Health care programmes rule – OK!

In 1989 the White Paper Working for patients\(^1\) introduced reforms to the National Health Service (NHS), including an internal market, intended to improve efficiency by stimulating a form of commercial competition. Initially there was to be a ‘steady state’ and ‘no surprises’ to avoid confusion for patients. Increased efficiency was to result gradually from the second year. Close working relationships between purchasers and providers were proscribed on the grounds that this might inhibit greater efficiency. Purchasers and providers initially negotiated block contracts which perpetuated the type, volume and cost of service that had been available previously. During the second year there were some marginal changes between providers and volumes of work, and costs began to vary, especially as the new provider Trusts became increasingly autonomous.

Failings in the process made the market the subject of lasting criticism\(^2\). Contracts based on historic levels of services continued. Negotiations were adversarial, reducing the likelihood of achieving desirable change. Clinician involvement was slight.

Impending changes

Describing the market as ‘divisive’, the new Labour government now proposes its abolition in The new NHS: modern, dependable\(^3\) and in the Scottish White Paper Designed to care – renewing the National Health Service in Scotland\(^4\). Although both these White Papers make clear the intention to retain a distinction between the strategic planning of services and their provision, the procurement of secondary care services will be markedly different, reinforcing the impending devolution of responsibility for health matters to a Scottish parliament in 2000. Commissioning of secondary care remains with Health Boards in Scotland but in England the responsibility will be transferred from Health Authorities to Primary Care Groups. General practice involvement in commissioning secondary care has been developing steadily since 1991 but implementation of the White Paper intentions means that all practitioners, including those previously uninterested, will become involved, together with nursing, social work and other colleagues. The suggestion that disgruntled English practitioners might move to Scotland to avoid being involved is perhaps facetious\(^5\) but underlines the fact that some will need assistance with their new commissioning responsibilities. Similarly, English Health Authorities moving from contract negotiations to collaborative strategic planning will need new approaches.

Help exists. It stems from an agreement with the Secretary of State for Health, early in 1993, that the UK Medical Royal Colleges would try to help improve the situation by undertaking a pilot project to test the feasibility of using a condition-specific approach to commissioning health care programmes (HCP) in the NHS market. Further impetus was given to the project by an Audit Commission report on contracting in the NHS\(^6\), after which the NHS Executive issued guidance on improving the system\(^7\).

Piloting health care programmes

Two Health Authorities (Gloucestershire and Oxfordshire) took part in the project, which began in November 1993\(^8\). The steps taken in each of the districts included:

1. Identification of a condition. Ischaemic heart disease was chosen as the condition for the pilot project, because it is a major cause of morbidity and premature mortality with scope for improvement, and it was a Health of the Nation\(^9\) key area.

2. Appointment of a project manager. One district appointed a person from a scientific research background and the other chose a junior doctor with experience of both primary and secondary care. Both served admirably.

3. Derivation of a condition-specific budget bringing together activity costs from previously separate sectors of the NHS.

4. Formation of working groups, with members recruited from both purchasers (NHS managers and public health physicians) and providers (clinicians and managers), to give detailed attention to specific parts of the HCP.

5. Incorporation of the products of the working groups into a specification setting out what was required to meet the needs of the local population, unlike standard contracts which simply described the previous year's activity with some marginal changes.

The project used a systematic and rigorous method of focusing the attention of contract negotiators on the requirements of the chosen condition by the use of a matrix (Fig 1) to clarify the respective contributions of purchasers and providers for ensuring the comprehensive nature of the service and adapting the range of effective interventions to local needs and available resources:

- Local needs were derived from demography and epidemiology, highlighting the prevalence of both risk factors and identified disease.
Effective action was identified from clinical and health services research.

Negotiations under the headings of Location and Resource Inputs allowed balances to be struck between domiciliary and hospital care on the one hand and the degree of correlation between available resources (premises, plant, skills and funding) and those required to meet identified need, on the other.

Other matrix columns show areas where purchasers and providers collaborated to define the desired results of services and set realistic targets for activity levels and outcomes that could be assessed by monitoring and audit.

Findings of the pilot health care programmes

The project was appraised externally in two ways. Firstly, it was supported by the Audit Commission in its report, Dear to our hearts. Secondly, it was presented by Oxfordshire to the annual King’s Fund/Glaxo Wellcome Health Management Awards, where it won a first prize in 1996. In reporting on the project, the judges said, ‘This is a major and ambitious piece of work implemented in a rigorous way. It has great integrity and credibility. It is long-term and strategic, picking off targets as it goes along, and is built on a cooperative model of change. This project is a vision of what we would hope the entire NHS would be like in a few years’ time.’

A particular advantage of the involvement of clinicians was the increased cooperation between managers and themselves, which led to more productive working relationships. The approach obliged managers to discuss with clinicians problems of practical patient care by constantly reinforcing the purpose for which the services are planned.

This active involvement of the clinical professions facilitated the incorporation of evidence of effectiveness, clinical audit and clinical outcome measures into contracts, ensuring that resulting performance measures had clinical relevance. The use of research evidence promoted convergence of clinicians’ views across primary, secondary and tertiary care.

The focus on health provided by concentrating on the named condition helped the clinicians to appreciate the impact of their decisions and practices both on other providers and on the health of the whole population. Similarly, the promotion of a comprehensive approach allowed individual providers to see their services in the context of the totality of the community’s health services.

A clinician in one of the pilot districts described the project as, ‘a very important novel approach to planning the provision of health care’ and ‘of great potential benefit to developing a needs-based clinically effective health care system.’

One of the useful products of this method is identifying the levels of unmet need and hence shortfall in overall resources. Making the best use of available resources is an essential step in deciding whether those resources are sufficient. The derivation of programme budgets which demonstrate the relative expenditure between primary, secondary and tertiary care, helps clarify issues of absolute and relative resource need. This evidence, together with analysis of marginal costs, indicates where net benefits might be increased by reallocating current spending within an existing programme, even if overall resources subsequently need to be increased.

It might not be possible to complete the matrix fully for every condition. Blanks provide evidence of the need for either better information or further research.

| Service level | Needs | Effective action | Location | Input | Activity targets | Output | Service outcome | Health objective |
|---------------|-------|------------------|----------|-------|------------------|--------|----------------|-----------------|
| Primary prevention |       |                  |          |       |                  |        |                | Reduced incidence and prevalence of the condition |
| Screening and early treatment |       |                  |          |       |                  |        |                | Reduced incidence and prevalence of illness |
| Acute care |       |                  |          |       |                  |        | Reduced premature mortality |
| Rehabilitation and continuing care |       |                  |          |       |                  |        | Reduced mortality, incidence and prevalence of disability and handicap |

Fig 1. Matrix used to give focus to NHS contract negotiations. (Adapted from Academy of Medical Royal Colleges project.)
The future

Both pilot districts were sufficiently impressed with the approach to extend its use to commissioning for other conditions (stroke, cancers, asthma and diabetes). It is ideally suited to the recommendations of the Expert Advisory Group which proposed site-specific contracts for cancer services. Other districts have been influenced by the project. It was an external factor associated with the development of the Northumberland Heart Health Programme. With support from the Stroke Association, an exercise to test the utility of the method when social services as well as health services were involved was used in Gateshead and South Tyneside to develop their stroke services.

NHS jargon is changing again. Contracts are to become service agreements. However, service agreements derived from the use of condition specific health care programmes, as piloted by the UK Medical Royal Colleges, will help Primary Care Groups to link directly with the disease-specific National Service Frameworks proposed in the White Paper. A series of such agreements will form the backbone of the Health Improvement Programmes required in England by April 1999.

References

1 Department of Health. Working for patients. London: HMSO, 1989.
2 Bury B. Letter to Mrs Bottomley. Br Med J 1993;306:702–3.
3 Northern & Yorkshire Region. Contracting between Health Authorities and NHS Trusts: a working group report. Newcastle: NHS Executive Regional Office, 1995.

4 Milner P and Meekings J. Failings of the purchaser–provider split. J Public Health Med 1996;18:379–80.
5 The Department of Health. The new NHS: modern – dependable. London: The Stationery Office, 1997.
6 The Scottish Office. Designed to care – renewing the National Health Service in Scotland. Edinburgh: The Stationery Office, 1997.
7 Dixon J, Mays N. New Labour; new NHS? Br Med J 1997;315:1639–40.
8 Audit Commission. Their health, your business: the role of the District Health Authority. London: HMSO, 1993.
9 Mawhinney B, Nichol D. Purchasing for health: a framework for action. Leeds: NHS Executive, 1993.
10 O'Brien M, Halpin J, Hicks N, Pearson S, et al. Health-care commissioning development project. J Epidemiol 1996;6:589–92.
11 Department of Health. Health of the Nation: a strategy for England. London: HMSO, 1992.
12 Audit Commission. Dear to our hearts? Commissioning services for the treatment and prevention of coronary heart disease. London: HMSO, 1995.
13 Health Management Awards: Purchaser. Health Serv J 1996;105(5530):12.
14 Health care programmes in the NHS. vols 1–3. London: Academy of Medical Royal Colleges, 1997.
15 Expert advisory group on cancer. A policy framework for commissioning cancer services: consultative document. London: Department of Health, 1994.
16 Northumberland Heart Health Programme: A strategy for the prevention and treatment of heart disease. Morpeth: Northumberland Health Authority, 1997.
17 Chappel D, Halpin J, O'Brien JM, Rodgers H, Thomson R. Health care programme based purchasing of services for patients with stroke in Gateshead & South Tyneside. Report to the Stroke Association, 1998.

Address for correspondence: Dr Michael O'Brien, Chairman, Northumberland Health Authority, East Cottingwood, Morpeth NE61 2PD.