feature

Peter Mason

All change in the health market

Eight years ago in *Druglink*, Peter Mason predicted that market forces would fragment drug services and called for a minimum standard service framework.[1] What the intervening years have shown us is that the NHS internal market has failed to establish a special case for comprehensive integrated services for drug users. Perhaps we expected too much without a national drug strategy. This time, though, we have a new government, new NHS reforms, new national strategy and a new sense of urgency about drug problems in the UK. Will it be any different the second time around?

The new national drug strategy is a much needed beacon in a complex policy environment. It differs from its predecessor in that it re-focuses action onto the 'root causes' of drug misuse. In doing so it links the strategy to key social policy issues – namely poverty, unemployment, crime and exclusion.

That said, to date the Labour government has continued to pursue the policies started during the Thatcher-Major years. The Conservative response to crime continues to remain in the ascendency with the view that drug addiction is a multiplier of crime. As the fear of HIV/AIDS recedes and is replaced by the fear of crime, drug policy looks set to be entrenched in its 'Criminal Justice Phase'.

This shift away from the days of blanket harm reduction will have to be achieved by the Drug Czar, Keith Hellawell, and his deputy, Mike Trace, with great delicacy. But the Criminal Justice Phase does not necessarily mean, unlike previous phases, that criminal justice will get all the money. In fact, the strategy hints quite openly at a funding shift *away* from "reactive" enforcement activity.

Rather, spending on prevention and on high priority groups – vulnerable young people, drug-related offenders and problem drug misusers – will almost certainly increase. As pointed out in the last *Druglink*, this spending will not be 'new'. Rather, most of the money is likely to be already in the system and will simply be redirected away from enforcement activities. 'Partnership funding', familiar to everyone who has ever considered applying to the Lottery or the Drugs Challenge Fund, will be the other main funding mechanism used to channel money towards more demand reduction activities. So, given this situation, what policy options is the government left with to reform the health market?

Trust me, I'm a doctor

The New NHS: Modern: Dependable White Paper leads the way, not only setting out to halt the internal health market but also to reverse the divisiveness and inequities in the distribution of care that arose under it. These reforms aim to create level playing fields, end competition and stop secrecy about costs and pricing. In theory at least, they signal a return to more collaborative working arrangements between purchaser and provider, as evinced by the rolling programme of about 10 new Health Action Zones every year:

"They will bring together all those in a health authority area or wider, to improve the health of local people. The accent will be on partnership and innovation, finding new ways to tackle health problems and reshape local services. Health Action Zones will be concentrated in areas of pronounced deprivation and poor health".[2] Those 'root causes' of drug misuse again.

Hipper and healthier

Of particular relevance to drug treatment services will be the new emphasis on Health Improvement Plans (HIPs). The HIP will be the local strategy for improving health and health care. It will be the means to deliver the national targets in each

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district. These plans will be led by health authorities but will involve NHS Trusts, Primary Care Groups and other primary care professionals working with local authorities and local interests. The first HIPs covering a three years period are expected to be in place by April 1999.

Primary Care Groups (PCGs) will become the new local commissioning consortia (consisting of General Practitioners and community nurses with health authority support). These will be established within new configurations of Trusts and health and local authorities to meet local needs and geography.

How PCGs will impact on drug services will require careful thought, but it is likely that given the small size of contracts and the speciality nature of much drug service provision, services may continue to be commissioned by the respective lead agencies within the Drug Action Teams.

The bigger picture

The hallmarks of the new health market commissioning processes will be a focus on collaboration, reduction of bureaucracy and an accommodation with providers through long-term funding agreements.

Health authorities are now also to be charged with new statutory formal responsibilities for improving the health of the population and for working in partnership with NHS and other local bodies. A new statutory duty of partnership will also be placed on local NHS bodies to work together for the 'common good', while local authorities could soon have a statutory duty to promote the economic and environmental well-being of their areas.

Plans to commission specialist services (where one centre covers the population of a number of health authorities) will be determined at the Regional NHS Executive Office level. The NHS Executive will be discussing options with health authorities and NHS Trusts and it is here where drug treatment services which operate at a sub-regional or national level will be dealt with.

1. Mason P. "Dealing with the health market." *Druglink*: 1990, 5(3), p8-9.
2. NHS White Paper. *The New NHS: Modern: Dependable*. Stationery Office, 1997.

The new managerialism

With all this talk of partnership, it would still be wrong to think that the new reforms will discard the emphasis on 'value for money'.

Although the NHS White Paper is veiled in comforting language about 'collaboration' and an 'end to competition' it maintains an emphasis on 'buy right' strategies that will continue to pressure providers for data to allow for price and outcome comparisons. This will increasingly lead to more standardised outcome monitoring systems and information about quality, costs and managed care – even in the drug field.

Trusts will be required to publish and benchmark their prices for services. Health authorities will also have new wide-ranging powers to lever up standards and efficiency at a local NHS Trust level and to change providers if performance does not improve.

The multi-factorial problems that create and arise from drug misuse, and the responses that are required to tackle it, create a complex set of multi-agency issues. These can only be addressed through a strategy that consolidates the policy, funding, management and monitoring mechanisms at a national level but whose action is expressed through services at a local level.

The key arena where both the drug strategy and NHS reforms meet will therefore be the Drug Action Team (DAT). These teams of senior leaders are to agree corporate plans annually with the Drug Czar, plans which will be used to track outcomes and targets and form the benchmark for distributing resources. The other significant change for DATs is the widening of their representative base and the active engagement of elected officials and MPs to ensure that there is no 'democratic deficit'.

Other movements in the regulation of the drug market include the establishment of a panoply of working groups under the Drug Czar and the re-launch of the Health Advisory Service's Substance Misuse Advisory Group (SMAS-2000). These groups will operate at policy and commissioning levels as well as in collaboration with DATs, provider groups, umbrella organisations and professional bodies.

Providers revisited

The upshot of all this is that service providers will have to respond to increasing calls for a national system of outcome monitoring which will relive some of the issues that surrounded the introduction of the Regional Drug Misuse Databases. Increasing calls for minimum standards, accreditation for providers and regulation for doctors and clinical prescribing all point to a return to an accountability culture with teeth.

There are also signs that, despite some likely blood-letting in the near future, the treatment market will continue to expand, not only through the consolidation of prison-based treatment but increasingly through a new focus on alternatives to custody (the new Treatment and Testing Order being a case in point).

Keith Hellawell has arrived in an already crowded and rapidly changing policy environment, with edicts bombarding all sectors. In such a turbulent atmosphere there is a danger that systems will crash and key reforms work against each other. The real challenge for the 'centre' will be to prevent the desire to 'micro-manage' the drug field and force out innovation. DATs must therefore develop mechanisms for ensuring local resource collaboration and for strategically mapping the way forward locally.

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Unlike past Conservative governments where compliance and accountability were simply matters of how guidelines were interpreted, the Brave New World of New Labour's health market for drug services looks set to be characterised by the concepts of best value, outcome monitoring, accreditation, renewed collaboration, regulation, rewards . . . not forgetting the big sticks! ■