

**BRI INQUIRY PAPER ON COMMISSIONING, PURCHASING,
CONTRACTING AND QUALITY OF CARE IN THE NHS INTERNAL
MARKET**

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EXECUTIVE SUMMARY

The purpose of this paper is to look at how issues of quality were taken account of in the processes of purchasing and contracting for care in the first five years following the introduction of the NHS internal market in 1991. The paper draws on policy documents, reviews, evaluations and commentaries and some original research reports. The focus of the paper is primarily on the activities of district health authorities rather than GP fundholders as, during the period of interest, the range of services bought by fundholders was quite limited in scope and did not cover the types of care relevant to the Inquiry. Reflecting the dominant preoccupations of health authorities in the years to 1995, the emphasis is mainly on purchasing and contracting rather than the more strategic activity of commissioning.

The paper does not deal directly with contracting arrangements for the small range of specialised services - including neonatal and infant cardiac surgery - which were designated as Supra-Regional Services after 1983.² These services were commissioned centrally by the Department of Health and funded from a central levy topsliced from health authority allocations. As such, they were not affected by the introduction of the internal market after 1991, except that from then onwards agreements for the provision of such services between the Department of Health and the units in which they were located took the form of a (relatively standard) contract. Neo-natal and infant cardiac surgery was one of two Supra-Regional Services that were re-designated from April 1994 as Specialised Services and consequently entered the internal market for the first time at that point.

However, despite the different arrangements for commissioning Supra-Regional Services, it may be argued that many of the difficulties of quality specification and measurement identified below in relation to health authority purchasing were generic in the health service during the period in question and are therefore relevant to the Supra-Regional Services also.

Section 1 outlines the main principles of the NHS internal market as introduced in 1991 and discusses what it was intended to achieve.

Para 1.1 begins by briefly outlining some of key concerns about the NHS during the 1980s, which the 1990 reforms were intended to address. It then outlines the aims and principles of the NHS internal market, shows how the purchaser and provider functions within the service were separated and describes the newly created roles of NHS trusts and GP fundholders. Basic expectations of the types of contracts that would be used and what they should contain are then described. The section ends with a brief account of subsequent policy developments aimed at moving beyond the initial narrow focus on financial transactions between purchasers and providers towards a more active commitment to using negotiations within the internal market to actively pursue the goal of better health.

Section 2 summarises the evidence available on how expectations regarding the specification, promotion and monitoring of quality of care were built into contracts between purchasers and providers during the period 1991 to 1995.

Para 2.1 uses data from the small number of relevant descriptive case studies undertaken during the period in question to look at: the way quality issues were addressed in health authority purchasing plans; the extent and nature of quality specifications in contracts for specific clinical services; the use of guidelines, protocols and outcome measures in contract documents; and intended arrangements for monitoring quality standards. All the studies discussed found extensive general references to quality issues, but much less evidence as to what these actually signified in practice. Many of the quality statements were too general to be meaningful. There was little evidence of health authorities having any sanctions for use in the event of providers failing to deliver on any specific aspect of quality.

Section 3 outlines a variety of reasons which help to explain why health authorities failed to establish more robust and effective means to assure and promote high quality care through the purchasing process during the first five years after 1991.

Para 3.1 draws attention to the financial pressures on purchasers in the early 1990s and the difficulties of trying to develop their purchasing function in the context of unprecedented and continuing organisational change. Other problems then considered include the shortcomings in information about hospital activity, lack of meaningful involvement with provider audit programmes, limits on the capacity to define and pursue appropriate care and constraints deriving from the purchasing process itself. The section ends with a summary of the main points raised in the paper.

1. AIMS AND PRINCIPLES OF THE NHS INTERNAL MARKET

This section:

- * outlines the aims and principles of the NHS internal market as introduced in 1991
- * summarises key subsequent developments relevant to purchasing for quality up to 1995

1.1 Aims and principles of the NHS internal market

- i. Until 1991, the NHS was funded as a unified provider of health services. From 1982 onwards, health authorities were allocated a sum of money at the beginning of each year which they distributed on down to the units that incurred the costs of providing care. During the 1980s, against a background of rising costs and increasing demand for care, there was growing concern about the capacity of the NHS to keep functioning effectively within the funds available to it. By 1987, the NHS had entered a particularly severe financial crisis. Many district health authorities were having to use their cash reserves, delaying payment of bills, closing wards and cancelling non-emergency admissions in order to stay within budget. Professional and public pressure for more money for the NHS grew. In 1988 a wide-ranging review of the NHS was announced. The outcome of this review was the NHS reforms which were enacted by the *NHS and Community Care Act 1990* and implemented in April 1991.
- i. In addition to widespread concerns about under-funding it was argued that the NHS was badly flawed because there were no incentives for health-care providers to be efficient. There was also criticism of the limited extent of patient choice and the insensitivity of managers to consumer views. These were blamed on the near-monopoly position of the NHS in the health care market, which had allowed a paternalistic, professionally dominated and inflexible system to develop.³
- ii. The reforms did not lead to increased funding for the NHS. Rather, it was decided to address the problems identified above by creating an 'internal market' for health care. The basic logic behind the new arrangements was that providers would have to compete for business, since money would no longer flow to them automatically from the health authority. The resulting competition was expected to encourage providers to be more efficient, more responsive and offer better quality care.

1.1.1 The purchaser/provider split

- i. The key innovation was the separation of the purchaser and provider functions within the service. District health authorities (DHAs) and some GP practices (fundholders) became purchasers, buying secondary care and community health services (apart from Supra-Regional Services) on behalf of their resident populations or registered patients. These services were provided by a combination of newly created NHS Trusts, some units which were still run by their local district health authorities (known as directly managed units (DMUs)) and private hospitals. Services were purchased through a series of contracts. District health authorities received budgets from central government for purchasing care, which were determined on the basis of a weighted capitation formula.

1.1.2 NHS trusts

- i. Those provider units which became NHS trusts received a block grant to cover core expenditures directly from the Department of Health. All other income had to be secured through competition for contracts. Although the idea of NHS trusts was originally developed as a model for acute hospital care provision, it was very quickly extended well beyond this to include the full range of NHS patient services from mental health care to ambulance services. The proportion of hospitals with Trust status expanded rapidly, such that by April 1993 more than two thirds of hospital beds were in NHS trusts.

1.1.3 GP fundholding

- i. Those GP practices that became fundholders were given budgets to purchase a limited range of secondary care services for their patients. Initially only practices with more than 11,000 patients were eligible for fundholding status and the budget covered the purchase of a small number of mainly elective treatments. In the first wave of fundholding after 1991, GPs covering approximately 7.5% of the population became fundholders. In the years that followed the list size criterion was relaxed, numbers of fundholders increased and practices were also permitted to group together to form fundholding consortia (and non-fundholding GP commissioning groups). The range of services purchasable by fundholders was also extended over time. By 1996, one in three practices, covering approximately half the population, were fundholders. Standard fundholders were managing about 7% of all NHS expenditure on hospital and community services, while the recently introduced "total purchasing pilot practices" (much fewer in number, but responsible for purchasing 100% of their patients' care) accounted for a further 4%.⁴ However, even in those areas with the most fundholders, the district health authority was still responsible for the great majority of expenditure.

1.1.4 *Types of contract*

- i. When the internal market was introduced, three basic types of contract were envisaged⁵:

Block contracts Where access to a specified range of services is purchased in advance of service delivery. Under this arrangement, purchasers do not purchase a specified number of operations of a certain kind, but the possibility of sending for treatment any patient who needs such an operation during the period of time covered by the contract.

Cost and volume contracts Where a set of charges for a given number of courses of treatment is agreed. Under this arrangement purchasers buy, say, up to 100 specified operations at £1000 each, falling to £800 each if more than 100 operations are purchased.

Cost per case contracts Where a set of charges per individual case are set. This type of contract was intended to fund referrals which did not fall within either of the two other forms of contract.

- ii. Initially, most contracts were set in the form of simple block contracts. However, over the first four years after 1991 both the number of contracts and their complexity increased (block contracts with ceilings and floors, cost and volume and cost-per-case).^{6,7}
- iii. Contracts were required to set out what services would be provided, how standards for customer service would be met, how the quality, efficiency and where possible the outcome of the services would be judged (including the role of medical audit), what changes might be introduced during the course of the year, and the respective roles of authority or hospital in monitoring performance.⁸

1.1.5 *From purchasing to commissioning*

- i. In the first year of the internal market, health authorities were specifically instructed to aim for "steady state" i.e. as far as possible, contracts should reproduce existing patterns of activity and referrals. For at least the first two years after 1991, the main focus was on setting up the NHS Trusts, establishing fundholding and creating the infrastructure and essential knowledge base for contracting. For both these reasons, relatively less attention was paid initially to developing the purchasing process as a means of securing improvements in care. A critical view was that commissioners at this time were hardly more than a channel for financing provider units, with no strategy of their own either for contracting or for improving health.¹

- ii. By the end of 1993, efforts were being made to redress this balance and emphasise the role of purchasing as "the main vehicle for achieving better health and better health services" and to move commissioning from a 'paymaster' to a more proactive role through implementation of seven recommended steps to successful purchasing.⁹ Health authorities were urged to: develop five year strategic plans; secure tangible improvements in services in next year's contracts; compile data on needs and outcomes; implement the 'local voices' guidance on community involvement; build long-term 'mature' relationships with providers; seek wide health benefits by working more vigorously with other agencies; and give urgent attention to their own management and organisation development needs.
- iii. The new emphasis was also reflected in a series of executive letters from the NHS Executive urging all trusts and health authorities to take clinical effectiveness and clinical guidelines into account in contracting¹⁰, to specify performance indicators and standards and to regard clinical audit as an essential component of all contracts.¹¹ Planning guidance issued for 1995-6 reflected the increasing focus on purchasing effective care by requiring purchasing authorities to increase investment in at least two interventions known to be effective and to reduce investment in at least two interventions that evidence has identified as ineffective.¹²

2. THE ROLE OF QUALITY IN THE CONTRACTING PROCESS

This section:

- * summarises the evidence available on how expectations regarding the specification, promotion and monitoring of quality of care were built into contracts between purchasers and providers during the period 1991 to 1995

2.1 The role of quality in the contracting process

2.1.1 *Sources of evidence*

- i. As with other areas of the NHS reforms, there was no built in formal evaluation of the purchasing process, nor were any major national studies of health authority purchasing carried out. Most of the research that was undertaken in this area was more concerned with the technical processes of purchasing than with its impact on health or the provision of health care. Thus most of the relevant information on quality comes from a small number of descriptive case studies from different regions of the country and from expert opinion pieces written by commentators with first hand experience of the commissioning process.

2.1.2 *Evidence of contracting for quality in health authority purchasing plans*

- i. Lord and Littlejohns¹³ carried out a content analysis of purchasing intentions documents for 1994-95 contracts for six of the ten DHAs in the South West Thames region. The documents contained many statements relating to the quality of services to be purchased. In some cases purchasers quoted specific standards or guidelines (such as *Patient's Charter* standards or British Thoracic Society asthma guidelines), or stated that they would look for these to be agreed during contract negotiations or developed over the coming year. Other statements specified that quality improvement processes should be used by providers, some quoting particular methodologies. Many of the statements referred to clinical audit arrangements or requested audits on given topics. The authors comment that a surprisingly large number of the statements related to aspects of clinical effectiveness rather than 'service' issues, but there were relatively few statements relating to outcomes, and those tended to be both general and weakly specified.
- ii. However, as the authors also observe, only so much can be read into statements in purchasing plans. They represent a negotiation stance, and will not necessarily be translated into agreed contractual requirements or influence service provision. It is not the quantity but the 'quality' of quality statements which matters and without clear definitions and agreement between purchasers and providers on responsibilities for implementation and monitoring, such statements have little credibility. The documents analysed in this study frequently failed to indicate whether these conditions had been met, or would be addressed in the coming negotiations. In these circumstances, the authors' suggestion that much of what was written about quality amounted to little more than rhetoric and pre-contract posturing cannot be discounted.

2.1.3 *Evidence of quality specifications in contracts for clinical services*

- i. Gray and Donaldson¹⁴ undertook a study of the quality specifications used in contracting for clinical services by all health authorities in the Northern region in 1993-94. The purchasing organisations were asked to submit all quality specifications in the contracts for health care in six clinical specialities (general medicine, general surgery, ophthalmology, obstetrics, psychiatry, trauma and orthopaedics).
- ii. The approach to contracting by all eleven purchasing organisations was virtually the same. Nine of them used a general quality document with a wide range of quality specifications which were applicable to every contract placed and were not service specific. Ten also used quality clauses in service specific contract documents. When purchasing care from providers of a service outside their authority's boundaries, the health authorities adopted the quality specifications which had been developed by the relevant host purchasing organisation.

- iii. The general quality documents were far more detailed than the service specific contracts. All referred to the Patient's Charter, customer and hotel services, complaints procedures and safety and statutory regulations. Six of the eleven contained some reference to clinical care. The categories of quality issue referred to in the service specific contracts varied between specialities. For example, clinical care was referred to in 82% of the contracts for psychiatric services, but was not mentioned in any of the contracts for general surgery. However, reference to audit was more consistent, being mentioned in around three quarters of the service contracts for each speciality.
- iv. The clarity of the quality statements varied considerably and were frequently so all-encompassing or broadly worded as to contain no clear indications for actual practice. Much less often, the approach was very specific, clearly allowing providers to work to the specifications.

2.1.4 *Use of guidelines and protocols in purchasing*

- i. There is relatively little evidence about the extent of the specification of guidelines and protocols by purchasers, although one 1995 study¹⁵ reports that Dorset health authority included in all its clinical contracts a series of quality criteria relating to clinical effectiveness, derived from such sources as the Effective Health Care bulletins.

2.1.5 *Use of outcome measures in setting quality standards in contracts*

- i. A survey of purchasers¹⁶ undertaken in 1993 to determine how far health authorities were using outcome measures in setting quality standards in contracts found that more than 60% of the authorities studied included measures of health outcomes in at least some of their contracts. However, less than 20% involved any formal linkage with financial arrangements which might enable purchasers to exert leverage by offering incentives or imposing financial penalties if targets were not met.

2.1.6 *Evidence of mechanisms for monitoring quality*

- i. In the Gray and Donaldson study¹⁴ referred to above, the purchasers' usual approach to monitoring was to set out the intended arrangements in the general quality documents. These arrangements were given in broad terms and did not clarify details of how the different quality issues would be monitored. The categories of quality issue for which monitoring arrangements were most often described were the Patient's Charter, complaints procedures and medical/clinical audit. Less often (38% of documents) monitoring arrangements were described for issues of service delivery. None of the general quality documents described monitoring arrangements for issues directly related to quality of clinical care. None of the service contracts for general medicine, general surgery, trauma and orthopaedics or ophthalmology contained any reference to standards of clinical care. Where standards of clinical care did feature (in a minority of the service contracts for obstetrics and psychiatry) they focused on elements of the provision of clinical care, rather than its content, appropriateness or effectiveness. None of the purchasers in this study made reference to any sanctions in the event of providers failing to deliver on any specific aspect of their quality contract specifications.

- ii. These authors summarise a number of weaknesses evident in health authorities' approach to contracting for quality improvement¹⁴:
 - * they were not systematically considering established features of quality improvement such as quality assurance based on objective measures, nor were they drawing on established definitions and dimensions of quality in health care

 - * different quality specifications were used with different providers of the same service and the health authorities only used the quality specifications which they had developed themselves when purchasing services from their local providers

 - * the many different quality documents were often poorly referenced, unstructured and uncoordinated and most health authorities set out their specifications in very broad or non-specific terms which were open to different interpretations and impossible to measure

 - * the focus on quality improvement through the contracting process was not generally directed towards health outcomes, referred only sometimes in superficial terms to quality of clinical care and hardly at all to standards of medical care

3. OBSTACLES TO PURCHASING FOR QUALITY

This section:

- * outlines a variety of reasons which help to explain why health authorities failed to establish more robust and effective means to assure and promote high quality care through the purchasing process during the five years after 1991

3.1 Obstacles to purchasing for quality

- i. In a key commentary¹⁷ in 1993, one district health authority director of public health commented: "Although the potential of the internal market to contribute [to maintaining and improving quality] is clear, it is less clear whether the quality specifications in contracts yet seep into the hearts and minds of those delivering care. There is a risk that they will remain as they started - a bureaucratic irritant, for which a quarterly submission to the purchaser called a "quality monitoring report", cobbled together by a manager who is second in line, provides adequate balm."
- ii. A number of reasons have been suggested as to why health authorities had so little success in developing robust mechanisms for improving quality through purchasing. These include financial pressures and pressures deriving from organisational change, shortcomings in information about hospital activity and access to audit data, lack of good measures of appropriate care, and constraints deriving from the purchasing process itself. Each of these are considered in more detail below.

3.1.1 *Financial pressures*

- i. Enormous financial pressures faced by health authorities and trusts alike, allied with the continuous pressure of an apparently inexorable rise in demand for care, pushed issues of volume and price into overwhelming prominence in the contracting process, especially for districts losing revenue through capitation funding. As Gill¹⁷ observes, the main objective for many health authorities seems to have been "damage limitation" rather than the introduction of imaginative approaches to quality improvement.

3.1.2 *Organisational change*

- i. Following the introduction of the 1990 NHS reforms, health authorities struggled to deliver numerous efficiency and quality targets in the face of unprecedented organisational change. Over the next few years, those trying to develop purchasing were faced with continuing environmental turbulence including mergers of health authorities, mergers with family health services authorities, mergers with subsequent abolition of regions and substantial increases in the coverage of GP fundholding. Little formal training in either purchasing or quality management was provided for those managers faced with delivering their new function and any opportunity to develop and maintain specialist skills in managing quality improvements through contracts was constrained by the continuing pressure to reduce management costs.¹⁴

3.1.3 *Shortcomings in information*

- i. Problems have been identified both with the type of information potentially available about hospital activity and with the capacity of purchasers to access that information:
- ii. Following the 1984 *Korner Report*¹⁸ the 'completed consultant episode' (during which an inpatient is under the care of a particular consultant) was introduced as the main measure of hospital activity, replacing previous measures based on deaths, discharges and transfers. The currency of the completed consultant episode (now called finished consultant episode) was widely criticised for being difficult to use and interpret and giving rise to perverse incentives to providers to organise the care of individual patients in ways that would amplify the recorded number of consultant episodes and thus maximise their income without increasing their work. While 'working the system' in this way would probably not affect overall costs, it was recognised as likely to seriously distort patterns of contracts for purchasers.¹⁹
- iii. A further problem following the introduction of the internal market and the new rhetoric of competition was that district health authorities technically had access only to information on health service use by their own residents. Activity information relating to a whole hospital was not available except that which statutorily appeared in trusts' annual accounts or unless health authorities collaborated to reaggregate a provider unit's data.

- iv. These shortfalls in information quality seem to have acted as major constraints. As Gill¹⁷ comments, purchasers had to negotiate for similar volumes of activity - often with less money at their disposal - while hampered by inadequate descriptions of that activity: "Even within a narrow definition of efficiency, based on the relation between cost and volume, there remains the uncertainty about whether more, less or the same amount of health care has actually been bought this year compared with last. To strive for improvements in dimensions of quality other than efficiency (such as effectiveness and appropriateness) through well informed and carefully negotiated service specifications feels akin to shining the spotlight on grains of quicksand: the completed consultant episode is well lit up, but illuminates little."
- v. Recognising these problems, the NHS Management Executive issued an executive letter²⁰ in 1993 explicitly acknowledging that purchasers could not hope to improve quality and value for money if they had little or no information available to them about the performance of providers. The letter commented that: "it is too simple to classify everything as 'Commercial, in confidence' and we need to remember we are all part of one National Health Service" and expressed the hope that discussions around contracts would in future take place within the context of shared information, so that robust and challenging negotiations could take place to the benefit of the population being served.

3.1.4 *Involvement with audit*

- i. The proposals for medical audit in the 1989 white paper *Working for Patients* placed great emphasis on professional ownership of the process and the paramount need for confidentiality. In addition, they identified some limited powers for purchasers and provider managers in terms of access to general results of audit and a right to initiate independent audit in exceptional circumstances. It was also suggested that health authorities might use evidence of active provider audit programmes when placing contracts.²¹ In practice, during the early 1990s control of medical audit in hospitals and information about what was being done stayed firmly in the hands of clinicians and both purchasers and provider managers were left very much on the outside.²²
- ii. By 1993, Department of Health views on the appropriate relationship between clinical audit and the contracting process had strengthened. It was proposed that clinical audit should be integrated with wider provider quality programmes and that audit should be the "major plank" in the complete quality assurance that purchasers require of the unit with which they place contracts.²³ Increased emphasis was placed on purchasers' rights to influence the audit programme, including negotiation over topics and access to the general results of audits undertaken. In addition, purchasers gained control of funds previously ringfenced and allocated to professional audit committees via the regions. However, continuing professional-managerial and purchaser-provider tensions meant that the aspiration of significant purchaser involvement with provider audit programmes remained unrealised in many areas.

3.1.5 *Lack of good indicators of appropriate care*

- i. In the early 1990s there was relatively little information available to purchasers to ensure that, or assess whether, the activity and procedures they were purchasing were worthwhile. By 1993, pressure was growing from a number of sources for the NHS to stop purchasing activity and begin purchasing evidence-based protocols.²⁴ However, in practice, there were limits on how far purchasers could proceed along this path.²⁵ Despite the various initiatives (including the 'Outcomes Clearing House' and the *Effective Healthcare* bulletins) set up to collect and disseminate the best available evidence, there remained large areas of clinical practice for which clearcut research evidence on effectiveness did not exist. Moreover, many staff in purchasing organisations had little formal training in the concepts of effectiveness and appropriateness. Contracts managers often dealt with a wide variety of contracts covering a multiplicity of specialities and medical mystification could be used extremely effectively by clinicians to prevent contracts managers having an impact on their practice.

3.1.4 *Constraints of the health care system*

- i. The original aim of the NHS reforms was for an internal market imitating the private sector. However, real competition in the NHS is impracticable both because of inadequate information on costs and quality and because the actual opportunities of purchasers to move their contracts are constrained by traditional loyalties, historical and geographical referral patterns and organisational inertia.
- ii. In the first year of the internal market, purchasers were specifically encouraged to reflect existing patterns of provision in their contracts. But even without this requirement, there was pressure on purchasers from providers, particularly where there were no new monies to spend, to retain current patterns of service. Proposals for change might lead to threats of adverse publicity over bed closures and staff redundancies, and relatively small shifts in contract income could genuinely threaten viability in some instances. Often the continued existence of an individual provider was vital to the maintenance of essential local health care services. In this situation purchasers were understandably reluctant to force the issue of change in individual services at the possible expense of overall viability.²⁶ It is therefore perhaps not surprising that by 1995, few contracts had been changed or won on quality grounds¹

3.1.5 *Conclusion*

- i. The original assumption behind the introduction of the NHS internal market was that the resulting competition would encourage providers to be more efficient, more responsive, and offer better quality care. It was anticipated, and these expectations were later further reinforced, that quality specifications would be effectively incorporated within the purchasing process to ensure, improve and monitor the quality of care received by patients.

- ii. Evidence relating to the role of quality specifications in purchasing in the first five years after 1991 is fairly limited. It is clear that quality featured strongly as an issue within both the rhetoric and detail of purchasing statements and contracts. However, the meaning and operational significance of many of these statements was questionable. Purchasers' attempts to influence quality through the contracting process during that period seem to have been relatively disorganised and probably fairly ineffectual.
- iii. There are a number of reasons which help explain purchasers' difficulties in establishing more robust approaches to quality. These include financial and organisational pressures, a shortage of dedicated skilled staff to work in this area, inadequate information and access to audit data, problems with defining appropriate care and difficulties associated with the workings of the system as a whole.
- iv. Despite the different arrangements for commissioning Supra-Regional Services, it may be argued that many of the difficulties of quality specification and measurement identified in relation to health authority purchasing were generic in the health service during the period in question and are therefore likely to have been relevant to Supra-Regional Services also.

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