Purchasing for quality: still in the starting blocks?

Mike Gill

The NHS is now in its third year of contracting. We are repeatedly told by the Department of Health that purchasing is "the main vehicle for achieving better health and better health services."¹ To what extent are health authorities in a position to ensure more equitable distribution of health by commissioning the most appropriate package of high quality and value for money services?² Below I advance the thesis that, although some progress is being made in purchasing for efficiency, it is proving more difficult for other dimensions of quality, particularly appropriateness.

On the national and international level we await a verdict on the effects of the introduction of competitive principles into health care systems.³ Gains in what is described as "efficiency" may need to be set against reduction in access to health care and greater inequity in service delivery.⁴ At the local level the enormous pace of organisational change makes it hard to tease out the contribution of purchasing itself to changes in the quality of service delivery. In any case, for providers several forces are already driving quality, such as postgraduate and continuing education, medical and clinical audit, and accreditation. Although the potential of the internal market to contribute 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 "quality monitoring report," cobbled together by a manager who is second in line, provides adequate balm.

There are several reasons. Three merit emphasis: financial pressures; the shortcomings in the information on hospital and community activity; and, at least by standards in the United States (US), the poor state of development of indicators for "appropriate care."

Focus on maintaining volume, not value

Firstly, the enormous financial pressures, faced by health authorities and trusts alike, have pushed the issues of "volume" and "price" into overwhelming prominence in the contracting process, especially for districts losing revenue through capitation funding. The main objective seems to have been "damage limitation" rather than the introduction of imaginative approaches to quality improvement.

Deficiencies in information

Secondly, there are persisting problems with

the availability of information. Purchasing organisations are only now beginning to recover from two serious blows to information systems. The first was implementation of the Körner report, the second the reforms themselves. The Körner report's main effect on hospital information systems has been to make measures of activity (completed consultant episodes) less, not more, related to cost than what they replaced (deaths, discharges, and transfers).⁵ Contracting on the basis of specific conditions for which specific interventions are indicated remains hard, since we are still poor at knowing how to assess the effects of case mix on overall costs: cross subsidisation of costs between specialties, procedures, or contracts is not officially allowed, but breaches are nigh impossible to detect. The currency of the completed consultant episode has proved so difficult to use in practice that, as Jarman's recent analysis showed,⁶ any attempts to make sense of aggregated hospital data after the demise of Hospital Activity Analysis and Hospital Inpatient Enquiry in 1986 seem to require personal communications from the Department of Health to fill in data for subsequent years.

The reforms themselves have made the air so stiff with the rhetoric of competition that

*The reforms themselves have
made the air . . . stiff with the
rhetoric of competition . . .*

district health authorities (DHAs) have technically had access only to information on health service use by their own residents and not to that on use by residents of other authorities, even within their own region. Activity information relating to a whole hospital has most certainly not been available to DHAs, except that which statutorily appears in trusts' annual accounts, or unless DHAs collaborate to reaggregate a provider unit's data. The Department of Health's health service indicators have been insufficiently timely to keep pace with the rapidity of changes either in health care delivery, particularly in day case work, or in the configuration of provider units as trusts.

These shortfalls in information quality and flow have been major constraints. Purchasers have had to negotiate for similar volumes of activity with, often, less money at their

disposal, while hampered by inadequate descriptions of activity in the first place. 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.

Many purchasing organisations are now trying to change the basis and currency of contracts – for example, in elective work by contracting for numbers of patients who will have particular procedures or for new outpatients. GP fundholders have been quick off the mark here. But both provider and purchaser have reasons for “playing the system,” providers because patients can be assigned multiple completed consultant episodes, purchasers because they are held to account for their performance on the “efficiency index.” If purchasers are to concentrate as much energy on improving the quality of services as they have to date on maintaining and monitoring the quantity, they will need to have more confidence in measures of quantity and enjoy access to comparative activity information as least as good as DHAs had before Körner.

Trusts may now begin to come from behind their screens and realise that competitive advantage lies in laying out, not hiding, their performance indices. In London the specialty reviews after the Tomlinson report may have hastened that process. The importance of purchasers and providers sharing information is now being explicitly recognised by the NHS Management Executive and positively encouraged. “Purchasers cannot hope to improve quality and value for money if they have little or no information available to them about the performance of providers. 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 . . . The expectation is that the discussions around contracts will take place within the context of shared information so that robust and challenging negotiations can take place to the benefit of the health of and the service to patients and the general population being served.”⁷

Appropriateness

The third obstacle to progress is the limited attention so far paid in the United Kingdom (UK) to generating indicators of that key dimension of quality, appropriateness of care. In the US the RAND/UCLA Group, for example, has developed guidelines for more than thirty procedures or interventions, based on the consensus views of expert panels.⁸ These are used by insurance companies as a basis for limiting entitlement to reimburse-

ment. In the UK, where such an approach to defining standards of appropriateness and measuring performance against those standards has been followed, the results have been surprising.^{9 10} The rate of inappropriate use of procedures has been deemed high by both “appropriateness” panels in the UK and US, despite the rate for the procedures in question in the UK being low compared with in the US and there being long waiting lists. This confirms the findings within the US that the likelihood of a procedure being used inappropriately is unrelated to the rate of use of the procedure in the local population.^{11 12}

For purchasers the result is that in the face of wide variations in the rates of many interventions across the country, and in the absence of a regional or national consensus on appropriateness except in a few (but growing number of) areas, it remains hard to use contracting to improve this dimension of quality. Instead the patient’s charter generates its own “quality” requirements, for waiting times, for example, with more energy apparently being spent trying to meet these targets than to question whether patients were appropriately on the waiting list in the first place.

Implications for audit

The scene is changing fast. The output from the Outcomes Clearing House and the Cochrane Centre in combination with the *Effective Health Care* bulletins and the “Purchasing for Quality” series in this journal should go some way in sharpening our knowledge not just of “what works?” but also “for whom?” This in turn is likely to have fundamental effects on the focus and sharing of audit programmes. In future we can anticipate that purchasers will request evidence of the quality both of the *process* of care itself (technical competence) and of the decisions about who received particular interventions (appropriateness). No longer, therefore, can audit be seen as an activity engaged in by consenting adults within the privacy of a provider organisation. Providers and purchasers alike are beginning to understand that the content and outcome of audit activity are issues in which both parties have a legitimate interest, and which can reasonably be subject to contract. There is no doubt that the *Health of the Nation*¹³ has been a spur to this. If DHAs are being held to account for making progress in the five key areas, then so too should the providers with which they contract. Audit is one means of focusing and monitoring that progress. Packwood *et al* foreshadowed this: “contract specification by purchasers would . . . determine the nature of medical audit, representing a significant shift away from the principles of professional and provider control that initially shaped its organisation.”¹⁴

This shift has its own risks. Firstly, the effectiveness of audit activity within the provider unit must not be threatened by concerns about the use of the data generated: degrees of access to data should be defined for

all users.¹⁵ Secondly, requests by purchasers for specific audit activities under the banner, for example, of *Health of the Nation* might be felt reasonable in the first year or two, but will soon sound repetitive. Purchasers will have to display imagination and sensitivity if providers are to be kept enthused.

Appropriateness should be the axis around which the purchaser/provider relationship can evolve. As Frankel pointed out, the method required to define the indications for a

Appropriateness should be the axis around which the purchaser/provider relationship can evolve.

particular intervention is *the same* (my emphasis) as that required to determine the population distribution of those indications.¹⁶ In addressing appropriateness, and doing so collaboratively, the stakeholders, including the local population, will be addressing the issue of quality of care to the community, not just to the individual. Particularly in a cash limited system, there has to be as much emphasis on *who* is getting access to a particular service as on other dimensions of quality. Clinical thresholds for intervention will need to become a legitimate focus for discussion between purchasers and providers. The alternative for purchasers will be to leave unaddressed the possibility that while the total amount of service bought, for example, cardiac surgery, seems reasonable for their population and the cash available, access to the service is not determined by relative needs.

Outcome

Other benefits are to be gained from paying more attention to appropriateness. A system which allows confirmation that appropriateness criteria are applied in the individual case and in aggregate should in principle reduce the difficulties in interpreting outcome data; both case mix and the outcomes of interest are defined, even though in practice comparison between hospitals or patient groups will always be complicated by differences in comorbidity or severity.

CASE MIX

Purchaser and consumer involvement in quality has been taken for granted in the US for years, and comparison of death rates in hospital is public. The UK approach has been much more cautious. The argument is advanced that death is a relatively insensitive measure of quality of care, subject to serious confounders, such as length of stay, and only one of several outcomes in which patients and purchasers might reasonably be interested.¹⁷ Recent attempts to compare publicly death rates among hospitals in the UK raised hackles,¹⁸ and indeed there are probably good

reasons why the findings of the Confidential Enquiry into Perioperative Deaths as they apply to a particular hospital should remain confidential. But why should it be so difficult to say which is the “best” centre for a patient to have a CABG¹⁹ or breast cancer managed?²⁰ Surely the consumer is owed a better answer than one which emphasises confounding factors and thus makes decisions harder instead of easier? It is still not seen as part of a provider unit’s “marketing strategy” even to define, let alone publicise, the outcome measures which bear on such questions.

WHOSE OUTCOME MEASURES?

The NHS Management Executive Director of Research and Development Working Group’s report on appropriateness emphasises bringing appropriateness to the foreground, so that purchasers and providers are confronted by the need to take seriously the experiences and preferences of patients.²¹ Twenty years ago papers published in refereed journals still contained statements that the views of patients who had undergone prostatectomy were inherently fallacious.²² The work of Wennberg²³ and others researching outcomes of prostatectomy and the widespread interest in developing outcome measures beyond those reflecting technical competence make it less likely that such arrogant claims would now be published. The challenge now is to ensure that the discussion of appropriateness is not based on the fallacy that the lay views and those of clinicians coincide.¹⁶

Future prospects

The hope is that it will not be long before purchasers will spend as much time successfully challenging ineffective or inappropriately accessed clinical practices as trying to contract within budget. Two factors in particular will make the going rough: the patient’s charter and GP fundholding.

Whatever its undoubted value, the patient’s charter has the potential effect of requiring purchasers to spend more, not less, on hospital care, at a time when the trend is supposed to be in the opposite direction. Consider waiting time for an outpatient appointment. Meeting the charter’s requirements is conceived as a matter entirely for the providers. But the demand side, the referring GP, is central. For this reason clinical audit must increasingly embrace not just outpatients but also the general practice/outpatient interface. DHAs and family health services authorities (FHSAs) have an important catalytic role here.

For GP fundholders a main concern is to improve their own patients’ access to secondary care. For DHAs and FHSAs “contracting for health gain” at a population level is already hard enough, given, for example, the quality of our information systems. It will be immeasurably harder to get a multiplicity of purchasers not only to agree a service specification containing explicit intervention thresholds but also to live by it, when GP fundholders, who are already allocated more pounds per head of practice

population for elective care than DHAs have characteristically been spending, are being wooed by provider units offering short term cut price deals. The picture is complicated further since such interventions may give rise to tertiary referrals, which the DHA is obliged to fund.²⁴

In conclusion, it is now time to start using the contracting framework to deal with the fact that many patients receive too few services and some patients too many. This will require close collaboration between providers, purchasers, and the public. Its main objective will be the increasingly widespread development and application of appropriateness indicators. The beginnings are necessarily piecemeal. The result is unlikely to lead to the widespread introduction of "pre-procedural reviews of appropriateness" such as exist in the US. But it will have an impact on the content and sharing of audit activity, and it will enable health authorities to assess their populations' requirements for particular interventions in a more focused and contractually relevant way.

- 1 Appleby J. Department of Health sets priorities. *BMJ* 1993;306:1227.
- 2 Adam S. Purchasing for quality: the provider's view. Introduction. *Quality in Health Care* 1992;1:65-7.
- 3 Organisation for Economic Development and Cooperation. *The reform of health care: a comparative analysis of seven OECD countries*. Paris: OECD. 1992.
- 4 Ham C. *Health care reform*. *BMJ* 1993;306:1223-40.
- 5 Clarke A, McKee M. The completed consultant episode: an unhelpful measure. *BMJ* 1992;305:1307-8.
- 6 Jarman B. Is London overbedded? *BMJ* 1993;306:979-82.
- 7 Greenshields G. *Costing for contracting*. London: NHSME, 1993. (EL(93)26.)
- 8 Brook RH, Koseoff J, Park RE, *et al*. A method for the detailed assessment of the appropriateness of medical technologies. *Int J Technol Assess Health Care* 1986;2:53-63.
- 9 Gray D, Hampton JR, Bernstein SJ, Koseoff J, Brook RH. Audit of coronary angiography and bypass surgery. *Lancet* 1990;335:1317-20.
- 10 Bernstein SJ, Koseoff J, Gray D, Hampton JR, Brook RH. The appropriateness of the use of cardiovascular procedures. *Int J Technol Assess Health Care* 1993;9:3-10.
- 11 Chassin MR, Koseoff J, Park RE, Winslow M, Kahn KL, Merrick NJ, *et al*. Does inappropriate use explain geographic variations in the use of health care services? A study of three procedures. *JAMA* 1987;258:2533-7.
- 12 Leape LL, Park RE, Solomon DH, Chassin MR, Koseoff J, Brook RH. Does inappropriate use explain small-area variations in the use of health care services? *JAMA* 1990;263:669-72.
- 13 Secretary of State for Health. *The health of the nation*. London: HMSO, 1991.
- 14 Packwood T, Kerrison S, Buxton M. The audit process and medical organisation. *Quality in Health Care* 1992;1:192-6.
- 15 Shaw C. *Speciality medical audit*. London: King's Fund Centre, 1992:29.
- 16 Frankel S. The epidemiology of indications. *J Epidemiol Community Health* 1991;45:257-9.
- 17 Hopkins A. *Measuring the quality of medical care*. RCP Publications, 1990:33-41.
- 18 Dicing with death rates. [Editorial]. *Lancet* 1993;341:1183-4.
- 19 Kennedy JW, Kaiser GC, Fisher LD, Maynard C, Fritz JK, Myers, *et al*. Multivariate discriminant analysis of the clinical and angiographic predictors of operative mortality from the collaborative study in coronary artery surgery (CASS). *J Thorac Cardiovascular Surg* 1980;80:876-7.
- 20 Basnett I, Gill M, Tobias J. Variations in breast cancer management between a teaching and a non-teaching district. *Eur J Cancer* 1992;28A:1945-50.
- 21 Report of working group prepared for the Director of Research and Development of the NHS Management Executive. What do we mean by appropriate care? *Quality in Health Care* 1993;2:117-123.
- 22 Chilton CP, Morgan RJ, England HR, Paris AM, Blandy JP. A critical evaluation of the results of transurethral resection of the prostate. *Br J Urol* 1978;50:542-6.
- 23 Fowler FJ, Wennberg J, Timothy RP, Barry MJ, Mulley AG, Hanley D. Symptom status and quality of life following prostatectomy. *JAMA* 1988;259:3018-22.
- 24 NHS Management Executive. *Tertiary referrals*. London: NHSME, 1992. (EL(92)97.)