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# The role of wage bargaining partners in public sector reform: the case of primary care contracts

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## Abstract

The article takes the 2004 contract between British general practitioners (GPs) and the government as an example of the kind of dilemmas that confront all European health systems. The 2004 contract enabled commercial providers to enter the primary care market employing salaried GPs, and allowed doctors to withdraw from out-of-hours coverage. Our research suggests that the doctors underestimated the threat of commercialization of the previously socialised NHS primary care posed by these new contracts. Only after the consequences of the reform became clear did they take policy positions against the commercialization of the NHS facilitated by the contract they had agreed, an example of the way that wage bargaining partners in health become involved in the structural maintenance of the system as well as the pay and conditions of their members, with possible tradeoffs between the two.

## Keywords

Health policy, marketization, primary care, privatization, professional associations, trade unions

## Introduction, scope and methodology

Structural changes in a 'post-industrial' public sector are putting pressure on European welfare states and affect the strategies of actors with potential veto point power on major structural changes. Schelke's introduction to this issue sets out the kind of compromises unions must make in order to retain influence on the way that policy changes are implemented. In their article in this issue, Johnston et al show how unions can respond positively to welfare state retrenchment by co-operating with the implementation of new types of programmes that collectivise social risks. Our own focus is on a policy area – primary care services – where the supply of public resources and professional influence is strong, and might enable an objective of *structural maintenance* in which the bargaining parties would prioritise the preservation of an organizational basis of the system that accorded with their philosophy and the traditional roles played by their members. We suggest that it is difficult for the social partners to relate the *structural maintenance* objective to their *wage-bargaining* activities because they

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find it hard to concede that there may be tradeoffs between them and between short-term and long-term objectives.

The context of our analysis is the position of primary care physicians, who throughout Europe, are actors and partners in an essentially public system but in legal employment terms and in their sociological sense are nearly everywhere self-employed free professionals. Their professional associations have the unique 'insider' status of being a guardian of the system while also having wage bargaining power similar to that of a trade union. The UK's National Health Service (NHS), founded in 1948 as a universal service free at the point of delivery, is uniquely suitable for analysing this issue as it combines a centralized and politicized structure with strong professional influence. Much of its policy and administration is set separately for England, Scotland, Wales and Northern Ireland, but trade unions, professional associations and the regulation of health professions are UK-wide, and so wage-bargaining and contract setting is largely unified, with England (covering 85% of the UK population) the main focus for negotiations and so the main object of our research.

We have chosen the new GP contract of 2004 as our case study for examining the role of social partners in public sector reform as it involves both a social partner and a specific contractual issue where there might be a conflict between their immediate wage-bargaining strategy and their general political views on the NHS. More precisely, we will look at how the major social partner representing the employee side, the British Medical Association (BMA), behaved in relation to the contract (accepted in June 2003 with almost 80% of GPs in favour on a 70% turnout) that 'unbundled' the traditional role of the GP as self-employed practitioner offering the full range of primary services.

The significant increase in GP's average incomes and the consequences of allowing them to opt out of the provision of out-of-hours care as a result of this new contract have been widely discussed. But there is a lack of research on how a deal widely regarded as very generous in wage terms, but with the potential to undermine the GP monopoly of primary care provision, came about. Was there a strategy of buying in a potential veto player to primary care reform that would give the public purchasers of care alternatives to the traditional pattern of GP provision? Or was it a 'muddling through' to a comfortable deal that allowed all parties to claim success? Did the BMA accept the deal for reasons of short-term gain (more pay for less work) while being indifferent to its implied opening up of

competition to its members? Or did the BMA simply not realize what these wider implications were?

An important question for investigation is whether in agreeing to the new contract – which gave them much increased rewards – GPs traded away their partnership in the traditional, public NHS in favour of a fragmented and partially privatized service. Our main aim is to analyse the position of the BMA during the negotiations and their reaction in the aftermath of the implementation of the contract when its full consequences became unequivocally clear. We will look at BMA campaigns since the inception of the new contract and explore apparent inconsistencies between the acceptance of contracts that threatened the traditional basis of primary care in the NHS and participation in campaigns with other unions that defended the public sector. Finally, we suggest that the NHS governance proposals of the new UK government since May 2010 are consistent with our analysis.

Our methodology will be based on a review of the literature on trade unions' responses to health sector reform in Britain and reviews of documentary material relating to the negotiations of the 2004 GMS contract and the BMA's stance after the agreement, including campaign materials, conference resolutions and commissioned research, with some details confirmed by an interview with a BMA insider. We set our case within a comparative European context explored through secondary literature.

### **The European comparative context**

European health systems have traditionally been classified into *national health systems* which offer care to all citizens (in the UK, Nordic countries and southern Europe) and *social insurance systems* that reimburse the fees charged to eligible recipients (in northern continental Europe, and archetypically in Germany (Hassenteufel and Palier, 2007: 576)). It might seem that the former would be 'state-run' and control the conditions and rewards of doctors, and the latter respond passively to a doctor-run charging structure, but the reality is less clear-cut, especially when viewed from the production rather than the consumption side (Freeman and Frisina, 2010: 171-2). The UK may seem like a classic case of 'socialized medicine' in which there is strong state control of medical training, job opportunities, authorization of treatments, and of the health infrastructure (hospital ownership, pension schemes, wage setting). However, in the UK (along

with Italy, Norway and Denmark) GPs maintained their self-employed status - similar to physicians in social insurance systems but with reimbursement by patient capitation fee (a non-specific obligation of comprehensive service to all patients who register with and are accepted by them) rather than item of service. The only major European countries to have publicly salaried primary care physicians are Sweden - which during the 1970s reorganized its system through directly-employed local authority physicians - and Spain, which employs most primary care physicians in care teams, whose reimbursement includes smaller incentive elements set by the region, running in parallel with self-referrals to specialists who also offer private practice (Commonwealth Fund, 2010; Borkan et al, 2010: 1435).

There is a long history in European health care of physicians, as free professionals, seeking to control the circumstances under which they contribute to public health systems. The introduction of compulsory sickness insurance in Germany in 1883 led to dominant, near-monopsony power of the sickness funds which lowered physician incomes until they unionised and even took strike action, leading to government-brokered agreements in 1913 and 1923 that institutionalised consultation within the system and allowed transpositions of 'social partner' working' to new problems, including cost control (Genschel, 1997).

Wilsford's celebrated account of policy change in terms of path-dependency highlights Germany as a classic example of this concept, but suggests that a conjuncture of events can lead to a departure from the path, as in the way that from 1992 government sought protection from physician-driven cost increases by the typical international instruments of changing reimbursement procedures and setting maxima for particular categories of treatment (Wilsford, 1994: 262). Wilsford also notes that radical departures from a path are much easier in the UK, especially if made less visible to patients by the preservation of the iconic principle of no charge at the point of service use.

### **The degree of contractual incentivization of certain forms of practice**

NHS primary care has become exposed to two current international trends that in practice are related: the use of contracts to incentivise certain patterns of medical

practice, and the growing role of commercial providers of health care.<sup>2</sup> The first of these stems from the general tendency of 'new public management' to favour specific, short-term relationships with the suppliers of public services over long-term ones (Lane, 2000). The second is a consequence of the wish of governments for a plurality of suppliers in order to contrive a market for health services, and of trade liberalization that prevents governments, especially within the EU, from setting national barriers to corporate commercial interests in service sectors like health. We argue that the UK has 'leading edge' characteristics on both these variables.

The UK has the most developed methodology of target-based rewards for primary care (such as preventive care and patient satisfaction). Schoen et al (2009: 1179) reported that 89% of respondents had received some financial incentives and 84% extra money for achieving clinical care targets. The second placed country (the Netherlands, with 80% and 23% on the two indicators) also has characteristics of the GP as an incentivised gatekeeper to hospital care as managed by competitive insurance funds (Leu et al, 2009: 18). Therefore UK contract negotiations can be seen as prototypical of the pressures on social partners in other countries. Rather than being underwritten to do the job in the way they want (either through fee-for-service or a quasi-salary), UK primary care physicians have moved to a complex set of targets that is susceptible to game-playing, and to a range of contracts that have in effect broken the monopoly of the traditional self-employed GP. This takes them beyond the financial and structural reform efforts typical in other European countries like Germany and France that have institutionalised the social partner role of physicians (Hassenteufel and Palier, 2007: 586-7).

### **The opening-up of market entry for non-public providers**

The influence of the UK's approach is likely to be accelerated by the way that medical services are becoming an internationally traded commodity. Their market entry is being facilitated by Europeanization, in particular the role of the European Court of Justice (ECJ). Decisions by the ECJ on the free movement of capital, persons, goods and services had important implications for the delivery of health services in EU member states (Leibfried, 2005, Sindberg Martinsen, 2005 and 2007). The ECJ has interfered in national health legislation in many ways in

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<sup>2</sup> According to the latest available data there are currently 227 GP surgeries run by 23 different private primary care providers (see <http://www.circlehealth.co.uk/news/2010-july/more-than-200-gp-surgeries-now-run-by-private-companies>).

recent years, e.g. through the legislation in favour of cross-border patient mobility and the Working Time Directive (WTD) of 1993 which in effect demands the recruitment of extra staff for coverage, in particular for out-of-hours (Greer, 2008). While the WTD has some implications for the new GP contract in Britain - as it is often out-of-hours coverage which is contracted out (Heins et al, 2009) - more serious implications stem from EU competition law. Public procurement of health services usually has to be open to international private providers, including multinational corporations. Often US healthcare corporations test the European market first in the UK, for reasons of cultural affinity and a supportive business environment: for example, the US healthcare giant UnitedHealth first created a subsidiary called UnitedHealth Europe which was then renamed UnitedHealth UK, probably in an attempt to appear more British than foreign when bidding for UK contracts. The UnitedHealth group is also operating in other European countries with differing health systems, e.g. France, Ireland and Portugal, although not yet as providers of primary care.

Sweden, another centralized and socialized system, has also been active in admitting non-public, for-profit interests, from 1993 encouraging private providers of primary and hospital care to compete for business and receive public funding for it (Blomqvist, 2004). We suggest that the strong tradition of government control which these systems express puts them at the forefront of the marketization trends that are implicit in EU policy and will eventually impose themselves on professionally-dominated social insurance systems as well.

## **Social partners in the UK health sector and the role of the BMA**

Social partners in the NHS include general trade unions and associations organising a single profession. In the NHS the British Medical Association (BMA) and Royal College of Nursing (RCN) are the largest professional unions. The BMA represents approximately 140,000 doctors and medical students. The RCN represents 400,000 nurses, health care support workers and nursing students; its campaigns tend to emphasise care quality rather than governance issues. Unison is the largest general union with over 1.3 million total members, approximately 400,000 of which are from the health sector (Bach and Kolins Givan, 2008). Unlike Unison, the BMA and RCN are not affiliated to the Trades Union Congress (TUC), a reflection of their history as professional bodies that leaves them as the major non-TUC wage bargainers in the UK. They are strong national organizations

that are a main source of intelligence about the NHS as a whole, and they have political leverage.

As accepted partners in the co-operative, team concept of the NHS they can also influence the general direction of policy, but they have a difficult balance to strike between system maintenance and member rewards (in effect whether to buy-out, or put a price upon, the reservations they feel as social partners about radical system reform by ensuring that any income losses are minimised.) Whereas nurses are NHS employees within a common pay structure for all staff other than doctors, contracts for doctors raise complex issues around self-employment and private work. This makes the contracts – and the BMA that negotiates them – the best focus of our consideration of the system-reward interaction.

### **The British Medical Association**

The BMA has a self-image poised between that of an influential professional body and a trade union for the defence of worker rights, and it can draw rhetorical sustenance from both roles. Since the inception of the NHS in 1948 it has represented GPs and all NHS doctors in the hospital, public health and community services employed under national agreements in pay negotiations. Until the 1970s, the BMA was able to pretend that the active defence of members' pay and conditions was simply an extension of its professional functions, but it had to register as a trade union under the Industrial Relations Act 1971 in order to be legally protected. According to Ellis (1979: 1498) this new legal status had 'a catalytic effect' and led to a reappraisal of the BMA's structure and member services. The BMA's structure now resembled that of a typical industrial union with regional offices and industrial relations officers (BMA, 2007a; Ellis, 1982 and 1984) and working alongside other unionised occupations. Although GPs were self-employed contractors, the complexity of their position made them the biggest users of the BMA's advisory services for employment law, contracts, superannuation, etc. (Ellis, 1982).

Within the BMA, GPs have a distinctive role, since they simultaneously have the characteristics of being an employer, a self-employed person, and an employee. GP practices are typically run by teams of doctors, who operate as small businesses. Traditionally in the English NHS GPs were paid by capitation with supplementary allowances (Gosden et al., 2003). While free to do private work and to charge for services that are not part of their NHS contract, GPs are



financially dependent on the NHS, take part in its pension scheme and receive help with training, equipment and premises. The NHS does not provide or guarantee a salary to GPs, but does have a notion of a target income that comes close to it. GPs also employ many people themselves, mainly secretaries and practice nurses, and typically a practice will have some doctors on salary, especially part-timers. NHS model contracts and pension rules structure the role of GPs as employers and create further ambiguities about how far GP practices are fully part of the NHS 'family' or the NHS workforce. For the first 50 years of the NHS the issues were suppressed by the GPs' monopoly, with high public esteem, their gate-keeping role and the stable terms of the GP contract. But the spread of market-based reforms since the 1980s eventually reached primary care services, one area of the welfare state where contracts had always been used and were available to alter a traditionally comfortable social partnership.

### **Healthcare reform in the context of public sector marketization in the UK**

Reform developments over the last few decades posed a challenge to social partners in health. The traditional organisation of the NHS was ideologically consonant with the aims of these bodies, as it was based upon deference to professionals and to the concept of the public sector as a good employer. Recent healthcare reform threatened both of these conditions, even when it was accompanied by resource injections into the system. The keynote Conservative NHS and Community Care Act 1991 differentiated the previously monolithic health service and introduced a range of internal and external contractual mechanisms. By creating the category of GP fundholders, who purchased services for their patients from hospitals, GPs were made a central actor in an internal market in the NHS designed to combine the alleged efficiency gains of free markets with the equity benefits of traditional public sector administration.

Labour put an end to GP fundholding, but the purchaser-provider quasi-market concept remained as Primary Care Trusts (PCTs) 'commissioned' healthcare from providers. The *NHS Plan* of 2000 highlighted the importance of primary care reform as key to the modernisation of the NHS (Department of Health, 2000). Traditionally, primary care services were delivered through a general medical services contract between the Secretary of State and the individual practitioner (Pollock et al., 2007). GPs had a monopoly over primary care services and maintained a level of professional autonomy independent from the government (Pollock, 2004). Now GPs were no longer directly contracted to the Secretary of

State but to the PCT itself. This removed most of the control GPs had over the range and provision of primary care services they delivered and put these decisions into the hands of the PCT (Pollock et al., 2007).

### **The new GP contract**

A pay review body (the Review Body on Doctors' and Dentists' Remuneration, DDRB) had been set up in 1971 to make recommendations about the pay of doctors and dentists taking part in the NHS in the interests of recruitment, retention and motivation. The targets they set take account of changes in GPs' expenses and reflect the difficulty of defining a concept of 'income' separate from the financial performance of the practice.

The reform of GP contracts in 2004 brought together reform initiatives and the way that pay rewards to practitioners are determined in the NHS. Current contracts were seen as inadequate for obtaining the NHS Plan's goals of increasing accessibility, offering choice and moving more secondary care into primary. Furthermore, unrest was developing among GPs over the workload, hours and inflexibility that came along with working in a general practice (NAO, 2008). For the Department of Health, there was long-running frustration about the existence of 'under-doctored' areas where it was hard to get GPs to work and the resultant burden on secondary care. But negotiations faced a major conceptual obstacle. New contracts would inevitably involve an unbundling of the universal GP task into an assessment of the value of its components. In particular, the out-of-hours obligation was potentially very costly. If valued at the high end of estimates, it would make GPs look underpaid for their core work and suggest a large uplift in income; if valued at the low end it was liable to encourage them to withdraw from it. The NHS employers' dilemma was that they wanted to acquire flexibility in the provision of primary care services but faced an uncertain prospect of how to provide and pay for alternatives to GP supply. As a BMA insider put it to us, 'what is the going rate for buying out a monopoly?'

Already in 1998 doctors had conceded a more flexible contract, Personal Medical Services (PMS), to allow a more tailored, local specification of services compared with the general responsibilities taken on under the national General Medical Services (GMS) contract. In 2004, a new General Medical Services (nGMS) contract and a revised PMS contract as well as two new contracts were introduced: a primary care trust medical services (PCTMS) contract (an

instrument for direct salaried employment of GPs by PCTs) and, importantly, an Alternative Provider of Medical Services (APMS) contract. APMS is a vehicle for employing GPs on salary in a flexible way. It enables PCTs to contract GP services out to private sector providers (whether non-profit or for-profit). GP services were also differentiated between core 'office hours' consultation and exceptional services like out-of-hours cover that were traditionally done by GPs. Hence, so-called additional services, e.g. immunizations, can be contracted through local APMS negotiations with other providers including commercial companies (Heins et al., 2009). The entry of commercial providers was defended with the argument that as long as care was free at the point of delivery it did not matter who the provider is (Pollock et al., 2007) and that APMS contracts could improve capacity in deprived, 'under-doctored' areas (Department of Health, 2008). The manner of GP payment now also included a system of financial incentives for delivering clinical and organisational quality - the Quality and Outcomes Framework.

### **The BMA as a wage-bargaining social partner on the contracts issue**

Although the BMA had not expected any great threat from these contracts, imagining that they would be led by entrepreneurial local GPs, they emerged as the vehicle for undermining the socialized basis of NHS primary care that had previously survived the commercialization of hospital activity. Since 1991 health purchasers had the freedom to use private hospitals for NHS treatment, especially to reduce waiting lists for elective surgery. Now there was a primary care equivalent and GPs had lost their monopoly.

This was a challenging idea for the BMA, and the outcome was widely interpreted as a buying-out of their attachment to the 'old NHS' (which continued to be expressed by their other campaigning activities) by an offer amounting to more pay for less work. Only a few critical voices referring to some wider implications of the government's intention behind the contract reform were heard at the time of contract negotiations. Some doctors feared that the true intent would be 'privatisation or even destruction of primary care, or castration of the BMA' (Smith, 2003: 1098). Smith, then editor of the British Medical Journal, classified these speculations as 'wild rumours' and the main debate within the BMA about whether to accept the contract was on its financial impact. GPs were mainly worried about pensions and workload (ibid: 1097).

The contract negotiations proved difficult and it took three years to reach an agreement. Despite the government promising a spending increase of almost £2bn per year, it turned out that under a draft of the new contract about 70% of practices would receive less income than before. In response to this, a Minimum Practice Income Guarantee (MPIG) was offered, meaning that no practice would receive less money under the new system than under the old. Although MPIG was meant to be phased out, and did contract over the years, it reduced the risk factors in the new contract and allowed the mix of an old-style NHS partnership support with a new-style payment-by-results contract. The National Audit Office report of February 2008 identified the MPIG and its effects on the Quality and Outcomes Framework (QOF) as the central reason why doctors had been able to 'game' the system in their favour (NAO, 2008: 6). To pay for the MPIG the employers reallocated money intended to fund performance payments under the QOF to the Global Sum payable to doctors, justifying this by setting QOF targets more rigorously. In fact, doctors met these enhanced targets easily, achieving by 2005-06 96% of the available points, compared with the 75% estimated at the time of the contract, and this had to be paid (NAO, 2008: 23). In 2010 the Government conceded that 'the QOF made an initial contribution to improving patient care when introduced in 2004, but it is now failing to deliver any significant degree of continuous quality improvement for patients' (Department of Health, 2010b: para 3.17).

With MPIG to protect historical incomes initially being received by 90% of GPs (NAO, 2008: 17) and the QOF, unpiloted before its introduction and using easily attainable indicators, doctors were on a one-way ticket to higher pay. It also became clear that GPs' income loss from the NHS for withdrawing from out-of-hours services was far less than the cost of providing these services by other means – estimated by NAO as £6,000 against £13,000 (NAO, 2008: 19).

By 2005-06 expenditure on GP services was 12%, or £800 million a year, higher than the planned total (NAO, 2008: 19). This was quickly corrected (partly by reducing spending on premises and training) but the increased income had been locked in. Following the acceptance of the new contract the Review Body on Doctors' and Dentists' Remuneration did not make any pay recommendations for 2004-2006 and has subsequently seen no need for large increases. It saw evidence that GPs were altering the balance between expenses and income to take more out of practice as personal income, which rose from £81,5966 in 2003-04 to £110,004 in 2005-06 (Review Body on Doctors' and Dentists'

Remuneration, 2009: fig 3.2 and table 3.2). After the QOF was altered to curb public spending, GP incomes fell from 2006 to 2009 (ibid: para 3.50), prompting the Review Body to recommend a 1.5% uplift in net income, splitting the difference in the employers' favour (the BMA having asked for a 4% net uplift) (ibid: table 3.1). The small or non-existent rises in headline GP income allowed doctors to return to a demander role in wage bargaining and redefine the issue as one of general NHS policy and financing.

The BMA's reaction to the contract expresses its mix of professional and wage bargaining roles within a strong, indeed self-righteous, defence of its members' position. The BMA's most comprehensive document on NHS policy ('A rational way forward for the NHS in England', May 2007) does not mention the GP contract at all and does not link it to the growth of private medicine (which it criticises) (BMA, 2007b). It advances the concept of a heavily corporatist NHS with core values and a written constitution, and the social partners as central to the definition of what the service can do. *Towards a Model of Healthcare Delivery* (June 2008) proposed integrated geographically-defined Health Economy Foundation Trusts under clinical leadership. It was offered as 'a workable alternative to the current direction of travel in England, which appears to us to lead inexorably to a more commercial model of health care, whereby the NHS serves simply as a commissioning body' (BMA, 2008: 1). It is more nuanced on the mechanics of system delivery than the earlier document but again does not appraise the GP contract or discuss whether the BMA is complicit in the 'current direction of travel', including the increased role for the commercial private sector that it condemns (BMA, 2008: 3). Ironically, Concordia Health, winner of several APMS contracts, was formed by John Chisholm and Simon Fradd, the lead BMA negotiators on the 2004 contract.

The BMA annual conference resolutions that become BMA policy show that concern about contracts post-dated their introduction. Our analysis of the 47 resolutions passed on contracts between 2002 and 2009 by the GP conference shows that the only mentions of APMS came in 2008, when one resolution said that 'all GPs working under an APMS contract should have access to the NHS pensions scheme' and another stated that:

'(i) APMS poses a major threat to the future of the traditional and highly successful model of general practice, whether delivered under GMS or PMS contractual arrangements;

(ii) recent statements and actions of the Department of Health demonstrate its desire to dismantle the 2004 GMS contract and replace traditional general practice with APMS providers;

(iii) the ongoing measures by the present government to sell off NHS primary and secondary care to the private sector through encouraging the development of APMS should be deplored.'

(<http://web2.bma.org.uk/bmapolicies.nsf/WebHome?OpenForm>)

These resolutions express a slowly developing debate within the BMA but the main thrust of policy continued to be about the overall value of contractual arrangements. The foreword of the 2009 GP Committee annual report is typical of clear defence of GP income without any reference to NHS policy:

'we have secured a reasonable, but very modest award from the DDRB [...] designed to decrease the profession's reliance on the Minimum Practice Income Guarantee [...]the GPC remains vigilant in the face of repeated assertions by Government that practices without correction factor payments are in some way more worthy of new resources year-on-year than those with correction factors.' (BMA, 2009b: 2)

This focus extends to the way that points under the QOF can be secured, and thus it remains preoccupied with GP income rather than wider system changes.

That being said, at the annual conference in 2006 BMA delegates voted 'to stop further involvement of the private sector in the NHS in England and to campaign to return those services that have been privatised back to the public sector' and restated 'its belief in the core values of the NHS' (Kmietowicz, 2006: 61). Likewise, the BMA and Unison were unequivocal in their condemnation of attempts by the Department of Health starting in 2006 to bring in private providers as commissioners of NHS health care (Day, 2006: 61).

The same year also saw the joining of forces of the campaigning forces of the BMA, the RCN and Unison as well as other TUC-affiliated trade unions under the 'NHS Together' organization to combat the fragmentation of the NHS and particularly the 'expanding role of the private sector in the health services' (O'Dowd, 2006: 718). BMA concern about privatization is now much more evident than it was at the time of the contract negotiation, with campaigns taking an explicit anti-privatization stance. The 2008 campaign 'Support Your Surgery' highlighted 'the threat Government policies could have on general practice as well as focusing on the quality of care and customer service provided by GP practices'

(BMA, 2009b: 6). It culminated in a 1.3 million strong petition handed into Downing Street during the 2008 BMA conference (ibid: 2). The 'Look After Our NHS' campaign started in 2009 urges doctors to sign up for a publicly funded, publicly provided NHS. While the Annual Representatives Meeting 2009 agreed that the BMA council should launch a public information campaign against privatization, they resisted calls to go on strike in response to privatization or go on marches or rallies (BMA, 2009a).

What we see is a twin-track approach in which pay bargaining uses different rhetoric and procedures from campaigning. The two activities address different audiences and concerns and are not seen as incompatible. As we have seen, the new contract embodies both partnership and free-market elements, but its negotiation involved concessions to doctors that removed much of the downside risk. The unexpected rise in GP incomes after 2004 suggests miscalculation by the Department of Health, which are rooted in the complexity of the transmission belt between particular contractual provisions and final income received by GPs. The NAO report (2008) depicts health departments and the NHS Confederation as soft negotiators, putting a business case to the Treasury that proved to be unsound. Increased costs were justified by the need to improve recruitment and retention in GP services, which indeed happened; but the price appeared to be too high. GPs took the higher income, and then after the terms that allowed it had been corrected launched vigorous campaigns on the basis that their income had been frozen. They 'gamed' the contract in their favour but were less aware of the long-term risk to their position that it implied.

## **Discussion**

Our study has assessed whether trade-offs have been made between the wage bargaining role of social partners and their role as defenders of a publicly provided primary care service – whether they might accept deals advantageous in wage terms but thereby sacrificing the traditional type of organization for the long term. We took as our case a contract that has a major element of structural change but was negotiated with short-term cost and long-term consequences unanticipated by negotiators.

Our analysis suggests that the initial contract negotiations were not a case of new strategies by the social partners to address structural maintenance issues. The BMA did not relate its general views on the NHS to the terms of the contract. It

did not address the risk to social partnership in the NHS, and ultimately to its own membership power, coming from the new model. Although the issue was noted by individual doctors it only started to figure in BMA conference debates from 2006 onwards after it became clear that it was not entrepreneurial GPs but (often foreign) big healthcare corporations which profited from the new contract form commissioned through competitive tenders.

It could be argued that the contracts opening the way to commercial sector provision were an inevitable outcome of the search for new instruments in the primary care field all over Europe. Thus GPs could not have resisted them and were right to concentrate on the terms of the GMS contract and gain benefit from a government's desire to use its additional spending on health to improve the position of GPs. But the trend of policy has shown that the 2004 contract was a fundamental part of a political choice to marketize the primary care sector. While in Scotland, Wales and Northern Ireland the devolved administrations agreed the same settlement but chose not to use the new APMS contracts, in England they became the tool of a commercial expansion in primary care that employed doctors on lesser pay and threatened the socialised 'team' basis of the NHS.

Campaigning and pay bargaining continue in parallel, but the influence of the social partners is unsystematic and without any peak governance structures for setting NHS objectives. A wish for integration drives rhetoric about the NHS, including the unions' political campaigns, a wish for competitive contracts drives management practices, and the unions do the best that they can for their members. Strategies of the social partners have not yet responded to the political context they now find themselves in, with strong NHS managerial control from the centre and a lack of local political accountability at the operational level.

This context has now changed with a new Conservative/Liberal Democrat government from May 2010. Their health proposals of 12 July 2010 (Department of Health, 2010a, being enacted in the Health and Social Care Bill 2011) aim to abolish Primary Care Trusts and give their commissioning and purchasing powers to consortiums of GPs that will be accountable public bodies – rather like a maximal version of GP fundholding in the 1990s, but in a service where purchases could be made without restriction from public or private providers and 'funding should follow the registered patient, on a weighted capitation model, adjusted for quality' (ibid: para 3.21). This would imply a new contract requiring GPs to enter consortia, commission services and provide accountability for money



spent (ibid: para 4.6). A new NHS Commissioning Board will have to ensure that all of England is covered by consortia, and to do this will inherit the Primary Care Trusts' powers to make contractual arrangements 'with any willing provider' of primary care. In other words, the previously specific contract form of APMS now becomes the general norm.

A further paper (Department of Health, 2010b: para 1.16) makes it clear that practices, while expected to do most clinical commissioning themselves, will be free to contract these tasks out to independent sector providers. Having commercial organizations on both sides of the purchaser-provider divide is a challenge for the NHS and is a consequence of the unbundling of the universal GP provision. With networks sustained by neither state bureaucracy nor mutuality, GPs faced with obligations to manage commissioning may turn to commercial agents and accept a normatively non-socialized position – exactly the opposite of what the social partners in health imagined they were in a position to defend, and a direct consequence of the contractual flexibility they had previously conceded.

BMA reaction to the proposals sums up the ambivalence in its long-term approach to NHS reform, its GP chairman Laurence Buckman writing that 'while this is clearly a potentially huge opportunity for GPs, we recognise that it could also be a major threat both to the current form of general practice and even to the NHS as a public service' (BMA, 2010a). The BMA's detailed response maintained its generalized opposition to increased commercial involvement in the NHS, stating that 'we do not support the creation of further opportunities for private sector companies to provide health services or back room support or the promotion of competition in healthcare, except where the NHS does not provide a service or existing services are inadequate to meet patient need' (BMA, 2010b: 16). But the response did not address the issue of private for-profit input to GP consortia. The BMA emphasis seemed to be on protecting GP pay and pensions whatever the organizational form; for instance, a further briefing paper of December 2010 proposed that 'all staff providing publicly funded healthcare services under an NHS clinical contract should have the right to accrue that service towards the NHS pension scheme with the employers' contribution funded by that provider.' (BMA 2010c: 8). On 15 March 2011 a Special Representative Meeting of the BMA voted to oppose the Bill, suggesting that the BMA's strategy of working reform to its advantage was becoming untenable; public funding in itself seemed no longer capable of providing the basis for protection of their members' positions.

## **Conclusion**

In a European comparative context, the UK has set the pace on the two phenomena we identify: detailed contractual incentives for primary physicians, and the facilitation of market entry by commercial providers. UK internal market reforms in 1991 were explicitly recognized as a role model for subsequent Swedish developments (Blomqvist, 2004: 146) that took further than the UK the quasi-voucher concept of private market entrants (in education and social care as well as health) having a right to state funding; but Sweden is bottom of the table for primary physician incentives (only 10% reporting any) because most are salaried (Schoen, Helms and Folsom 2009: 1179). The UK and Sweden are unusual because their centralized national health systems allow the contractual and commercial routes to be pursued should the political will be set. In Southern Europe, the national health systems of Spain and Italy have incentive elements in their funding of primary care but are delivered by regional governments and so are less susceptible to radical uniform change. For countries in the social insurance tradition, even much-reported conflict (as with new German contracts in 2004 and 2009) is usually about matters that little affect the fundamentals of a doctor's job. The German system is moving only cautiously from its traditional primary and secondary care roles to a UK-style gate-keeping function (Schoen, Helms and Folsom. 2009: 9-11); health care reform in the early 2000s led to greater specificity of acceptable practice and some cost-shifting to patients but no significant structural reform (Hudson, Hwang and Kühner, 2008: 215-216). German incentives are targeted on patients by sickness funds and doctors have tried, with some success, to resist policing patient behaviour on behalf of the funds (Schmidt et al, 2009: 727).

In the short term, social insurance health systems characterized by physician power are in a position to protect their social partner role. But in the longer term we suggest that the interacting processes on contractualization and commercialization are likely to have an effect in all European health systems in the context of a common healthcare market. The case also demonstrates that in a comparatively strong politically-directed system doctors and other social partners can lose control over the structural maintenance of health delivery as physicians are drawn into a more individual and entrepreneurial role by the structure of rewards and constraints that is put before them. The gap between the wage bargaining and structural maintenance roles is bridged by political campaigns against unwelcome reconfigurations of the system; but initial miscalculations about the direction of policy can unwittingly undermine the basis of protection of

the partners' position. In many European systems this basis has been strong, but the health reform agenda is also present in much the same terms as the UK – the wish is to contain the costs of treatment and pay practitioners according to the alignment of their clinical practice with health policy. This means that the challenges to social partners are ultimately similar, with the rate of change determined by the strength of path-dependency in the system.

The BMA's position started from the primacy of their wage-bargaining role: they try to safeguard their members' incomes. Their success in doing this is evident in the data that informs pay review recommendations, which also reflects pay movements stemming from contract changes. But what is harder for wage-bargainers to judge is the long-term effect of these changes. While in the short term they may manage the system to their advantage, in the long-run they find themselves in a less comfortable contractual environment that allows the emergence of commercial primary care interests whose salaried employees are unlikely to match the income level of their self-employed colleagues. The UK coalition proposals of 2010 rely on the availability of commercial providers to fill any gaps in the commissioning role now given to GPs. The debate on the proposals exposed the difficulties of the BMA in defending its vision of the system while promoting the economic interests of its members. By 2010 they found themselves in a situation where the structures that they had allowed to develop threatened, in the long run, to undermine their position as social partners in the NHS.

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### **References**

Bach S and Kolins Givan R (2008) Public service modernization and trade union reform: towards managerial led renewal. *Public Administration* 86(2): 523-539.

Blomqvist P (2004) The choice revolution: Privatization of Swedish welfare services in the 1990s. *Social Policy and Administration* 38(2): 139-155.

BMA (2007a) *The trade union role of the BMA in the National Health Service*. Available at: [http://www.bma.org.uk/about\\_bma/what\\_the\\_BMA\\_does/TUroleoftheBMANHS.jsp](http://www.bma.org.uk/about_bma/what_the_BMA_does/TUroleoftheBMANHS.jsp) [Accessed on: February 10, 2010].

BMA (2007b) *A rational way forward for the NHS in England*. Available at: [http://www.bma.org.uk/healthcare\\_policy/nhs\\_system\\_reform/rationalwayforward.jsp](http://www.bma.org.uk/healthcare_policy/nhs_system_reform/rationalwayforward.jsp) [Accessed on February 3, 2010].

BMA (2008) *Towards a model of healthcare delivery*. Available at: [http://www.bma.org.uk/healthcare\\_policy/nhs\\_system\\_reform/healthcare2008.jsp](http://www.bma.org.uk/healthcare_policy/nhs_system_reform/healthcare2008.jsp) [Accessed on February 3, 2010].

BMA (2009a) *BMA campaign wins overwhelming support*. Available at: [http://www.bma.org.uk/whats\\_on/annual\\_representative\\_meeting/arm09\\_monday/arm09bmanewsmonday03.jsp](http://www.bma.org.uk/whats_on/annual_representative_meeting/arm09_monday/arm09bmanewsmonday03.jsp) [Accessed on February 3, 2010].

BMA (2009b) *General Practitioners Committee Annual Report 2009*. Available at: [http://www.bma.org.uk/about\\_bma/annual\\_reports/gpcannreport09.jsp](http://www.bma.org.uk/about_bma/annual_reports/gpcannreport09.jsp) [Accessed on February 3, 2010].

BMA (2010a) *Chairman of the General Practitioners Committee letter to all GPs in England*. Available at: [http://www.pulsetoday.co.uk/Journals/Medical/Pulse/2010\\_August\\_11/attachments/GPCwhitepaperletter.pdf](http://www.pulsetoday.co.uk/Journals/Medical/Pulse/2010_August_11/attachments/GPCwhitepaperletter.pdf) [Accessed on November 30, 2010].

BMA (2010b), *Equity and Excellence: Liberating the NHS; BMA response* Available at [http://www.bma.org.uk/healthcare\\_policy/nhs\\_white\\_paper/whitepaperbmabriefingpaper.jsp](http://www.bma.org.uk/healthcare_policy/nhs_white_paper/whitepaperbmabriefingpaper.jsp) [Accessed on December 14, 2010]

BMA (2010c), *Shaping Change: BMA's position on future development of the proposed NHS reforms*. Available at [http://www.bma.org.uk/images/whitepaperbmabriefingdec2010\\_tcm41-202540.pdf](http://www.bma.org.uk/images/whitepaperbmabriefingdec2010_tcm41-202540.pdf) [Accessed on December 14, 2010]

Borkan J, Eaton CB Novillo-Ortiz D, Rivero Corte P. and Jadad AR (2010), *Renewing Primary Care: Lessons Learned from the Spanish Health Care System*. *Health Affairs* 2(3), 1432-1441

Commonwealth Fund (2010), *International Profiles of Health Care Systems*. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/International-Profiles-of-Health-Care-Systems.aspx> [accessed February 16, 2011]

Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. London: The Stationery Office.

Department of Health (2008) *Equitable Access to Primary Medical Care services (EAPMC) programme*. Available at: [http://www.dh.gov.uk/en/Procurementandproposals/Procurement/ProcurementatPCTs/DH\\_080719](http://www.dh.gov.uk/en/Procurementandproposals/Procurement/ProcurementatPCTs/DH_080719) [Accessed on July 5, 2009].

Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117794.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf) [Accessed on July 23, 2010].

Department of Health (2010b) *Liberating the NHS: Commissioning for Patients*. Available at: [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_117587](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117587) [Accessed on July 23, 2010].

- Day, M (2006) UK government accused of privatising the NHS. *British Medical Journal* 333(7558): 61.
- Ellis N (1979) The BMA as a trade union. *British Medical Journal* 284(6176): 1498-1499.
- Ellis N (1982) The BMA's trade union structure – four years on. *British Medical Journal* 285(6334):71-72.
- Ellis N (1984) Impact of the Trade Union Act 1984 on the BMA. *British Medical Journal* 289(6458): 1637-1638.
- Freeman R, and Frisina L. (2010), Health care systems and the problems of classification. *Journal of Comparative Policy Analysis* 12(1-2): 163-178.
- Genschel P. (1997), The dynamics of inertia: Institutional persistence and change in telecommunications and health care. *Governance*10(1): 43-66
- Gosden T, Sibbald B, Williams J, Petchey R and Leese B (2003) Paying doctors by salary: a controlled study of general practitioner behaviour in England. *Health Policy* 64(3): 415-423.
- Greer SL (2008) Choosing paths in European Union health services policy: a political analysis of a critical juncture. *Journal of European Social Policy* 18(3): 219-231.
- Hassenteufel P. and Palier B, (2007) Towards Neo-Bismarckian health care states? Comparing Health Insurance Reforms in Bismarckian Welfare Systems. *Social Policy and Administration* 41(6): 574-596.
- Heins E, Pollock AM and Price D (2009) The commercialisation of GP services: a survey of APMS contracts and new GP ownership. *British Journal of General Practice* 59(567): 750-753.
- Hudson J, Hwang G-J and Kühner, S (2008) Between ideas, interests and institutions: analysing third way welfare reform programmes in Germany and the UK. *Journal of Social Policy* 37(2): 207-30.
- Kmietowicz, Z (2006) Doctors say no to more privatisation of NHS in England. *British Medical Journal* 333(7558): 61.
- Lane, J-E (2000), *New Public Management*. London: Routledge.
- Lecky, J (2002) Salaried doctors: the problems. *British Journal of General Practice* 58(546): 60.
- Leu RE, Rutten FFH, Brouwer W., Matter P. and Rüttschi C (2009), *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*. New York: Commonwealth Fund publication 1220.
- NAO (National Audit Office) (2008) *NHS Pay Modernisation: new contracts for general practice services in England*. London: The Stationery Office, HC 307 2007-2008.
- O'Dowd A (2006) BMA joins health unions in bid to change Labour policy. *British Medical Journal* 333(7571): 718.

Pollock AM (2004) *NHS plc*. London: Verso.

Pollock AM, Price D, Viebrock E, Miller E and Watt G (2007) The market in primary care. *British Medical Journal* 335(7618): 475-477.

Review Body on Doctors' and Dentists' Remuneration (2009) *Thirty-Eighth Report 2009*. Cm 7579. London: The Stationery Office.

Schoen C., Osborn R, Doty M, Squires D, Peugh J and Applebaum, S (2009) A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives on Care, Costs and Experience. *Health Affairs* 28(6): 1171-83.

Schoen C, Helms D and Folsom A (2009) *Harnessing Health Care markets for the Public Interest: insights for US health reform from the German and Dutch Multipayer Systems*. New York: Commonwealth Fund.

Schmidt H, Gerber A and Stock S (2009), What can we learn from German health incentive systems? *British Medical Journal* 339 (3504): 725-728.

Sindberg Martinsen, D, (2005) 'Towards an internal health market with the European Court', *West European Politics* 28(5): 1035-1056.

Sindberg Martinsen, D. (2007) *EU for the Patients: Developments, Impacts, Challenges*, SIEPS, Stockholm.

Smith, R (2003) The failures of two contracts. *British Medical Journal* 326(7399): 1097-1098.

Wilsford, D. (1994) Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy* 14(3): 285-309.

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