Health Care Commissioning Development Project

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Methods: Needs for services for people with ischaemic heart disease were assessed for two defined county populations. Current clinical, epidemiological and health services research evidence were used to prepare technical descriptions of services. Data on needs and evidence of effective services were assembled into an interconnected matrix of information to advise the negotiations between the county authorities (the purchasers) and general practitioners, community services and hospitals (the providers).

Results: Negotiations between purchasers and providers resulted in agreed specifications to commission services for people with ischaemic heart disease (IHD). Contracts for IHD services for 1996/7 will be based upon this method which applies to specific conditions instead of the previous historical cost and volume method. Use of the method has allowed target outcomes for services to be defined and agreed between the parties.

Conclusion: Condition specific programmes of care appear to be feasible, relevant and potentially beneficial. It is possible to gain the co-operation of both managers and clinicians in defining service specifications, which are related to measured need and scientific evidence of effectiveness, for people with ischaemic heart disease. Initial failings of the market, in particular confrontation between purchasers and providers, can be reduced.

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The government document “Working for Patients” introduced reforms to the UK National Health Service (NHS), including an internal market which began to operate in 1991. The stated purpose of the market was to improve efficiency in the NHS by stimulating a form of commercial competition.

Health Authorities which had been responsible for planning and providing health services since 1974 retained responsibility for the health of defined populations but ceased to provide services directly. Hospitals, which had been managed by the Health Authorities previously, were given a degree of independence and became self-governing “Trusts”. Health Authorities (purchasers) were to fulfil their responsibilities by negotiating contracts to purchase services from the Trusts (providers). This process became known as commissioning.

A set of rules was established to prevent disruption of services through the wholesale movement of health care from one provider to another. There was to be a “steady state” and “no surprises”. Changes to bring about increased efficiency were to be achieved by gradual movement from the beginning of the second year. A second rule effectively prohibited close working relationships between purchasers and providers. The purpose of this rule was to prevent collusion which might have prevented changes to improve efficiency.

For these reasons purchasers and providers initially negotiated block contracts which perpetuated the type, volume and cost of service that had been available the previous year. From the beginning of the second year there was some marginal movement of services from one provider to another and volumes of work and costs began to vary.

The market quickly became the subject of criticism. In particular money was fully spent and contracted volumes of work were concluded before the end of the year. Inexperienced managers were unable to cope with the implications which left patients waiting without care until the new fis-
cal year began.
Other failings in the commissioning process were highlighted in the second and subsequent years.
Contracts continued to be based upon historic volumes of services.
Contracts continued to relate to the type of Trust hospital (e.g., general acute or community).
Contracts neither related to the assessed needs of the population nor to the problems of individual patients.
Contracts did not specify intended health outcomes.
Clinicians were rarely involved so that few contracts incorporated guidelines on effective clinical care or clinical quality assurance.
Contract negotiations were conducted in a confrontational manner, reducing the likelihood of achieving necessary change.
At the end of the second year of its operation, the market was the subject of discussion between the UK Medical Royal Colleges and the Secretary of State for Health. The outcome of the discussions was an agreement that the Medical Royal Colleges would try to help improve the operation of the market in health care in the UK NHS. Early in 1993 the Medical Royal Colleges asked the Faculty of Public Health Medicine to undertake a pilot project to test the feasibility of applying a condition specific approach to the commissioning process in the UK NHS market.
Later in 1993 further impetus was given to the project by external audit commentary on the process of contracting for services in the NHS 3). After the publication of this report guidance on improving the system was published by the Department of Health 4. The guidance required future contacts to achieve:
- comprehensive services based upon locally assessed clinical need
- dialogue between purchasers and providers
- involvement of clinicians
- use of evidence of effectiveness of treatments
- auditable measures of outcome of care, and
- integration of primary, secondary and other levels of care.
Even now, in the sixth year of the NHS market critical commentaries are still being written and in many areas the intentions of the guidance are not being achieved 5). There are tensions between purchasers and providers over the availability of finance and the charges made by the latter for their services. There are tensions between managers and clinicians who do not believe that the former understand the complexities and demands of clinical care.

**METHOD**

The project method was designed to be applied, one at a time, to single named conditions, using a systematic and rigorous method of focusing the attention of contract negotiators on the requirements of the guidance. The focus was maintained by using a matrix created to clarify the respective contributions of purchasers and providers to the contract negotiation process. The matrix is illustrated in the figure.

As can be seen from the figure, a health objective is specified for each level of health service activity. Primary prevention (health promotion and health education) seeks to reduce

| Service level       | Needs | Effective action | Location | Input | Activity targets | Output | Service outcome | Health objective                                      |
|---------------------|-------|------------------|----------|-------|------------------|--------|-----------------|-------------------------------------------------------|
| Primary prevention  |       |                  |          |       |                  |        |                 | reduced incidence and prevalence of the condition     |
| Screening           |       |                  |          |       |                  |        |                 | reduced incidence and prevalence of illness           |
| Treatment care and rehabilitation |       |                  |          |       |                  |        |                 | reduced premature mortality and reduced incidence and prevalence of disability and handicap |

*Figure*: Matrix used to clarify roles of purchaser and provider in NHS contract negotiations.
the incidence and prevalence of the chosen condition. Screening, when appropriate, seeks to reduce the incidence and prevalence of the illness which results from the chosen condition. Treatment of the established illness, care and rehabilitation seek to reduce both premature mortality and the incidence and prevalence of resulting disability and handicap.

Discussion focused on each of the spaces in the matrix is intended to allow the purchasers and providers to agree on a contract specification for services to deal with the chosen condition.

"Needs" refers to the population at risk and the risk factors which are operational in the locality.

"Effective action" brings to bear the current clinical and health services research findings of effectiveness.

"Location" allows for agreement as to whether the action is at the patient's home, in a primary or community care setting or at a distant hospital. It allows for movement between and integration of primary, secondary and tertiary care sectors.

"Input" indicates the resources required. This includes money, staff, skills, plant and equipment.

"Activity targets" should be the agreed volume of service to be provided. They should specify the proportion of the population at risk which is to receive the effective intervention.

"Output" represents a performance measurement agreed between the parties to the contract. It measures the proportion of the activity targets which are achieved. Occasionally it will act as a surrogate for an outcome measurement.

"Service outcome" measures the incidence and prevalence of the chosen condition and its sequelae. Over time service outcome measures will be aggregated and developed into trends to test the achievement of the health objectives.

Two Health Authorities were identified to take part in the project. One (Gloucestershire) volunteered and the second (Oxford) was selected by the NHS Executive.

Ischaemic Heart Disease was chosen as the condition for the pilot project. It is a major cause of morbidity and premature mortality and there is need for improvement. There is a large amount of good quality evidence available giving scope for achievement of improvement. National targets for improvement have been set and are monitored.

A small overall national steering group was established to co-ordinate the work in the two pilot districts.

Work commenced in Gloucestershire in November 1993 and in Oxford a few months later. In each of the districts the first year was spent in recruiting small groups from both purchasers (for example NHS managers and public health physicians) and providers (for example clinicians and managers). The groups were created to look at each of the levels of service in the context of local need.

The tasks performed by the groups included:

- the establishment of agreed local service and information needs;
- the creation of agreed guidelines for care at each level of service in the context of the latest available peer reviewed scientific research evidence;
- the derivation of a condition specific budget bringing together activity costs from previously separate sectors of the NHS and agreement on performance measures so that the degree to which the specification was met could be judged when the theoretical contract was operational.

Throughout 1995, the work of the small groups was integrated to give condition specific contract specifications for services for patients with ischaemic heart disease in the two districts.

From April 1996 both districts have used the outcome of the pilot project work to commission services for ischaemic heart disease for their populations

RESULTS

Condition specific health care commissioning brings together managers and clinicians to discuss problems that make practical sense to patients, to clinicians and to the purchasers and providers themselves. The use of research evidence promotes convergence of clinicians views across the primary, secondary and tertiary care sectors.

The increased co-operation between managers and clinicians, which results from work on one condition, has a beneficial effect in other areas. It leads to attitudinal change and more productive working relationships. The focus on health provided by using the example of the specific condition can help the clinicians to appreciate the impact of their practices on the health of the whole population and the impact of their decisions on other providers. Similarly, the promotion of a comprehensive approach allows individual providers (Trust hospitals) to see their services in the context of the totality of health services for the community.

The clear identification of needs and the promotion of an appropriate balance of services across primary prevention, early diagnosis, treatment, care and rehabilitation makes purchasers and providers jointly address some basic health economic questions. Such questions include relative effectiveness of clinical interventions, the overall availability of resources and their best use. Purchasers have to identify the discrepancies between assessed need and actual provision.

It has to be understood between purchasers and providers that although strategic shift is intended, both to deal with unmet need and to improve the balance between the various components of service, the issue is one of pace of change rather than wholesale shift in resource allocation.

The issue of the best use of available resources is ultimately a separate one from whether those resources are sufficient, but the method gives clear evidence on both questions. The utility of condition specific programmes of health care in prioritisa-
tion and questions of resource allocation can only be as good as the evidence available. Even where this is strong the method helps decide priorities within and not between programmes. Deciding on priorities between programmes needs evidence of burdens of disease upon populations. More accurate costing data would help judgements within and between programmes.

Use of the matrix in purchaser/provider negotiations reinforces the message of what the exercise is about by constant reference to the required outcomes. In this way clinically relevant outcomes in routine use can be identified in preference to initiatives designed to produce theoretical outcomes in isolation. Negotiations demonstrate less pressure in areas where there is a choice of possible interventions (e.g.: different health promotion programmes) than in areas which are more discrete (e.g. cardiac revascularisation).

The method has been commended in the Audit Commission report Dear to our Hearts 7). It is also ideally suited to the recommendations in the Expert Advisory Group on Cancer report which recommends commissioning cancer services on an anatomical site specific basis 8).

CONCLUSIONS

In summary the adoption of the condition specific approach to commissioning services for patients with ischaemic heart disease has demonstrated:

A focus on health, not just health care services
Clearer identification of needs and a resulting comprehensive balance of services, taking account of resources and priorities.
Greatly enhanced clinician involvement in and ownership of commissioning, thereby reducing confrontational commissioning.
Integration of clinical audit, clinical guidelines and clinical outcome measures into commissioning
Better utilisation of research evidence and control over the introduction of new technologies.
Improvement of information systems.
Identification of deficiencies in current knowledge of effectiveness and cost effectiveness of treatments stimulating further research.

The condition specific method of commissioning health care is consistent with current advice on good practice in the UK NHS. It has demonstrated that service specifications can be made comprehensive and that both clinical audit and evidence of effectiveness can be introduced into contracts. It has dealt satisfactorily with many of the criticisms which have been levelled at the commissioning process in the UK NHS market, particularly those concerned with confrontation.

Challenges which arise as a result of the approach are relatively few and minor. They include the fact that high quality epidemiological, clinical and health services research findings are not always available.

Efforts are now being made to apply the method to other clinical conditions.

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REFERENCES

1. Department of Health. Working for Patients, London; HMSO, 1989.
2. Bury B. Letter to Mrs Bottomley. Brit Med J 1993; 306:702-703.
3. Audit Commission. Their Health, Your Business: the role of the District Health Authority. London, HMSO, 1993.
4. Mawhinney B and Nichol D. Purchasing for Health: a framework for action. Leeds, NHS Executive 1993.
5. Northern & Yorkshire Region. Contracting between Health Authorities and NHS Trusts: a working group report. Newcastle, NHS Executive Regional Office, 1995.
6. Department of Health, Health of the Nation: a strategy for England. London, HMSO, 1992.
7. Audit Commission. Dear to our hearts? Commissioning services for the Treatment and Prevention of Coronary Heart Disease. London, HMSO, 1995.
8. Expert advisory group on cancer. A Policy framework for commissioning Cancer Services: consultative document. London, Department of Health, 1994.