DEALING WITH THE HEALTH MARKET

From a health service manager, ways for your service and your clients to survive the health/care services 'internal market'.

The NHS and community care reorganisations will create a health/care market with many purchasers and providers. Market forces could further fragment services and force even popular agencies to close. To regulate the market both sides should establish consortiums or coalitions negotiating within a nationally agreed framework of minimum service provision, with the demand for services channelled through a single lead agency.

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THE NHS AND Community Care Bill now making its way through Parliament is the first legislative stage in the implementation of two recent white papers: the *Working for Patients* paper on the NHS published last year, and the recent *Caring for People* white paper which laid out the Government's proposals for implementing the Griffiths report on community care.

SCODA, the Standing Conference on Drug Abuse, has already flagged up the problems for residential services in the bill,[1] and is pressing hard for amendments. However, planning for change is accelerating as authorities try to meet the April 1991 deadline for contracting out health and social care. There is now a desperate need for all agencies to synchronise their thinking around services for drug users.

Both white papers heavily emphasised business and economic concepts. In future, each district health authority (DHA) will be allocated a sum of money which the Government thinks sufficient to meet the health needs of their population including, presumably, drug users. This will be determined using weighting factors such as deprivation, unemployment and homelessness, plus available information about drug use incidence and prevalence.

The district's allocation will then be used to fund its own directly managed services and on top of this to buy in health services from hospitals and other service-providing organisations. Relationships between the DHA (the purchaser) and these services (the providers) will basically be contractual.

The DHA will have the power to buy services from other DHAs, from self-governing hospitals, and from the independent sector, including voluntary agencies as well as private companies. DHAs will be expected to 'shop around' in this health care market to try to make their money go further.

In addition, large GP general practices will be able to act as mini health authorities, drawing up and placing service contracts for their patients funded from their own practice budgets. Meantime, the community care provisions of the legislation will bring local authorities in as the major purchasers of social care for drug users, including residential rehabilitation and elements of advice and counselling work.

Preventing disintegration

So in the post-white paper environment, the main service-purchasing power will lie with DHAs, local government, and with budget-holding general practices. In addition, changes to the criminal justice system may bring probation services into the purchasing arena (see diagram).

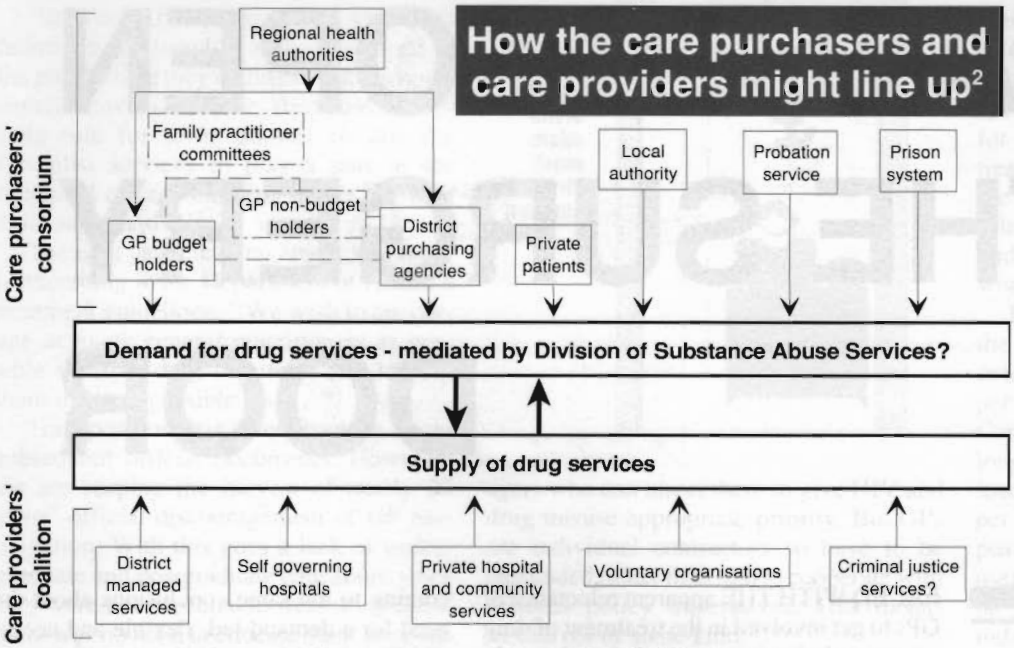
If these resources could be harnessed together we could not only secure the funding base for services but also see the development of a national, integrated drug treatment and rehabilitation system.

In achieving this goal we would not be starting from scratch. Service planning has already been well advanced through the Advisory Council on the Misuse of Drugs and the NHS Drug Advisory Service.

Central government funding has meant that most DHAs now have some service provision, although this is not universal. A pluralistic pattern has developed with a number of providers of different types. Although contracts are not in place, relationships between grant-giving bodies and providers have already developed in the drug field. However, no national drug treatment and rehabilitation policy exists and information about what works and about health outcomes is scanty.

The need now is for multi-agency collaboration between providers and between providers and purchasers. One problem is that care providers in the drugs field tend to be suspicious of their funders and of each other. The new white paper thinking does suggest a detente could exist between purchasers and providers, but only if a number of structures are put in place to protect both from the excesses of the market.

Inter-agency competition can be seen as mainly caused by the limited supply of



Minimum Standard Service Areas

- Prevention and education
- Counselling, advice and information services
- Community and outpatient services, including GPs
- Inpatient detoxification assessment
- Access to regional services
- Access to rehabilitation and aftercare

trained staff and funding as well as by deep-seated philosophical differences.

This competitive ethos allied to the new health/care services market could adversely affect the range of services available to drug users. There is now a growing paranoia that the first round of contracts might see many agencies go to the wall and benefit only statutory services and large voluntary bodies. Access into the drug treatment system could thus be restricted and the move on to rehabilitation left to a social services case manager's assessment.

To regulate the market in the interests of drug users, district drug advisory committees will have to respond to the new purchaser/provider split. The most immediate response could be for committees to incorporate the role of purchaser and provider forum. Here coalitions of providers and the purchasing consortium could come together to plan service provision and monitor fund-management and contract arrangements, while continuing to ensure services are delivered and needs assessed within the district; the diagram shows how these groups might line up.

Organise coalitions

Provider coalitions are well established in the USA, with large national lobbying organisations such as the National Hospitals of America Corporation. At state level there are treatment-provider coalitions such as the North-East Methadone Maintenance Treatment Coalition Inc., which protects and negotiates on behalf of over 225 clinics with 65,000 patients.

Drug service purchasers too are well organised in America, where each state has allocated purchasing, planning, quality assurance and monitoring roles to a single lead agency, the Division of Substance Abuse Services. This agency contracts to buy drug treatment services from providers, and has proved essential to ensure the service framework is supported and funded, mainly through the welfare system.

District-based service-provider coalitions in the UK could act as a major force to safeguard quality and choice by preventing price wars leading to a drop in standards and a reduction in the range of services. (The danger is that such coalitions could resist change.) All this power building may be seen as a bureaucratic nightmare, but mechanisms to afford a dialogue between purchasers and providers will be essential.

Achieving integration

With the planning and purchasing forum in place, the real and most exciting work opportunity provided by the white papers is to develop a comprehensive, integrated service for drug users. As a basis for cooperation, it will be important to reach clearly defined common ground on how contracts will operate and be measured, and on what works in treatment and rehabilitation.

An opportunity exists to provide the basis for a national drug treatment and rehabilitation system. On the other hand, poor integration between the NHS and community care sides could lead us back to the days of boundary disputes, arguments about relative responsibilities and confusion for drug users, at a time when we are urging them to come into treatment.

Crucial to a truly national service will be a 'safety net' consisting of an agreed minimum standard of service provision which should be available to residents in each district.

This would cover six areas (see box) reflecting the current pattern of services available to drug users. Using these headings a model framework can be constructed to provide the basic services required to meet minimum safety net standards.

Depending on local need and district capacity, services may be core (ie, provided locally) or non-core (purchased from outside the district). Models already exist of districts buying in another district's treatment service to run satellite prescribing services within the purchaser's boundaries.

Minimum standards would ensure that no districts can opt out of providing basic services; the cost of buying these in would put pressure on them to develop drug services within their own areas. It must be remembered that the model is just a minimum standard; some districts will need more than others.

Most important will be the funding and contract management within the model framework structure. Some districts may gain a bad reputation for failing to pay bills on time or not at all for their residents. The risk is that patients referred from these 'bad payers' may be turned away through no fault of their own, or their treatment delayed until payment was assured.

Problems with bad debtors may also force services to close despite high demand and good quality care. Services could be crippled if some mechanism to underwrite payment and bad debts was not in place. For this reason, all major purchasers and providers should push for the creation of a lead agency. Setting up a US-style district-wide Division of Substance Abuse Services may be the best solution. There may also be an underwriting role for health regions.

DRUG SERVICES must be expanded if we are to have the capacity to act quickly to meet needs, to be flexible enough to respond to new priorities or epidemics, and give due consideration to drug users' rights. Most health plans have a charter to ensure that clients' voices are heard in the debate. Self-advocacy is as important as professional pressure and drug users must speak up in defence of treatment and rehabilitation and support the united call for a special case to be made for drug services. ■

1. Alcohol Concern, SCODA and Turning Point. "Bid to save Cinderella drug and alcohol centres." Press Release, 6 February 1990.
2. Based on figure in Ray Robinson's article "New health care market", *British Medical Journal*, 18 February 1989.