CONTRACTS FOR HEALTH SERVICES: OPERATIONAL PRINCIPLES

Comments from the Association of Community Health Councils for England and Wales

Introduction

1. At the end of September, the Department of Health circulated a paper entitled "Contracts for Health Services: Operational Principles." This was sent to RHA Chairmen and General Managers, DHA Chairmen and General Managers, and to Unit General Managers. It was not circulated to Community Health Councils. This omission is particularly unfortunate given that the document relates to the contractual process which is going to underpin NHS operational provision from 1991 onwards (with all NHS Services to be provided on this basis by 1994/5) and that there are sections relating to the way in which standards of service are going to be specified within contracts, which will be crucial to the quality of care that patients ultimately receive.

2. It is also noticeable that the document fails to consider how the views of the users of services are to be fed into the process. Community Health Councils are not mentioned. Indeed, it would appear that the perspective of the providers of service will dominate in the standard setting process with comparatively little leverage being given to the purchasers of service, let alone to the people who will use the services.

General Principles

3. The paper emphasizes the different role of purchasers and providers. Thus, DHAs as purchasers will identify the service requirements of their resident population and will then seek to purchase service to meet these requirements, subject presumably to the limitations of the resources available to them. The managers of health care units (ie the providers) will aim to deliver services under the terms of contracts, specifying quality and quantity, to one or more clients in exchange for agreed levels of payment.

4. DHAs will be expected to make sure that their resident population has "good access to a comprehensive range of high quality, value for money, hospital and community health services." The paper makes it clear that "the process for specifying and letting contracts will be the main mechanism for meeting these responsibilities." Community Health Councils will, of course, also be concerned to see that the local community has good access to a full range of high quality services that are cost effective. Given this, it is essential that CHCs have an explicit role in commenting on the range of contracts to be taken out by a DHA and be consulted on the specification of standards. It is particularly unfortunate that the paper does not consider these issues.

5. DHAs will need to embark on a "wide-ranging" review of the requirements of the District's population. The document envisages that this will involve:

" - local assessments of the current state of the health of the population;

- an appraisal of how best their health could be improved and current needs be met, taking account of national and regional priorities;

- consultation with local GPs to identify their preferred referral patterns ;

- consideration of how contracts can be drawn up and placed to meet the goals of the district for access to services, quality and efficiency;

- assessment annually of the outcomes of contracted provision and its contribution towards health improvements."

The document does not refer to involving the CHC in this process. However as the representatives of the community's interests in the local NHS, CHCs should certainly be fully involved in this consideration of the population's requirements for health care. Over the last fifteen years CHCs have built up considerable experience of assessing the services needed by local people and in identifying areas of unmet need. If in the future DHAs are "to specify much more precisely than in the past exactly what services they aim to secure for their population," then CHCs must be involved.

6. Two paragraphs in the paper are of particular concern, in that they clearly imply that the standards of service will be specified more by the provider interests than by the purchasers, acting on behalf of the service users. It is worth quoting these

"2.11 The contractual process will give hospitals, whether self governing or directly-managed increasing freedom to manage the delivery of services as they think best. The changing role of DHAs from service managers to service purchasers will increasingly mean that they will concentrate on <u>what</u> services their residents need without specifying in detail <u>how</u> every service is to be provided. This will be an evolutionary process that will move forward faster in some places than in others. It will depend on hospitals' growing ability to specify to DHAs the levels of quality and efficiency with which they can provide treatment, allowing DHAs to concern themselves less with the detail of the way in which the specifications are met.

2.12 This process is likely to place the onus generally on providers rather than purchasers to put forward detailed specifications of the services that can be provided. Self-governing hospitals and, as soon as practicable, directly-managed units will wish to provide potential purchasers with a full description of their services. This may be in the form of a prospectus. Such specifications are likely to provide the basis of the initial discussion of the contractual terms and prices although, no doubt, they will be modified in the course of negotiation with DHAs."

The emphasis in this is the wrong way round: for example, hospitals will specify to DHAs the levels of quality and efficiency they can provide, rather than DHAs setting out what they expect, if patient needs are to be met. Placing the onus on providers rather than purchasers is a recipe for marginalising patients' interests and for services to be run for the convenience of consultants. Although, some negotiation is expected the paper clearly envisages that standards will be specified on a take it or leave it basis.

Setting the framework for negotiating contracts

7. DHAs are expected to begin by deciding what services their residents need and then decide which of these should be "core services" that need to be provided locally, and which can be provided by contracts with providers outside the district. A number of Districts are to be selected, on the recommendation of RHAs, to take the lead on determining their use of core services to provide models of good practice for wider dissemination.

8. The paper emphasizes that "quality must be regarded as just as important as price" in choosing contracts, but no indication is given as to what incentives will be in place to make sure that this is the case. If a District has a limited budget, it is likely that price will take precedence over quality whatever the pious hopes in this document.

9. A section of the paper is given over to discussing consultation arrangements for DHA contracts and GP referrals. The section starts by stating clearly that:

> "The responsibility for placing contracts lies with DHAs, but it is patients who will use them (sic) and GPs are best-placed to give effect to their wishes."

There is nothing else in the paper about consulting patients or their representatives and it has to be recognized that consulting GPs is no substitute for consulting service users.

10. Great emphasis is, however, given to the role of GPs. Thus the object of the exercise is "to secure the referral patterns which local GPs wish to see put in place unless there are compelling reasons for not doing so." GPs are to be asked to set out where they presently refer their patients for treatment and why. This will clearly add significantly to the GPs workload

while this analysis is being done. The paper also describes a process for consulting GPs, through the Local Medical Committee, on the plans for contract placement so as to allow comments to be made before final decisions are taken. If the LMC is being consulted in this way, there is no reason why the CHC should not also be consulted at the same time.

11. The paper discusses non-contractual referrals and gives the reassurance that "GPs should be free, when necessary, to refer non emergency cases outside the contract." Each DHA will hold a contingency reserve to deal with such cases and the paper promises that "the DHA will not challenge the GP's choice of provider unless it can be shown that the proposed referral is wholly unjustified on clinical grounds, or where an alternative referral would be equally efficacious for the patient, taking into account the patient's wishes." However, this is followed by the warning that "A presumption of the right to make an extra-contractual referral cannot therefore be a guarantee that the DHA would in all cases agree to meet the cost."

12. Clearly, there is potential for conflict in deciding whether a non-contractual referral will go ahead. The paper is not clear as to how this will be resolved in practice. DHAs will set up a clinical panel to advise on such cases, GPs are urged to clear referrals with the DHA, and hospitals receiving such referrals are expected to check with the patient's DHA that they will in fact be paid. It is difficult to see how this can conceivably be "simple, quick and non-bureaucratic" as the paper hopes.

Negotiating contracts

13. The paper outlines that contracts should as a minimum cover the following matters:

"- the nature and level of services to be provided;

- price to be paid for these services;

- duration of the contract

- general or specific population characteristics;

- the facilities that will be employed, insofar as measures of outcome cannot be substituted;

- the criteria for admission and discharge of in-patients and for day/out patient referrals;

- the speed with which patients will get access to services (waiting time).

- other measures of quality that will be applied;

- information the parties will make available to each other (this will include, where appropriate, nationally agreed minimum data sets);

- means of monitoring the contract, including access to premises and data;

- mechanics of billing, authorization and settlement."

Clearly, such items as the facilities to be employed, the criteria for admission and for discharge, and the speed with which patients will get access to services are all matters on which CHCs would expect to make a significant input. It is therefore important that CHCs are consulted on the content of contracts and on the specifications to be used before the contracts are finalised. If CHCs do not have an opportunity to comment at an early stage, it may be too late, as once the terms of the contracts are agreed, it will be difficult to change them.

14. The paper emphasizes that the contractual process should aim to improve the quality of services provided and should not focus on efficiency and cost-effectiveness alone. The paper suggests that contracts should guarantee such matters as:

"a. the appropriateness of treatment and care;

b. achievement of the optimum clinical outcome;

c. all clinically-recognised procedures to minimise complications and similar preventable events;

d. an attitude which treats patients with dignity and as individuals;

e. an environment conducive to patient safety, reassurance and contentment.

f. speed of response to patient needs and minimum inconvenience to them (and their relatives and friends);

g. the involvement of patients in their own care."

Again these are all issues of major relevance to the work of CHCs who should be consulted about proposals relating to them. Unless, this is done the patients' interests are likely to be marginalised as financial pressures crowd in on those negotiating the contracts.

15. The paper suggest that the contracts should enable purchasers to pay both announced and unannounced visits to health care units to check whether the standards of facilities are as promised in the specification. This is important, but the relevant CHC should also be given the same right, and this should be written into the contracts.

Monitoring

16. The section on monitoring in the paper is just ten lines, which presumably reflects the fact that further work needs to be done by the Department of Health of this topic. The importance of adequate monitoring systems is quite rightly stressed, but nothing is said about how CHCs and service users are to be involved in this process.