiency, equity, quality, consumer choice, and responsiveness. Much less attention has been devoted to the potential impact of institutional change on the nature of relationships between stakeholders of the NHS. This paper provides an initial exploration of how the 1990 and 1997 legislation affected the belief and value structure underlying the pre-1990 NHS and how it contributed to the erosion of trust in and within the health service.

Our interest in the consequences of institutional change for trust has been stimulated by recent work which regards trust as a potential source of enhanced economic performance (see, for instance, Arrighetti et al., 1997). Such a link would suggest that any erosion of trust induced by the 1990 and 1997 legislation is likely to adversely affect the narrow efficiency targets sought by the previous and current government. This is a much neglected side effect of the reforms and is in stark contrast with the projected cost savings of £1 billion as reported in the 1997 White Paper (Secretary of State for Health, 1997a).

The paper initially outlines the concept of trust and reviews and comments upon economic, sociological, and institutional approaches to trust. The health service reforms of 1990 and 1997 are described and the possible implications of these changes for the degree of entrustment between the various stakeholders of the NHS are explored. The paper specifically focuses on the impact of institutional change on three relationships: between purchasers and providers, between clinicians and patients, and between clinicians and NHS management.

2. DEFINITION OF TRUST.

Famously, Arrow called on analysts to recognise trust as both a necessary and sufficient condition for economic activity. He emphasised that "virtually every transaction has within itself an element of trust, certainly any commercial transaction conducted over a period of time" (Arrow, 1975, p. 24). Despite Arrow's attempt to map out the impact of trust on economic development and performance, he was less successful in fashioning a robust definition.

Gambetta (1998) provides a definition of trust that is framed in principal-agent theory: "trust is a particular level of subjective probability with which an agent assesses that

another agent or group of agents will perform a particular action, both before he can monitor such action and in a context in which it affects his own action".

Hence, to trust implies that there is some diminution in behavioural uncertainty (Zucker, 1986). In this respect, Sako's delineation of trust which reflects different types of behavioural risk in commercial contracting should be noted. He distinguished between three different types of trust in exchange relationships: contractual trust, where a party is trusted to adhere to the terms of the agreement, competence trust, that is the belief in a party's ability to provide commodities of a specified quality, and goodwill trust, which pertains to the extent to which a party can go beyond mere fulfilment of her/his tasks to taking new initiatives for mutual benefit without seeking undue personal advantage.

In health care, trust is likely to play a role in three relationships: between purchasers and providers in the NHS, between clinicians and patients, and between clinicians and NHS management. Given the fundamental uncertainty about the incidence and severity of illness in the population and the uncertain effect of health care on health status, patients and managers have to rely on the judgement and clinical expertise of clinicians to provide care in the best interests of the patient and the NHS. Due to the difficulties involved in accurately measuring and predicting the range, volume, price and quality of health care services to be provided, contracts between purchasers and providers will necessarily be incomplete. In the presence of information asymmetry between parties, trust allows parties to cope with environmental uncertainty by reducing behavioural uncertainty. For

instance, GPs can more easily deal with unpredicted fluctuations in demand by orienting their actions on the basis of the expected behaviour of NHS Trusts.

3. THEORIES OF TRUST.

This section briefly describes and criticises different approaches to trust. More specifically, the calculative, self-interested trust of mainstream economics is contrasted with the socially-embedded trust of anthropology, sociology and heterodox economic approaches.

Conventional economists tend to encapsulate trust in a rational choice framework and conjecture that parties are motivated to trust for calculated, self-interested reasons. Trust in this context follows directly from the economic assumptions of rational utility maximisation (Fisman and Khanna, 1999). The interest in trust in economics has mainly come from two perspectives: transaction cost economics and game theory.

In transaction cost economics, the concept of trust is generally discarded in favour of the notion of opportunism, that is self-interest-seeking with guile. Williamson even goes so far as to say that "the study of economic organization is better served by treating commercial contracts without reference to trust" (Williamson, 1993, p. 99). Under conditions of bounded rationality, asset specificity, uncertainty, complexity, frequency, and small-numbers bargaining, parties may engage in post-contractual opportunistic behaviour

and extract concessions from the other party. Consequently, trade would be severely impaired without recourse to appropriate enforcement mechanisms to attenuate the occurrence of opportunism. Following Williamson, trust is regarded as an insufficient safeguard against opportunism and parties should instead rely on other governance structures such as vertical integration and long-term contracts (Williamson, 1985).

However, by presuming that opportunism is innate human behaviour, Williamson fails to fully appreciate the potential of trust as a governance structure. First, the establishment of a relationship based on trust may allow parties to economise on transaction costs, both ex ante and ex post. Ex ante transaction costs refer to the costs of writing and negotiating an agreement. Ex post transaction costs refer to the costs of enforcing, monitoring and, possibly, renegotiating contracts. Professional associations such as the British Medical Association and Royal Colleges effectively reduce costs to the NHS of monitoring professional behaviour through, for instance, peer review and ethical codes (Croxson, 1999).

Second, game theory recognises the importance of trust as rational self-interested behaviour in long-term relationships. Repetition makes parties realise that rivalrous behaviour in the short run could impair the sustenance of co-operation and undermine mutual long-term benefit flows. Therefore, the desire to safeguard a reputation of trustworthiness may act as a constraint on opportunism.

As opposed to the Williamsonian *homo economicus* who is purposefully calculative, sociological theories focus on the social mechanisms that foster trust and that provide a rich variety of enforcement mechanisms. The reductionist perspective of human behaviour adopted by conventional economists is replaced by the notion of socially-embedded trust that is the product of either affectual, traditional or value-rational behaviour (Lyons and Mehta, 1997a,b). Affectual behaviour refers to personal trust relationships built on feelings of friendship and even devotion to the exchange party. Traditional behaviour becomes manifest in the adherence of parties to routines or customary practices. Value-rational behaviour reflects the commitment of parties to the same belief system and to shared values. North (1990) points out that trust engendered by any of these types of behaviour may help to resolve ubiquitous agency problems.

However, both economic and sociological approaches marginalise the role of institutional normative structures in creating and sustaining trust. Williamson, for instance, fails to appreciate the influence of the institutional environment which, in his analysis, "is mainly taken as exogenous" (Williamson, 1993, p. 476). In general, three institutions can be identified that act as a vehicle for trust production: the legal system, professional associations, and technical standards (Deakin et al., 1997). Arrighetti et al. (1997) argued that institutional trust can play an important role in promoting stability, especially in intra-organisational interactions, in offsetting asymmetries of power between parties, and in decreasing uncertainty.

4. THE 1990 NHS REFORMS.

Prior to the 1990 reforms, District Health Authorities exercised the joint responsibility of planning health care services and managing the providers of these services, i.e. hospitals. The previous government's legislation, *Working for Patients*, radically altered this organisational structure by introducing market-oriented interactions between parties in the health service and by imposing a contractual relationship between different bodies in the NHS. The centrepiece of the reforms was the division between purchasers and providers, and the devolution of budgetary responsibility from Health Authorities.

On the purchaser side, District Health Authorities were expected to reduce their role in providing health care and to move towards a commissioning role. In addition, GPs could opt to become fundholders and hold a budget to purchase a limited range of hospital services for their patients. District Health Authorities continued to purchase services for those GPs who did not elect to become GP fundholders and for those services that did not fall under the responsibility of GP fundholders. On the provider side, hospitals could gain independence from their Health Authority by becoming NHS Trusts. Hospitals that did not obtain Trust status remained under the management of the Health Authority.

The separation of functions and the devolution of budgetary responsibility was intended to stimulate competitive pressures at both primary and secondary care levels, and in this manner enhance cost awareness, whilst simultaneously improving the quality, if not the equity, of care (Chalkley and Malcolmson, 1996; Flynn and Williams, 1997). This reform package represented a considerable shift in the culture of NHS activities (Flynn and Williams, 1997; Hughes et al., 1997; Montgomery, 1997). Contracting formalised relationships between actors across the purchaser-provider split. Communication between parties was inevitably drawn into recognised channels, as opposed to informal arrangements. However, contracts in the internal market carried no legal recognition. Thus, whilst the shift to contracting is clearly a market-oriented alignment, it does not represent full-scale privatisation in that contracting parties do not possess the property rights to seek judicial arbitration and are subject to NHS Executive guidance. Consequently, Montgomery (1997) argued that the 1990 reforms are better interpreted as a means of performance management.

5. THE 1997 NHS REFORMS.

The current government claimed to be committed to abandoning the internal market for health care. Certainly, the White Paper, *The new NHS: modern, dependable*, emphasises integrated care and co-operation as opposed to the competitive imperative previously sought, but seldom attained. Working with Health Authorities, Primary Care Groups and clinicians from NHS Trusts are to take the lead in planning the local patterns of service

provision within the three-year Health Improvement Programme. This trilateral arrangement envisages Health Authorities to act in a regulatory capacity, and Primary Care Groups and NHS Trusts to work in partnership.

The reorganisation further empowers GPs, despite the cessation of GP fundholding. New, larger Primary Care Groups are established consisting of all GPs in a local area together with community nurses. Over time, these Primary Care Groups can become freestanding Primary Care Trusts, which hold a unified group budget covering General Medical Services, hospital and community health services, and prescribing. Within the context of this new, collaborative approach, Primary Care Groups will agree long-term service agreements with NHS Trusts.

Nevertheless, there are aspects of the 1997 reforms that suggest that not only has the internal market apparatus not entirely been abandoned, it has also been reinforced in some respects. Witness, for instance, the retention of the purchaser-provider split, the persistence of contracting interfaces, and the further devolution of budgetary responsibility.

By separating the planning of secondary care, as articulated through the commissioning process, from its provision, the 1997 legislation not only retains the integral structure of the internal market, but also the divergence of incentives to agents within it. Even in an atmosphere of co-operation, the flow of funds from Primary Care Groups to secondary care providers will at least be influenced by considerations of appropriation. Moreover,

the reform package stresses the importance of decentralised management, characteristic of other market-oriented initiatives of the previous government, and places great emphasis on devolved budgeting (Montgomery, 1997).

6. THE PRE-1990 NHS AND ITS FOUNDATION UPON TRUST.

The pre-1990 NHS operated on a basis of high value congruence. Given that the underlying value structure in the NHS was governed by the Hippocratic ethos, health care providers were viewed as sharing a common set of values based upon professional ethics and caring (Robinson and Le Grand, 1994). Barker et al. (1997) contended that common ownership across any exchange interface within the NHS implied that actors were likely to share objectives rather than pursue independent and conflicting goals. The adherence to a common belief system and behavioural patterns consistent with the prevailing culture in the health service established and sustained high levels of trust in and within the NHS.

Prior to the 1990 reforms, the NHS was characterised by a high degree of clinician autonomy (Klein, 1995). Clinicians retained ultimate authority over the allocation of resources and the provision of services, usually based on professionally defined criteria of need. This injected a considerable degree of goodwill trust in the relationship between clinician and patient, and supported the expectation that the clinician's actions were solely guided by the patient's interests.

Public trust in the NHS was reinforced by the ability of clinicians to provide high-quality care. Professional organisations enforced high standards of medical and postgraduate education and controlled entry into the profession. Competence trust was (and still is) invested in physicians and other clinical staff by means of the professional code of practice of clinicians and training accreditation as ratified by the Royal Colleges. Montgomery (1997) further indicated that the NHS prior to the 1990 reforms had an array of quality control mechanisms, ranging from the Audit Commission to community health councils.

The dominance of the clinical profession and the prevailing Hippocratic ethos, however, were accompanied by considerable performance ambiguity and actor discretion. In addition, professional accreditation was viewed as a constraint on the market mechanism - analogous to an entry barrier that inflates costs - by encouraging the potential pursuit of "Rolls Royce" service standards without any awareness of costs.

This perception of a lack of accountability shaped certain aspects of the 1990 reforms. First, the pre-1990 NHS exhibited too much entrustment in the ability and incentives of clinicians. The absence of a robust evaluatory framework provided clinicians with the opportunity to free-ride. Second, the extensive degree of entrustment invested in clinicians was allocatively inefficient.

By introducing more market traits in the NHS, accountability and efficiency were expected to be enhanced. As Keaney and Lorimer (1999) noted, such an interpretation of the 1990 reforms is predicated on a rather weak neo-classical analysis, which does not take account

of knowledge gaps and which assumes that patients are sovereign consumers. Moreover, the ramifications of these reforms on the role of trust within the NHS received no attention in the government's legislation.

7. THE 1990 NHS REFORMS AND THE EROSION OF TRUST.

The 1990 reforms introduced specifically market-oriented mechanisms into both the allocation of resources and the organisation of the NHS. These reforms represented significant institutional change and, obviously, the patterns and extent of trust between parties cannot be isolated from such change. Yet there is little direct empirical evidence tracing out the nature of this change and how it impacts on the ability of the health service to meet its ultimate objectives.

The internal market was based on the assumption that allowing purchasers to switch contracts between rival providers creates efficiency gains in the provision of health care. The message implicit in the 1990 legislation was that the health care sector could be regarded as a market place and that health care resembled other commodities. Although the previous government presented the reforms as a continuing evolution of, rather than a breach with, the fundamental principles of the NHS, the introduction of the internal market represented a significant change in how health care professionals and the public thought about health care.

It is argued that the government's legislation resulted in a deterioration in the degree of entrustment because of the scope for potential conflict between the established egalitarian and Hippocratic ethos of the pre-1990 NHS and the value structure associated with a more market aligned incentive structure introduced by the 1990 reforms. Three factors contributed to the erosion of trust in the post-1990 NHS: the prominent role of managers in the health service, the implementation of an evaluatory framework for assessing performance, and the introduction of contractual relationships between purchasers and providers.

The division between planning and delivery created by the 1990 legislation combined with a prominent role for the NHS Executive in setting contract guidelines and regulating the conduct of purchasers and providers increased the role of managers in the health service. The 1990 reforms further supported the shift towards a managerialistic NHS – initiated by the Griffiths Report in 1983 (DHSS, 1983) - in which decisions about the organisation and provision of health care were increasingly made by individuals whose background in medicine was limited. This process was compounded by the recruitment policy of managers. NHS Trusts were encouraged to actively recruit managers with private sector experience and to further their positions of responsibility. Again, this can be interpreted as a weakening in the Hippocratic ethos as the dominant value structure. The external recruitment of managers with little previous knowledge of the pre-1990 health service implied that such staff was less influenced by, and more detached from the prevailing value structure.

An evaluatory framework was set up in response to the lack of accountability that characterised the pre-1990 NHS. The 1990 legislation created an additional body, the Clinical Standards Advisory Group, to oversee standards of care, access to, and availability of services. The role of management was expanded through the deployment of the Purchaser Efficiency Index as an evaluatory benchmark for relative performance. This acted as a limited constraint on the discretion of clinicians in that NHS Trust performance was (partially) judged on the throughput of patients. NHS Trust managers could legitimately insist that managers adopt practices that were conducive to increasing the number of consultant episodes. This adjusted the relative position of NHS managers and clinicians in favour of the former.

The division between purchasers and providers and the emphasis on contractual relationships may have contributed to a decline in goodwill and contract trust. By superimposing potentially conflicting values, the nature of interaction changes and purchasers and providers become less inclined to reciprocate shared values in an informal manner. The very nature of any sort of contractual relationship implies that parties extract different benefit flows (Macneil, 1981). Although parties may not be entirely disengaged from shared beliefs, the pattern of expressing those beliefs has been radically altered. Flynn et al. (1997) examined the particular features of community health services and found evidence that District Health Authority purchasers expressed their commitment to developing collaborative relationships with providers, but in bargaining and negotiations over financial resources frequently engaged in adversarial behaviour.

Studies into the process of contracting in the NHS have documented the rising importance of the language and style of corporate activity in U.K. hospitals (Hughes et al., 1997; McHale et al., 1997; Kitchener, 1998). Moreover, Hughes et al. (1997) and Kitchener (1998) traced instances of considerable deteriorations in the relationships between contracting parties (usually NHS Trusts and contracting Health Authorities). Both studies illustrated that disputes were more likely to arise where a more formal contracting frame was adopted. In one study on contracting policies adopted by Welsh Health Authorities and NHS Trusts (Hughes et al., 1997), instances were identified where central authority had to be exerted to resolve disputes.

Although the introduction of contractual relationships may have engendered a diminution in the level of trust between the internal actors in the NHS, the magnitude of any such erosion of trust is likely to have been constrained by the specific nature of NHS contracts. Contracts between purchasers and providers are not legally enforceable. This implies that the contracting process in the NHS had to rely on other aspects of the contractual environment, such as trust, routines and cultural factors (Goddard and Mannion, 1998). Therefore, the value structure that prevailed in the NHS prior to 1990 still played a significant role in governing relationships between parties in the internal market.

GP fundholding, introduced by the 1990 legislation, illustrates the incursion by a more cost-conscious belief structure and the resulting erosion of trust. The motives and decisions of such organisations can be questioned given that the incentives to physicians

embodied by GP fundholding potentially threaten the credibility of the GP's role as the patient's agent. In particular, the GP's increased budgetary responsibility alters his or her decision making frame and may create a conflict between the clinician's interests and the patient's interests. For instance, Glennerster et al. (1994) showed how the GP fundholding scheme included financial incentives for GPs to indulge in "cream skimming", that is to remove patients with expensive health care needs from their lists.

Moreover, public trust in the health service may suffer when different arrangements for organising and financing care are perceived to influence the provision of health care. The GP fundholding scheme has been accused of introducing a "two-tier system", i.e. to offer better access to hospital care for patients registered with fundholding practices compared with those registered with non-fundholding practices, regardless of need (Dixon and Glennerster, 1995). A related concern was the perceived inequality in funding arising from the various financial incentives offered to fundholding practices (Robinson and Hayter, 1995). Such claims are likely to diminish popular trust in the egalitarian and Hippocratic ethos of the NHS.

In effect, the internal market may have produced counter-productive results by inducing agency type problems between managers and clinicians, between clinicians and patients, and between purchasers and providers. The resulting behavioural and environmental uncertainty may, ultimately, adversely affect the narrow efficiency targets sought by the previous government.

8. THE 1997 NHS REFORMS: THE RESTORATION OF TRUST ?

The question can be raised as to whether the 1997 reforms will redress any trust deterioration induced by the 1990 legislation. Trust received little attention in the government's White Papers (Secretary of State for Health, 1997a,b). The promotion of trust between parties in the NHS may thus be considered not to be a priority of the 1997 reform package.

At the moment, the question remains open. On the one hand, the government's emphasis on relational contracting models and the proposed shift away from competitive relations and annual contracts towards collaborative partnerships and long-term agreements (Goddard and Mannion, 1998), are likely to provide a basis for fostering both contract and goodwill trust. Moreover, the inclusion of representatives from the local community in the Boards of Primary Care Groups and NHS Trusts, the requirement that NHS Trusts hold their meeting in public, and the development of a new NHS Patient's Charter may go some way to restoring popular trust in the health service.

On the other hand, despite the rhetoric of the government, the current reform package retains - and in some instances even strengthens - the central elements of the 1990 reforms. First, the 1997 reforms devolve even more budgetary responsibility to the successors of GP fundholders (Primary Care Groups and Primary Care Trusts in England and, to a lesser extent, Primary Care Trusts in Scotland). Second, the imposition of further dimensions in the evaluatory framework through the creation of two NHS watchdogs – the National Institute for Clinical Excellence and the Commission for Health Improvement – may be the source of tension: will the formalised monitoring of clinical activities make health care professionals more accountable, or more resistant to the implementation of the government's legislation?

The only safe conclusion to draw is that it appears that the current government has not fully appreciated the potential importance of trust within a complex organisational system, such as the NHS, and is as culpable as many conventional economists in not grasping how institutional change affects the degree of entrustment between parties in the NHS.

9. CONCLUDING COMMENTS.

The creation of an "internal market" has led to some erosion of trust between the stakeholders of the NHS. Although a new, more market aligned incentive structure has been superimposed on the Hippocratic ethos that governed the pre-1990 NHS, the new value structure has not entirely replaced the old culture. Therefore, economic

relationships in the post-1997 NHS are likely to be characterised by a mixture of the socially-embedded trust of sociology and the calculative self-interested trust of mainstream economics.

The importance of trust and entrustment in and within the NHS is an under-developed area of research. Hence, it is difficult to gauge the impact of diminished trust between parties on the ability of the NHS to meet its hybrid objectives. The Hippocratic ethos underpinning clinical activity may be insulated from any climatical change in the degree of trust between actors in the new organisational structure. However, there may be an indirect qualitative influence on the ability and motivation of staff to perform their tasks effectively. There is no doubt that the 1990 reforms introduced more rigidities, via the contracting process, into the health service. At the same time, it did pose clinicians with important questions as to the cost-effectiveness of many treatment methods, although perhaps in a rather alien fashion that engendered resistance and distaste.

Any further research by policy makers and economists should focus on the potential role of trust in general, and with respect to the provision of health care in particular. The unique nature of the NHS presents an opportunity for redressing this oversight. Moreover, attention should be paid to the impact of trust on NHS performance. Finally, identifying and developing new structures and practices that enhance the public credibility of the NHS and that foster trust between the internal actors of the NHS is an important avenue of future research.

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