The state of the market

How the players are lining up across the purchaser-provider divide

THE PURCHASER-PROVIDER split has become the central concern for the health authorities in year one of the NHS and Community Care Act. The **purchasers** in the blue corner are now a mixture of regional health authorities (RHAs), district health authorities (DHAs) and family health service authorities (FHSAs), including GPs. In the red corner are the **providers** – NHS trusts and district units and, particularly in the community and mental health field, a range of independent providers in the voluntary and private sectors. The state of play between and within these two camps – competitive or cooperative – and the balance of powers will be crucial for the maintenance and improvement of drug services.

The basic assumption is that purchasers will now buy drug services from the providers on behalf of their resident populations. This mechanistic division between purchaser and provider is being seen as the real powerhouse of the NHS changes. DHA-level purchasers are now being identified and commissioning teams and contract managers have been appointed. All over England, DHAs and FHSAs are now pooling their purchasing functions and larger commissioning agencies and consortia signal the way forward.

Amidst all this structural movement there has been little time for discussion about shared values and visions about how services should be provided for drug users. Furthermore, there is the realisation that little information exists to guide purchasing decisions.

Voluntary agencies are still facing uncertainty in many districts as they struggle to arrange contracts with purchasers. This is particularly noticeable for the counselling, advice and information services and the residential sector, where the debate about health care costs versus social care costs plagues negotiations. This latter debate, although helped by the recent research from Turning Point,[1] is still messy at the margins. In addition, the Department of Health is in discussions about how the specific grant for community care in the drug and alcohol field will be disbursed post 1993.

Recently the Association of Directors of Social Services declared that underfunding and chargecapping threatened their existing statutory obligations to community care. The chances of local authorities wishing to take on 'core funding' of residential services or even to eke out more 'topping up' payments for drug users seems remote at this stage. Overall, the discussions between local and health authorities about community care plans for drug users are moving slowly.

Risks of blocking

As with contracts in other areas of work, most of the energy being put into purchasing drug services is being expended on allocating large amounts of money, much of it being spent within the NHS. However, large voluntary sector organisations are also expanding.

The two main types of contracts being used by the NHS are:

by

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> The purchaser-provider split is meant to open the health market to independent providers (private and voluntary) but this movement is hampered by confusion between health and social care costs and by 'steady state' policies which favour NHS units. Fixed payment contracts can act as a disincentive to taking on extra patients, particularly due to the unnecessarily high cost of methadone treatment. In this transitional period it is important to maintain earmarked funding while purchasers and providers gear up for post-1993.

❑ **Block contracts**, where the arrangement is to deliver a particular service for residents/service users from the purchaser's area. The cost of the contract is agreed at the start of the year and usually does not change. Paying a fixed amount of money for unspecified work levels mirrors the grant-aid system.

❑ **Cost and volume.** This contract is more specific and states how much service will be provided for a given number of residents at an agreed cost. The cost can be varied depending on the levels of activity actually achieved. These contracts could become more refined with exact rates being worked out in the future.

Grant funding continues when small amounts of money are involved, and purchasers are being urged to continue to earmark development funds to support research, development and innovation.

Most contracts in the drugs field are block contracts. Many DHA purchasers have opted for large outpatient drug dependency units to be granted 'self-referral status'. This should ensure that drug treatment is an essential element of the district provision, and that hospital services treat all comers without the intervention of bureaucratic delays such as boundary disputes.

However, the high cost of methadone is problematic in self-referral block contracts. If more referrals are taken on than are provided for in the working agreement, then the provider loses money due to 'excess' methadone prescribing – or, more likely, is forced to place excess referrals on a growing waiting list, defeating the accessibility objective inherent in self-referral status.

The result is that there is a perverse incentive either to refuse self-referrals or to shift the cost of methadone prescribing on to GPs. In contrast, a case-by-case payment system, or some guarantee that methadone costs would be covered, would encourage services to open up to more new patients.

Residential services, particularly those

where a 'health care' component can be identified, and inpatient drug units are now entering into block contract arrangements with DHAs and RHAs. However, there are growing concerns from the voluntary sector that self-referrals and direct referrals to hospitals or the residential sector are beginning to be blocked unless the referral is made by a doctor and complies with the district's extra-contractual referral mechanism. It is clear from the demands for out-of-district referral to local detoxification beds that local supply is limited for these patients in the NHS.

A major problem for the voluntary sector in the contract culture is that many old grants have just been rolled into contracts; the price remains the same leaving many services stuck in an underfunding position.

Level playing field?

At this early stage in the uncoupling of the purchasing and providing function it is unclear how sharply the providers really will separate from the purchasers. For decades these two functions have been unified in the health service's management structure, and the suspicion is that a 'special relationship' will remain which favours NHS or former NHS provider units. Independent providers are concerned that the 'level playing field' is not quite as even as it should be.

At the moment there is a clear bias to statutory services which in some ways can be explained by the 'steady state' approach – providing what was provided last year. Doing this inevitably means the statutory sector will get the lion's share of the contracts. This could change in future years. Once beyond the safety of simply doing what was done before, purchasers will require information on which to base decisions – information on help-seeking, demand, assessments of unmet need, outcome and client choice among others.

Claims are being made by NHS drug services that they would beat independent providers if it came to a contest over health outcomes. But before throwing down the gauntlet to the non-statutory sector, the NHS would do well to put its own house in order. Already there are signs of internal pressures with outpatient treatment, GP prescribing and inpatient detoxification services all in short supply.

In all this turbulence, the power is difficult to locate; each side has their own. The providers' strength lies in their understanding of the services and of the clients. Provider coalitions are gaining support; the SCODA/Turning Point/Alcohol Concern campaign has shown what can be done by agencies lobbying on behalf of clients and services. These should start to broaden out and be more collaborative between statutory and non-statutory providers.

"There is concern that the 'level playing field' is not as even as it should be"

The purchasers' strength lies with their public health vision and financial muscle. However, this should not frighten providers in the drugs field. Any reduction in service is normally politically problematic and in some districts resource levels may already be insufficient to address needs. RHAs are being looked to as the regulators "ensuring contracts are met with the emphasis on health outcomes".[2] Not all RHAs will adopt this role, but as long as earmarked funding for drugs and AIDS work continues, someone will have to report on its spending.

Focus on outcomes

What goes into contracts is the big question and no one yet has all the answers. Clearly the way forward is to start to define what is being delivered and what the benefits are. In practice, the easily measurable nitty gritty of the service's expenditure and activity have become the starting place. This is perhaps dangerous as it could tie up hours of purchaser and provider time in elaborate audits of staff, rent, phone bills, expenses and so on. However, it is a start, and this information plays an important role in strategic planning. But we would do well to use all available information to focus the attention of purchasers on the broad range of health and social outcomes for our clients.

For services to survive they must understand the complex dynamics between purchaser, provider and regulators. They must understand that the political environment has changed and that purchasers are under increasing pressure to enforce accountability and value for money. To balance these 'business' pressures, providers, purchasers and regulators must share the same values and commitment to health that underpin the principles of the NHS, and maintain services for drug misuse as a national priority.

This transitional period as the health market opens up and local authorities prepare to take over community care funding is a crucial one for drug services. Within the NHS the trend is to devolve funding down to district health authorities based on 'capitation formulas' which assess the population's needs based on a range of social and health indices. But in the drugs field work on capitation formulas cannot seriously go forward without more information on prevalence, help-seeking, demand activity and a range of social indicators pertinent to the extent of drug problems in communities.

Until these are identified and measured, and until the new community care funding system has bedded down after 1993, government should continue its earmarked allocation of drugs and AIDS money to regional health authorities.

There is now an opportunity to develop a diverse range of local services which focus on outcomes, but this can only be done through partnerships, not winner-takes-all competition or monopolies. What's needed is an agreement between providers and purchasers over who provides what, focusing on maximising positive health outcomes for the clients.

ABOVE ALL ELSE drug services should not marginalise themselves but must stand in the mainstream of public health. Work must be started to identify what goes into the minimum standard service framework previously outlined in ***Druglink***.[3] ■

1. Marsden J. *et al. All change after the DSS*. SCODA, Turning Point and Alcohol Concern, 1991.
2. Parston G. *et al.* Health Service Journal: "Over the road to health gain." July 1991.
3. Mason P. "Dealing with the health market." *Druglink*: 1990, 5(3), p.8-9.

FOR MORE INFORMATION

■ **DEALING WITH THE HEALTH MARKET.** **Peter Mason.** ***Druglink*: 1990, 5(3), p.8-9.**
Recommends that providers and purchasers form coalitions and agree minimum service standards.
Copies available from ISDD's library, £0.60, phone 071-430 1993.

■ **A FUTURE FOR ALCOHOL AND DRUG MISUSE SERVICES. Department of Health, 1991.**
A DoH-funded report giving guidance to the voluntary sector on the implications of the NHS and Community Care Act.
Available from David Whitfield, DoH, Wellington House, 133 Waterloo Road, London SE1 8UG.