REVISITED

The state of the market

Take an aerial view of the purchaser-provider landscape. That way it's easier to see where you're going

LAST APRIL's NHS and Community Care Act represented the sharpest change to social care funding and delivery mechanisms for decades – and it seemed drug services and their clients would be its first victims. Fourteen months earlier, one of us had described the likely changes to drug service purchasing arrangements and warned of the turbulence to come.[1] Two years before community care, the NHS internal market initiated a restructuring of the health service which has yet to mature.

In both cases the principal objective was to disengage the purchasing of services from their provision, freeing purchasers (health and social services authorities) to shop for health and social care in a mixed market of statutory providers (NHS trusts, social services units), voluntary organisations and the private sector.

How are providers reacting to the upheaval, and how should they react? The first imperative for providers is not to underestimate the extent of the change. Purchasers' decisions are dramatically challenging established patterns of service buying, emphasising local provision and the reconfiguration of services. The models they promote do not necessarily match those of providers. Shifting control of the delivery system from providers to purchasers will continue to be a major priority for purchasers over the next two years; mid-term, the prospects are for increasingly aggressive buying.

The second imperative for providers is not to back away from change, but to engage with the new powers. We are early in the life cycles of both reforms; their growth can still be influenced. So now is a good time to look back on how they have affected drug services, and forward to some emerging issues likely to shape health and social care markets in the future. Into this pot we also throw some recent thinking about service delivery, which is likely to be equally influential.

Councils rise to challenge

Before the NHS and Community Care Act, for most local authorities planning and purchasing drug services was virgin territory. Almost forgotten now, there was a strong lobby to divert the new community care money to health authorities, with their track record in this area. But local government is rising to the challenge. Some important players were acutely aware that the fate of drug and alcohol services would be seen as the acid test of their fitness for new community care responsibilities – their "Achilles heel", as one social services director recently put it.[2] Spurring them on was the knowledge that drug misuse could become a major political issue for local residents, particularly around community safety.

Even before the act was implemented, the process of formalising funding relationships with local councils ranging from informal service-level agreements to detailed contracts generated heated debate. Early concerns that the system would be too bureaucratic and overburden voluntary sector providers have proved well founded, but goodwill, innovation and flexibility on both sides have prevented what remains an unsuitable system turning into a disaster.

The first shock wave of change has now subsided; so too has the disruption it brought to the accessibility and financing of drug services. However, a fresh wave of change has begun as health and social care markets bed down and new resource allocation and purchasing strategies take hold.

Many residential providers, battered by the about turn on the ringfencing of community care funding, were forced into energetic marketing to survive. Most secured a place for their service in the local purchasing strategy.

Local authorities have now set up their assessment and management arrangements for purchasing packages of care. Free to reconfigure services to meet local needs, where possible they have initiated a definite move from residential to day services.

But political will is no substitute for cash and appropriate systems for its dispersal. Last year's allocation of the grant between authorities severely

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Continuing realignment between purchasers and between purchasers and providers characterises the new markets for health and social care. Purchaser-driven changes in service delivery are likely to accelerate as the focus shifts to service outcomes. Services have shown themselves able to adapt to the new environment but there are concerns that inadequate funding is leading to cost-driven decrease in standards. The future lies in documenting service outcomes and in services collaborating to provide a range of provision for their clients.

disadvantaged many urban areas because it was based partly on the location of existing residential homes. Some councils calculated that the grant was unlikely to match independent estimates of need and were forced to allocate extra funding.[3]

Such problems are likely to continue until government comes up with a more sophisticated funding formula and allocation model which properly reimburses authorities in areas with a high demand for drug services. The strain on community care funds in some areas ripples through into problems with residential contracts, as purchasers are forced to limit costs and lengths of stay. Another impact is that hard-pressed urban councils may be unenthusiastic about accepting the care responsibility for their transient and homeless populations.

Next year (1994/95) the whole grant will be allocated according to local needs and population. This step in the right direction will relieve the pressure on urban areas, but further adjustment is needed to compensate for the extent of homelessness in each area. The downside is that the change in the allocation formula will leave some authorities which benefited from the previous system facing difficulty in matching funding to demand.

In the coming years a diminishing proportion of community care funding will be earmarked as the Special Transitional Grant. By 1997/98 it will be subsumed within the overall central grant to local authorities. With most central funds being channelled through local purchasers, services will become increasingly reliant on each local authority's ability to carve out a workable community care budget. The adequacy of local government financing and the efficiency and friendliness of local councils will become central concerns, not just for residential, but also for many non-residential services.

Healthy alliances?

As the local authorities' new purchasing role beds down, fluidity and uncertainty characterise the traditional purchasers of drug services, the health authorities. District health authority (DHA) purchasing boundaries have altered in many areas, and new agencies are likely to form from mergers between DHAs and family health service authorities (FHSAs). Coupled with reductions in the number and status of regional health authorities (RHAs), the health funding environment for substance misuse services is by no means stable.

Mergers creating larger purchasing consortia have fractured natural local service purchasing arrangements. These 'super' districts have the resources to look to a range of services – some well outside their areas – and to tender for new services in underprovided sectors. Providers can no longer be sure who their main funding agency is, let alone whether their service will be on its shopping list.

Such mergers are not universally welcomed. In some cases, such as the South East London Health Agency (SELHA), the scale of the centralisation of purchasing power causes concern and seems to mitigate against the emphasis on localism. For now, most districts are happy to be learning about working with their local FHSA partner without entering into grander alliances.

These developments probably mean the end of district-based drug advisory committees as the place where providers have a say in local policy. Uncertain of where they stand across the purchaser-provider split, and unable to shadow changes in purchasing boundaries, these forums seem fatally flawed. As these and other familiar oversight structures, such as the RHAs, are being superseded, how will the market for drug services be coordinated?

One tier up from the RHAs are the Department of Health's policy divisions, able to influence local spending decisions by earmarking grants for specific activities – methadone, syringe distribution, drug misuse, HIV/AIDS. But these divisions, and with them the role of central government grant making, are also under review; their influence is likely to diminish. Many health agencies feel that tying government grants to particular services is out of step with *local* business planning and decision making. Like the local councils, they want to be free to spend their money where they feel it will reap the greatest benefit for their residents.

Under this pressure, the immediate trend is likely to be towards undifferentiated central grants based on the number and nature of the local population. As with social services, the absence of adjustments to reflect homelessness, HIV rates, etc, could mean that the grant does not reflect the local need for substance misuse services. Without a protected pot of money to draw on, services now dependent on earmarked funds may find their local health funders allocate insufficient cash.

As local and health authorities restructure, tentative moves are being made to bring the two together. Joint health and local authority care plans are being considered, designed to link two coterminous purchasers into one larger consortium.

Some local authorities have created 'joint drug focus groups', bridging the

PRESCRIBING: COSTS AND QUALITY

Two important components of the response to drug problems and HIV – methadone programmes and community outreach – are receiving close scrutiny. Both are likely to emerge with renewed impetus but in a different direction. Most instructive in the present context is how the tension between purchaser and provider concerns is playing itself out with respect to methadone prescribing.

Purchasers have been unclear why there is no provider consensus about methadone doses and the benefits of the intervention. The ACMD too has questioned current maintenance programmes, finding that some lack clear structure and purpose meaning drug users become "stuck for a prolonged period at an intermediate goal".[10] They called for structured oral methadone programmes, which have received positive research evaluation internationally, to be piloted in the UK, carefully studied and regulated through protocols and standards.

Costs as much as research will shape the future of methadone maintenance in Britain. Services which allow open-ended self-referral of patients – the ideal for controlling HIV – but are funded by a block contract, find themselves in an economy trap: their funding is finite, yet methadone costs escalate as client volumes and dose levels increase.

This is the dynamic pushing services towards the cheaper US practice of on-site dosing, and towards structured counselling programmes which aim to move clients through a process of change, preventing the costly accretion of long-term patients. Apparently pushed to one side have been the advantages (convenience for the patient and normalisation of their treatment) of allowing selected drug users 'take home' doses dispensed at local pharmacies.

In the UK, user involvement and flexibility will be essential as guidelines are developed. Programmes inappropriately standardised with costs in mind risk losing their patients to the illicit market or the private prescriber.

The general practitioner is also being seen as a way out of the prescribing economy trap, with clinics referring 'stabilised' drug users back to their GP.

health-local government divide to complete a specific planning task over a limited period. Increasingly these will involve probation departments, which are preparing to become more substantial grant makers. It is not clear whether such arrangements will work in the new markets – nor whether the purchasing partners will be able to agree where social care ends, and health care begins.

Providers adapt and survive

Voluntary sector residential providers are now fully into the contract culture. Most have adapted to the new environment. Monitoring by Goldsmiths' College revealed considerable variation across the country in local authority assessment procedures, aggravating services' administrative burdens and financial anxieties.[4] Rather than caving in, agencies have shown a marked resilience and readiness to adapt. Cushioned at first by residents with preserved funding under the old system, many residential projects shortened programme length and budgeted to survive on reduced income.

Services that have adapted successfully have been able to manage costs, communicate their value to purchasers, and implement effective marketing strategies. Others have chosen an alternative destiny and opted out of the community care system by de-registering as care homes. By last September the residential market had undergone considerable restructuring, with the loss of some 400 registered beds (down 16 per cent) due to de-registration and bed losses.[5]

Providers are now being driven through contract specifications to develop guidelines and protocols which explicitly state services to be delivered and quality standards to be met. However, in many areas they are expressing concern that price cutting will see a reduction in standards and quality.

In the longer term, residential providers will maintain their place in the market only through a concerted effort to prove the positive impact of their programmes. As information on the costs and results of residential rehabilitation become more available to purchasers, competition between providers may become fierce. Purchasers may move towards licensing organisations to vet them before they are admitted to the local provider network, with periodic review.

What is missing in all this is independent, expert advice both sides can refer to. One candidate could be the NHS's Drug Advisory Service, which might play the role of assessor, measuring performance against external standards.

Also missing is a strong national lead. A Central Drugs Coordination Unit attached to the Privy Council Office is being developed,[6] but at the moment there is something of a vacuum in national strategy. National bodies are trying to keep communications open, but moves towards coalition and partnership are slow. Vested interest in your own service, or suspicion of it on the part of other services, impedes the sharing of information and the pooling of influence over government. In this policy void, larger agencies are relying on their own business plans as the driving force for developments.

> The challenge for providers is to overcome a competitive and suspicious climate

Without outcome measures or national policy to guide purchasing, *local* has become the chief marketing slogan, with agencies attempting to become preferred providers for their host local authority. The future is likely to be in purchasers selectively contracting with local preferred providers. The alternative spot contract approach – taking each case as it comes and choosing from services across the country – maximises client choice but does not lend itself to developing relationships with purchasers. A close relationship with a local purchaser maximises the security of the service and can provide for development as well as maintaining current provision.

To do the best for clients, services need to do more than simply survive – difficult as that has been. Just as the system needs a strong purchaser side, so it needs providers to be strong in defence of *their* bottom lines. It is imperative for them to stand fast against market pressures to standardise programmes and argue instead for a rich *diversity* of innovative provision.

The challenge for providers will be to overcome a competitive and suspicious climate and build credible networks across the statutory-voluntary divide. Instead of waiting for purchasers to do it for (to) them, ideally providers will come together to hammer out who will do what for which group of clients and to identify unmet need – with the best possible local network as their prime aim, rather than individual service survival. They will then be in a position to present advice which the purchaser(s) will feel is credible enough to integrate into their planning processes.

For this to happen, leadership from the field must not be compromised by self-interest but seen to be exercised in the interests of clients. The alternative is a dog-eat-dog scenario, services doing each other down with survival the prime objective. In some areas this is closer to the current reality.

Among statutory providers there has been a marked reduction in NHS inpatient detoxification and specialist beds, resulting in admission delays. Some purchasers have been quick to use equivocal findings on the effectiveness of these services to justify their cooling interest in funding them. In contrast, community services have flourished. Recently the Advisory Council on the Misuse of Drugs (ACMD) recommended that balance must be restored, with purchasers commissioning both community services and the specialist units needed to back up and complement their work.[7] One of their other major recommendations, for structured methadone maintenance, concerns an area where costs are likely to be important in shaping service delivery (see panel, p.9).

It is not just the purchasers who will be pressuring statutory drug services. The

1. Mason P. "The state of the market." *Druglink*: 1992, 8(1), p. 8-9.
2. Peter Hewitt speaking at the Local Government Drugs Forum conference "Community care for substance misusers", 26 January 1994.
3. Marsden J. *et al. All change after the DSS*. SCODA, Turning Point and Alcohol Concern, 1994.
4. MacGregor S. *et al. Vulnerable services for vulnerable people*. London: Goldsmiths' College, 1993.
5. MacGregor S. *et al*, op cit.
6. Home Office. "New unit to foster partnership in fight against drugs." News Release, 16 December 1993.
7. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse: update*. HMSO, 1993.
8. Mason P. op cit.
9. Williams H. and Webb A. *Outcome funding: a new approach for public sector grantmaking*. Rensselaerville Institute, 1992.
10. Advisory Council on the Misuse of Drugs 1993, op cit.
11. Department of Health. *Specific grant for making payments to voluntary organisations providing services for alcohol and drug misusers*. Local Authority Circular LAC(94)2, 1994.
12. Marsden J. and Killoran E. *Outcome monitoring for drug and alcohol residential care in Greater London*. Turning Point, 1993.
13. Greater London Association of Directors of Social Services. *Memorandum of understanding for a coordinated purchasing strategy for residential drug and alcohol services in Inner London*. London: GLADSS, 1993.
14. Marsden J. and Keaney F. *Matching clients with alcohol or drug problems to optimal treatments*. Centre for Research on Drugs and Health Behaviour, 1994.

Such measures are, of course, only the starting point for a assessment of outcomes as in themselves they cannot determine whether change was due to service intervention

OUTCOME FUNDING IN PRACTICE

For the last two years, Rensselaerville's outcome funding principles and methodology have been piloted by North West Thames RHA for the delivery of HIV and substance misuse services. Now the Department of Health is taking the radical step of applying outcome funding to all new bids under the specific grant for voluntary drug and alcohol services in 1994/95.[11]

"The focus is on outcomes rather than processes", says the DoH circular. "Proposals which state an intention to, for example, run training workshops, carry out liaison functions or outreach to the community will not be acceptable. Clear targets and outcomes must be identified."

Applying this approach to the specific grant may have a profound impact on the future. We are, for example, ideally positioned with the *Health of the Nation* framework to develop more targets in the drug field using outcome funding methods.

In a complementary way, the GLADSS group of social service directors in London has been considering substance misuse treatment outcomes.[12] An agreement between inner London local authorities on a coordinated purchasing strategy stipulates that placements in residential care are based on three-month episodes "pending a further assessment of both individual needs and the success of agreed care plans in meeting desired outcomes".[13]

In the coming year, a project to establish a standardised assessment protocol and outcome monitoring system for residential care is to be piloted among inner London authorities. The protocol serves as a 'front end' to the assessment and is designed to ensure that local authorities purchase a package of care matched to the individual's presenting needs. If successful, this could be repeated after rehabilitation to measure outcomes in terms of the before-after change.[14]

A central outcomes information clearing house to aid both purchaser and provider thinking in this area is looking more and more attractive.

Outcome misuse

The Rensselaerville model is firmly based on partnership between purchaser and provider to achieve results. But a hostile funder could latch on to the model's emphasis on outcomes to put services on the spot – 'Put up or (literally) shut up'. What follows is a short list of some of the concerns most often expressed about outcome funding and responses to these based on experience in the USA and the UK.

Q *Can performance targets be too high?*

A This often happens when the approach is unfamiliar and a track record of achievement has yet to build up. Outcome funding encourages providers to know what they do and enables course corrections to be made to reach targets. It is better to set targets that encourage high achieving than ones which do not require a stretch to reach them.

Q *Does the model lead to 'creaming' – selecting only those easy to treat?*

A Creaming is neither harder nor easier to do under outcome funding, but it is harder to hide. Outcome funding makes explicit through the customer specification who is being helped and who is not. Creaming can be controlled by the investors as they will get what they ask for and buy.

Q *Can purchasers use outcome funding as an excuse to threaten providers with withdrawal of funds?*

A Nothing in the model guarantees this will not happen. However, outcome funding stresses collaboration. A heavy-handed approach benefits nobody, including the purchaser, who will have wasted their investment to date. Purchasers also are judged by results: there is no glory for them in taking back money because results have not been achieved. The point is not to preserve money, but to spend it to create the greatest possible gain. The interdependence this creates between investor and provider is essential for this model to develop in the UK.

provider bodies of which many services are a part have their own agendas. With the application of corporate business plans, many mental health and community trusts are now pursuing an aggressive marketing strategy. Component services may find themselves forced to tender competitively for contracts; some will have to work hard to prevent pressure to reduce the trust's costs affecting their own resources. Those which see the writing on the wall may look outside their trust to form businesslike mergers and partnerships between statutory and voluntary sector agencies.

The big issue: outcomes

Purchasers are increasingly pushing for a demonstrable return on service investment in terms of health gain and improved social functioning. For example, the Greater London Association of Directors of Social Services (GLADSS) has taken the lead in developing a coordinated purchasing strategy for residential care. Their objectives have included the establishment of performance and quality measures.

Early social and health care contracts tended to focus on the volume of the *service* to be provided.[8] Today, value for money and quality are still important, but service outcomes are uppermost in the minds of government, purchasers and providers. As yet there is no clarity or consensus over the types of outcomes to be expected from substance misuse services nor how these should be measured.

However, developments are under way which will ensure that this issue remains on top of the purchaser-provider agenda. Outcome funding, a new approach for purchasing services using a results-based partnership model developed by the Rensselaerville Institute in the US, has aroused great interest in the UK (see panel).[9] In contrast to traditional grant making, which funds programme activity (inputs), outcome funding shifts purchaser-provider thinking towards customer involvement and the setting of performance targets with milestones to monitor progress towards the target.

This new thinking offers opportunities to simplify development and funding procedures for projects and to sharpen the effectiveness of purchasing strategies. However, there is no gain without pain. Outcome funding requires purchasers to become far more active partners in the design, development and monitoring of services than ever before. Providers will have to be much clearer about what results they can achieve with which clients, and how they can verify those results.

Purchasers and providers ideally see themselves as partners with a mutual interest in achieving desired outcomes. Rather than leaving provider partners to fail, the effective purchaser will have a relationship with services which permits problems to be jointly addressed before they get in the way of meeting targets. How these new relationships mature remains to be seen, but there are encouraging signs that a new era in fostering partnerships for community care may be around the corner.

For More Information

❑ **OUTCOME FUNDING: A NEW APPROACH FOR PUBLIC SECTOR GRANTMAKING.** Williams H. and Webb A. Rensselaerville Institute, 1992. UK edition.
Available from NCVO Publications or The Innovation Group, 31 Totterdown Street, London, SW17 8TB, phone 081 767 6577.