Exploring the development of Relationship Marketing in the National Health Service: An empirical analysis of supplier-purchaser relationships in a quasi-market environment

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Abstract

This paper attempts through empirical research to examine the extent to which the principles of relationship marketing have been developed within the National Health Service in England. The paper examines the propensity for NHS Trust acute hospitals to develop strategic relationships with Primary Care Trusts (PCTs) and other secondary care purchasers. Within the discussion, consideration is given to the impending changes to the National Health Service being introduced by the UK coalition Government.

The findings from this study appear to support the argument that the manifestation of relationship marketing within the health service takes a particular, and perhaps peculiar, form and have not yet developed into the customer focused relationship marketing found within commercial organisations.

Key words: Orientation, Relationships, Trust, Healthcare

1.0. Introduction

The sourcing and supply of goods and services within the public sector is conventionally viewed as devoid of some of the complexity that characterises contemporary purchasing and supply management. In this paper we examine how government policy has introduced quasi-markets within healthcare provision within England and we proceed to consider how this legacy may inform and influence the changes to the NHS being proposed by the coalition government.

Contextually, the state healthcare system in the UK (alongside other Western European developed nations) is facing numerous pressures necessitating further introduction of market imperatives into state healthcare provision and enhancing the strategic contribution of purchasing and supply management. Principally, these are the challenges of an ageing population, developing and implementing increasingly complex and costly healthcare treatments and ever increasing patient expectations.[1] In addition, many Western European nations have an added political imperative involving reducing large structural deficits and specific requirements for efficiency savings in state healthcare provision.

The conceptualisation and implementation of marketing within the National Health Service in England seemingly struggled aligning itself effectively with the broader field of marketing. During the 1990s, writing on marketing within the UK Health Service was largely preoccupied by the idea of de-marketing[2-4] in stark contrast to the main focus elsewhere within the discipline where the notion of relationship marketing was being developed.

Of course, many of the writers on the NHS were acutely aware of the need to bring thinking on the role of marketing in line with the broader discipline, however it is clear that the priority

was on establishing the idea of marketing within the NHS before developing the full suite of marketing.

There are some signs that this process of 'catch up' is occurring as relationship marketing has increasingly been examined in the not-for-profit area, especially in the area of fundraiser relationships and corporate/cause alliances.[5] Several authors have started examining the relevance of relationship marketing on the health service, seeking to illuminate the distinctive nature of the health service context.[6]

This paper attempts through empirical research to examine the extent to which the principles of relationship marketing have been developed within the National Health Service and specifically the propensity for NHS Trust acute hospitals to develop strategic relationships with Primary Care Trusts (PCTs) and other secondary care purchasers. In concluding we examine the extent to which these findings may offer insight into the proposed changes to health care commissioning being introduced by the Coalition Government.

2.0. Contextualisation and Literature

2.1. A Changing Political Climate

The English NHS in 2007 represented a model of quasi-markets with an emphasis upon efficiency, responsiveness, patient choice, patient access and equity of treatment.[7-8] This led to the promotion and adoption of a more managerialist culture and greater willingness to introduce marketing tools and language. The adoption of commercial marketing approaches within the public sector as part of 'new public sector marketing'. Recent commentators have suggested that relationship marketing may have relevance for the NHS.[6]

2.2. Relationship Marketing and the NHS Purchaser - Supplier Relationship

The popularisation in the 1980's and 1990's of theories of relationship marketing were presented partly as a response to impressions of consumer manipulation acquired by the transaction approach and partly to acknowledge the changing competitive environment and the increasingly broad range of organisational scenarios that marketing was being employed within. Accordingly, the decline of transactional marketing and the increasing prominence of relationship marketing are usually presented in an oppositional fashion[9] with relationship marketing frequently presented as incorporating a wider spectrum of stakeholders including relationships between parties to the supply and distribution channels and the organisation, the organisation and its employees, the organisation and the customers and the employees and the customers.

Whilst there is no single definition of relationship marketing[10-11] provides a generic definition as, "attracting, maintaining and in multi-service organisations enhancing customer relations". This principle of retention and networks is developed further by 'based on relationships,

networks and interaction, directed to win-win relationships with individual customers and where value is jointly created'.[12] Based upon earlier research[6,13] these definitions have particular resonance for the NHS given its provision of a multitude of services in primary, secondary and mental health care.

Recent evidence[14-15] indicates that the extent of relationship marketing within NHS contracting in secondary care is much more marked than earlier studies had suggested.[16-17] Moreover earlier research into NHS contracting identified that from an economic perspective, one key attribute of an emerging relationship marketing culture within the NHS during the Labour Government's first post-1997 term was the tendency for NHS Trust hospitals to include elements within basic service agreements which were not specifically costed up e.g. supplementary patient transport, information systems support and quality support systems.[14,18]

Thus from an economic perspective, the focus of the current research was upon non-price competitive aspects of the contracting process within the quasi-market in NHS secondary care. This focus is relevant given that with the ongoing development of payment by results systems within the NHS contracting process which effectively places a price ceiling on treatments, e.g. with respect to a hip replacement procedure, then *de facto*, non-price competition will become the primary means for suppliers of secondary state healthcare, i.e. NHS Trust hospitals strengthening their relationship with purchasers as the only mechanisms for competitive behaviour become the perceived quality of the treatment itself and the healthcare experience in general.

In order to systematically evaluate non-price competition as a means of relationship building within NHS contracting, it was necessary to employ a standardised evaluative framework

drawn from the relationship marketing field. Subsequently, the current research[19] employed five cornerstones of relationship marketing, i.e. service augmentation, service customisation, market segmentation, direct communications and the development of specialised distribution systems. The first two of these elements encompass specifically the act of suppliers of a service augmenting basic contract agreements and also the inclusion of default elements/default procedures within contracts with purchasers; service augmentation involves providing additional services over and above that required in terms of fulfilling basic service agreements which may not be core to clinical services including access to 'out of hours facilities', information systems support, mobile diagnostic clinics and additional quality support systems.

Owing to the ethical mandate and accountability regimes associated with public service, the application of such profit oriented concepts as service augmentation and direct communications strategies must be justified in the context of non-profit making organisations such as NHS Trust hospitals.

Firstly, whilst some elements of relationship marketing strategies when applied to the healthcare context may appear intangible, e.g. contract customisation, there is strong evidence[14-15,20] suggesting that NHS hospitals and their purchasing partners were actively designing governance procedures measuring contract performance against such intangible aspects of contracts.

Secondly, the re-introduction of competitive pressures into the NHS due to the re-emergence of a quasi-market structure can be predicted resulting in such relationship enhancing behaviour[10,21-22] from both the empirical perspective[23-24] and the perspective of theoretical

literature. In respect of the latter, both contract theory[25-27] and the new institutional economics[28-29] predicts that suppliers of health care services, uncertain of the share of costs and benefits stream arising from investment in highly specific assets as exist in health care will behave rationally by tying in contract partners as closely as possible**.**

3.0. Survey Design and Analysis

The survey design was influenced by the experience from an earlier national postal survey on secondary care contracting within English NHS Trust hospitals[20] and pilot semi-structured face-to-face interviews of ten local NHS Trust hospitals were undertaken in early 2005 to identify specific issues regarding relationship building within NHS health contracting and commissioning and the central decision makers within this process.

The focus is on English NHS hospitals to avoid the possible effects of national differences within the UK as the devolved administrations differentiated their national NHS systems. Furthermore, the English NHS constituted the largest element of the UKs NHS during the research period, caring for approximately 51 million of the UKs population and employing around 80% (1.3 million) of the UK NHS workforce.

The survey was a sent out in the middle of 2005 - a follow-up was not done as the 35% response rate was felt to be comparable with or better than similar studies of contracting relationships within the NHS.[20,23]

One important issue is the extent to which the respondents are representative of the whole population of acute NHS Trust hospitals in England?

Data from the current survey identifies when an acute NHS Trust was awarded NHS Trust status – this is important as it provides indirect evidence of the extent of market culture within the organisation as those who applied for and were awarded NHS Trust status in the first wave, i.e. in 1991/1992 were likely to be more market oriented than those seeking NHS Trust status in the sixth wave, i.e. 1996/1997 as they may have sought a competitive advantage over their local competing acute NHS hospitals through a first mover advantage allowing them to develop closer contractual relationships with purchasing agents within the NHS's emerging quasi-market.

The following table demonstrates that the sample obtained from the current research had a comparable distribution of award dates for NHS Trust status when compared to national data provided by the Institute for Health Service Management.

Table 1

Percentage of Responding acute NHS Trusts by Date of Award of NHS Trust Status

It is also possible to establish whether the sample is representative in respect of the numbers of competitors for an acute NHS Trust hospital. This involves defining the boundary of the local NHS health market which is done following Propper[30] by asking acute NHS Trust hospitals to identify the numbers of competing suppliers of secondary NHS health care within a thirty minute travel radius. Unfortunately, no national, normalised data exists defining the numbers of competing NHS Trust hospitals within such local health economies. However, there is evidence from a previous more extensive national survey of contracting within the NHS which used Propper's (ibid) definition of local health economies[14-15]; this study received 173 completed responses from NHS Trust hospitals in England - a response rate of 47% which is well above that usually achieved by detailed postal surveys. Moreover, the data gathered by Gray and Ghosh[14] was found to be representative of the whole population of NHS

Trust hospitals in England in respect of a series of key indicators including the date at which NHS trust status was conferred, type of NHS Trust and Trust annual budgets. The comparative data for the current research and for the earlier national survey of Gray and Ghosh[14] for numbers of competing local acute NHS Trusts is presented below.

Table 2

The Competitive Environment facing responding acute NHS Trusts: Numbers of Competitors

This indicates that the current study is broadly representative of the more extensive earlier national survey of NHS trusts in England by Gray and Ghosh.[14-15]

3.1. Statistical Analysis

The survey questionnaire included Likert scales to enable the calculation of a range of descriptive statistics. In addition, a wide range of dichotomous (yes/no) type questions were incorporated enabling the use of Logit analysis - a special variant of multiple regression analysis which makes investigation of the qualitative (yes/no) nature of the dependant variable feasible.[31]

With dichotomous responses, the analysis of the data is in respect of agreement with or disagreement with a question or statement, i.e. provides an affirmative or negative response which contrasts with, for example a 'how much?' type response.

A range of statistical techniques were adopted to test the explanatory power of specific independent variables within each model; in order to improve the overall robustness of each model, a decision was taken to reject those independent variables whose *t*-values were below a value of 1.0 as being lower than this meant that there was a greater than 50% probability that a false significance would be incorrectly accepted.

3.2. The Model Hypotheses

The response from the national postal survey was used to determine those factors that influence the likelihood of NHS Trust acute hospitals augmenting basic service agreements with PCTs and other secondary care suppliers.

3.3. Model: Augmentation of Basic Service Agreements

The theoretical literature drawn from economics[32-35], marketing[10,19] and empirical literature on NHS contracting[6,14-15] identify a number of independent variables of relevance in determining the likelihood of NHS Trust acute hospitals augmenting basic service agreements for purchasers of secondary health care within the context of a quasi-market.

Subsequently, the relevant independent variables were considered to be:

(a) The numbers of competing local secondary care suppliers (public sector and private sector within a 30 minute driving distance). This is a relevant variable as it is part of the four types of asset-specificity[33] which are likely to determine whether market or hierarchy is a more efficient resource allocation mechanism; specifically an increased variety of suppliers in a given locality may encourage competition in both the price and non-price dimensions.

(b) The extent of surplus capacity in local health markets. If assets are dedicated and costly then heathcare providers will seek to maximise the use of them to minimise risk – i.e. seek to minimise surplus capacity.

(c) The importance placed on developing long-term relationships. Dedicated assets encourage the development of long-term relationships as investment in dedicated, highly specific assets will only be made if there is a likelihood of selling a significant amount of services to specific buyers

which will be the case of a long-term contractual relationship. This is an example of the 'hold-up' problem[34] in respect of investing in dedicated, highly specific assets because of the uncertainty surrounding the volume of use and timing of use of such care.

(d) The importance of first mover advantage in respect of the granting of NHS Foundation Hospital status. Those trusts who gained Foundation Hospital status early are likely to have an higher level of managerial expertise in order to get said Foundation Hospital status given the highly complex application process and associated award requirements expected by the Department of Health and the experience of having such Foundation Hospital status early gives them a competitive advantage in terms of the experience gained in a more market-oriented culture than is the case for non-Foundation Hospital status hospital trusts.

(e) The existence of preferred-supplier relationships in local health markets. Longer term relationships imply that the supplier has a greater opportunity to gain an insight into the purchasers needs and thus will be in a better position to meet them.

(f) The existence of a specific marketing function within NHS trust management. This is important because relationship marketing strategies will be seen as an activity reducing the risk to Trust income.

(g) The importance placed upon the new 'payment by results' criteria. NHS Trusts who place a emphasis upon the role of 'payment by results' criteria within contracting are more likely to offer additional (augmented) services as this increases the probability of the desired outcome of the buyer being

achieved and thus gaining continuing contracts with associated income streams.

(h) The existence of volume discounting within contracts

(i) The existence of other discounting elements within contracts. Both volume discounting and other discounting criteria are likely to be tied to other incentives to purchasers.

Of note, given the exclusion criteria adopted of rejecting independent variables with *t*–values below 1.0, independent variables *a, b, d*, and *e* listed above were removed from the model's analysis. Of these, particular note in the context of the re-emergent quasi-market in NHS secondary care is the weakness of preferred-supplier relationships which are taken as a prime driver of supplier behaviour in the seminal literature on quasi-markets.[7-8]

The relevance of the remaining independent variables with *t*-values greater than or equal to 1.0, i.e. *c, f, g, h*, and *i* listed above requires brief further consideration:

(i) Independent Variable *c*: Importance placed on Long-term Relationship Building

Surveyed acute NHS Trusts were asked to identify how important it was to build long-term relationships with purchasers, i.e. a relationship beyond the statutory period of basic service agreements. This was taken as an implicit measure of the commitment to an organisational culture of relationship marketing. Subsequently, it was argued that the greater the importance given to long-term relationship building, the more likely that acute NHS Trusts would be to cement relationships through service augmentation.

(ii) Independent Variable *f*: Existence of Specific Marketing Functions

The pilot research phase identified that contracts managers perceived a greater role for dedicated marketing functions within the contracting process. It was argued that the reforms in respect of greater emphasis upon patient choice, the requirement for more responsive local health services, the focus upon improved NHS Trust performance and potential for enhanced financial and decision making autonomy via the extension of Foundation Trust status amongst the NHS Trust population encouraged and necessitated the development of specialised marketing functions. Thus it was argued that the likelihood of service augmentation would increase when NHS acute Trusts had a marketer engaged in the contracting process, given that service augmentation is a standard element of strategies designed to develop relationship marketing.[3]

(iii) Independent Variable *g:* Importance Associated with Payments by Results

The surveyed acute NHS Trusts identified the importance of the move towards the Department of Health's payment by results strategy in determining whether they would build closer ties with purchasers. It was argued that once payment by results was fully in place, under-performance of an NHS trust against target would lead to greater risk to the Trust's future income due to direct funding being affected and potential purchasers (having access to such publicly available information and the choice of alternative providers) switching to competing suppliers. The latter effect would be the result of purchasers using the information on a provider's 'under-performance' as a surrogate measure of failing service quality. However, by building closer relationships with purchasers via service augmentation, such

provider switching might be reduced should a given acute NHS Trust under-perform thus reducing risk to Trust income.

(iv) Independent Variable *h*: Volume Discounting

The basis for including volume discounting within the contracting process is two-fold. Firstly, from a theoretical perspective, it is well established that suppliers will tend to discount services when a purchaser is 'bulk' buying from a given firm - this is normally examined within the context of analysis of internal scale economies[36] and implies within the health care context that acute NHS Trusts were offering purchasers secondary health care at lower unit (average) costs as a result of purchasing relatively large numbers of treatments. Secondly, earlier evidence [20] identified that such 'gaming' behaviour within the NHS Internal Market of mid-late 1990's was more widespread than previously believed and was one strategy used to protect Trust income from capture by competing NHS providers.

In respect of the relationship with service augmentation, it was perceived that volume discounting was an implicitly indicator that NHS Trusts income distribution was in favour of relatively few, large purchasers of health care services and that subsequently, developing closer contractual ties through service augmentation was an important way of protecting Trust income. Moreover, this makes eminent sense in the context of the emergence of PCTs which implies the establishment of oligopolistic conditions in the buying half of the NHS health care market.

(v) Independent Variable *i*: Other Contract Discounting Measures

The surveyed acute NHS Trusts identified if they offered purchasers other contract discount measures than volume discounts. Whilst as indicated below, this variable proved to be statistically significant, only approximately 50% of respondents specified the exact form of this discounting - the most common being offering purchasers secondary care over and above target numbers at marginal rather than unit (average) cost. From a theoretical perspective, in terms of the long-run analysis of production this implies that acute NHS Trusts were operating below minimum efficient scale. This is another risk minimisation strategy.

4.0. Statistical Results & Policy Implications

Table 3 below provides the summary statistics for the model:

Table 3

Augmentation of Basic Service Agreements Model

The results were found to be statistically significant at the 99.99 per cent level with the model correctly predicting 80.33% of cases. The *a priori* predictions in respect of signs of the independent variable coefficients proved to be accurate with the exception of that for the existence of a specific marketing function within a Trust.

In respect of this variable, the evidence implies that as the numbers of acute NHS Trusts with marketing managers increases, the likelihood of basic service contract augmentation falls. This result is clearly at odds with the theory of relationship marketing being employed in this paper. Conversely relationship marketing writers promoted the idea of marketing as an organisational wide responsibility, making all staff part-time marketers with marketing specialists promoting these responsibilities through internal marketing.[37] Accordingly the appointment of marketers may not necessarily indicate the development of market orientation. Indeed as Wright & Taylor[6] note, much of the change within the NHS has been structural, with little change in attitudes and behaviour. This, the authors suggest indicates a continued internal service product driven outlook

However, one possible explanation is that contracting decisions involve clinical as well as non-clinical hospital managers: the former group's objective function is likely to be dominated by the desire to achieve clinical efficacy rather than commercial goals, so that the opportunity for marketing managers to fully develop relationship marketing strategies may be

constrained. This accords with the work of Smith & Fischbacher[38] who noted the resistance to user input into a professional clinical service delivery system.

In respect of the marginal analysis, the following policy implications can be made:

- The greater the importance placed upon building long-term relationships with providers, payment by results, the existence of volume discounting or other forms of discounted contract elements then the more likely it is that basic service agreements will be augmentated
- In respect of the marginal analysis of the results, the following observations can be made:

    i) A one unit increase in the emphasis placed upon building long-term relationships within the Likert scaling results in a 16% increase in the likelihood of contract augmentation.

    ii) A 'yes' response to the survey question on whether acute NHS Trusts engaged in volume discounting increases the likelihood of a given Trust augmenting basic service contracts for purchasers by 25%.

    iii) A 'yes' response to the posed question of whether acute NHS Trusts offered purchasers other forms of discounted contracts increases the likelihood of contract augmentation by 41%.

    iv) A one unit increase in the Likert scale response relating to the emphasis placed on the importance of payment by results criteria results in a 22% increase in the likelihood of contract augmentation.

    v) A 'yes' response regarding whether acute NHS Trusts had a specific marketing function reduces the likelihood of contract augmentation by 67%.

5.0. Discussion

The findings from this study appear to support Wright & Taylor[6]'s argument that the manifestation of relationship marketing within the health service takes a particular, and perhaps peculiar, form. Government policy has introduced structural reform with the promotion of quasi-market relations, however the principles, processes and culture of a holistic or integrated marketing doctrine have not yet developed into the customer focused relationship marketing found within commercial organisations. Econometric evidence supporting this view is presented in Table 3, where the sign on the coefficient for the specific marketing function variable was negative.

The marketing function within the health service has not been able to promote a strong user-focus, instead as McNulty cautioned over a decade ago, "at senior management level, marketing is being subsumed within the contracting function".[3] This is perhaps not too surprising; there is clearly a question of the desirability of a uni-dimensional user focus in the health care service. The historical development of the health service has produced a political and supply driven creature. The question really for the purchaser-provider relationship is how the user is incorporated and articulated in the contracting process. It is interesting, however, to reflect on whether the marketing function will become more distinct and the role of marketers more prominent within the commissioning process when the degree of market contestability in the NHS increases should, as is proposed, competitive tendering for clinical services be opened up to any qualified provider, be that within the NHS, private health care or charitable sector.[39]

The econometric analysis presented demonstrates how key elements of Government policy used to design the new quasi-market within the NHS are already beginning to influence the

relationships within the contracting process in NHS secondary care. The importance of payment by results suggests that the contractual relationship between purchasers and suppliers is moving towards a more market-oriented framework and away from an hierarchical (almost command driven) system. Moreover, the marginal analysis indicates that moderately greater emphasis given to key relationship marketing variables within the NHS contracting process can have major resource implications. This shift towards quasi-markets could result in substantial additional costs within the purchaser-supplier relationship due to the introduction of the transaction process as identified in Williamson[34] – these are the *ex ante* costs of drafting, negotiating & safeguarding an agreement, and the *ex post* costs of haggling, governance and guarantees costs to secure contractual commitments.

Meanwhile, the econometric evidence is especially noteworthy in respect of relationship marketing within the NHS. The results indicate that those acute NHS Trust hospitals offering either volume discounts, non-price competitive incentives or who are strongly aware of the link between payment by results and organisational performance are significantly more likely to offer NHS purchasers secondary care contracts which contain augmented services over and above the contractual minima required. Assuming the translation of the Health and Social Care Bill[39] guarantees the continuation of the payment by results system, thus ruling out price competition in the delivery of health care services, the most intense efforts in tying in purchasing GP Consortia (the replacement for the current Primary Care Trusts) may be seen around non-price competitive elements within the commissioning process.

Moreover, the empirical evidence presented more generally supports the existence of 'gaming behaviour'[28]) by acute NHS Trust hospitals. Within the policy context of the Department of Health's greater emphasis upon payment by results, acute NHS Trusts appear to be focusing

upon non-price competitive means of forging contractual relationships and thus reducing risk to trust income. The latter is paramount in a competitive health market and also in the context of the perennial funding crisis within the UK NHS. Moreover, from a theoretical perspective, the empirical evidence indicating the emphasis placed upon non-price competitive elements within the relationship building process provides indirect evidence of the emergence of contractually obligated relations[27] in NHS secondary care contracting, which stands in stark contrast to the classical contracts and associated arms-length relationships[27]historically witnessed in contracting within the NHS.[23]

Dwyer et al[40] proposed the need for marketing theory to reconsider its concentration on exchange as discrete transactions, instead looking at the relational aspects of the exchange signalling the importance of viewing the "multidimensionality of exchange" and proposing that relationships evolved through five stages - awareness, exploration, expansion, commitment and dissolution.

The emergence of non-price competitive elements within the NHS warrants further attention by marketing scholars because it would appear to signal a transformation from the discrete transactions that characterised earlier forms of NHS secondary care contracting to an 'exploration stage' of relationship development. This according to Dwyer et al[40]occurs where parties 'search and trial' potential exchange partners with minimal investment. Further research is required to establish how the parties traverse this phase and the motivations that encourage parties to feel the need to move beyond discrete transactions. Whilst we can speculate that this has occurred due to parties assessing the 'total association'[41] and reviewing the outcomes from alternative associations, it is necessary to examine the development of norms and communication between the parties and consider the balance of dependence. In

particular such research will need to examine how the incentive structures within the NHS are promoting the emergence of relationships and how the parties are managing the development of these relationships. Of note, this will involve exploring the relationship building process between purchasers and a wider, more diverse set of potential providers of clinical services. One area for further research in light of the move towards enhanced competitive tendering within NHS clinical services[39] is to explore the extent to which these diverse sets of potential providers have differentially developed marketing functions and to undertake a skills audit of their marketing skills to assess the degree to which they are equally placed to develop the required relationship building strategies. Further research will also need to consider how structural changes within the NHS impinge on the nature of the relationships that are emerging.

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Tables

Table 1

Percentage of Responding acute NHS Trusts by Date of Award of NHS Trust Status

NHS Trust Wave	% of respondents (Nos. of acute NHS Trusts)	% acute NHS Trusts in England
First (1991/1992)	13% (8)	11%
Second (1992/1993)	21% (13)	18%
Third (1993/1994)	28% (17)	32%
Fourth (1994/1995)	30% (18)	33%
Fifth (1995/1996)	5% (3)	5%
Sixth (1996/1997)	3% (2)	<1%

Table 2

The Competitive Environment facing Responding acute NHS Trusts: Numbers of Competitors

Local NHS Health Economy: Nos. of competitors	Current Study % (Nos.)	Gray and Ghosh (2000a; 2000b)
Monopoly	10% (6)	12%
Duopoly	7% (4)	9%
3-5 competitors	43% (26)	47%
6-9 competitors	28% (17)	23%
10 or more competitors	13% (8)	9%

Table 1.2: The Competitive Environment facing Responding acute NHS Trusts: Numbers of Competitors

Table 3

Augmentation of Basic Service Agreements Model

Variables	Marginal effect (t-ratio)
Importance placed on developing long – term relationships	0.1612 (1.520)
Existence of Specific Marketing Function	-0.6726 (-3.145)
Importance associated with payment by results	0.2246 (2.333)
Volume discounting	0.2450 (3.052)
Other contract discounting methods	0.4144 (2.887)
Constant	-1.4951 (-2.307)
McFadden Pseudo R^2	0.3908
Percentage of correct predictions	80.33