Purchasing for Quality: the Providers' View

Introduction

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This new journal is launched at a time of unprecedented change within British health care. The NHS reforms^{1 2 3} are now in place and have resulted in, among other things, a new emphasis on health status and health outcomes.

*The Health of the Nation*⁴ was published in June 1991, and the results of consultation will be drawn together with a view to publishing a white paper this spring. This is likely to highlight the importance of multisectoral action to promote health nationally and locally but will also require a more critical appraisal of the role of the NHS itself and the responsibilities of health professionals.

Pieces of the jigsaw

The introduction of the NHS reforms has established a climate for change and stimulated activity in a series of related but often disparate areas:

- Medical audit and clinical audit
- Quality assurance
- Effectiveness
- Appropriateness
- Health outcomes
- Research and development
- Health technology assessment
- Postgraduate and continuing education
- Health needs assessment
- Economic appraisal.

It has been important to focus energy to enable early progress, but we now need to begin to bring the work together in a more integrated drive for quality. Those who are developing ideas in each of these areas also need to establish clear interfaces with both purchasers and providers to ensure implementation of their evolving ideas.

Purchasers

Health authorities in their new role as purchasers or commissioners of health care will be required to:

- Assess the range of health needs of their resident population
- Agree the priorities for investment, which increasingly will be informed by a structured dialogue between the health authority and individuals and groups within the local community
- Construct a balanced package of health services which are most likely to meet priority health needs
- Specify the volume, price, and quality of these services

- Agree contracts with providers of health care
- Monitor compliance with contracts in terms of volume and quality standards
- Evaluate the changes in health status and begin the process again.

Health authorities will therefore be concerned with knowing the demographic structure and epidemiological characteristics of their local population, understanding the effectiveness of the range of possible interventions, and undertaking economic appraisal to ensure the optimum use of finite resources. In summary, health authorities will wish to ensure more equitable distribution of health by commissioning the most appropriate package of high quality and value for money health services.

Providers

Providers of health care, within and outside hospital, will focus increasingly on the delivery of services which are clinically effective, appropriate for each patient's health needs, responsive to the wishes and preferences of health service users, and cost effective and represent value for money. They will need to manage changes in medical practice, including clinical and technological developments. The challenge is to look critically at the effectiveness of care and at what aspects of care are essential to quality. Both patients and purchasers need to be drawn into the debate.

Traditionally, there have been problems in ensuring that the understanding derived from a successful research project results in systematic changes in clinical practice, and new emphasis on research and development will require considerable improvements in this respect. The Department of Health launched the NHS research and development strategy in September 1991.^{5 6} By the end of September 1992 each regional health authority is required to have published a regional strategy, to have appointed a director of research and development plus the infrastructure to support the appointment, and to have established a regional research and development committee. Regions will be expected to commission research within national and regional priorities and to improve the "development" function within the NHS.

Changing patterns of care

There now is the opportunity to look for imaginative patient focused approaches to

health care and, in so doing, to challenge some of the traditional patterns of care. Both providers and purchasers will wish to achieve changes in the way care is delivered. For example, evidence is increasing that higher proportions of investigation and treatment can be provided within primary care rather than within the hospital setting, or on an outpatient or day patient basis rather than through inpatient care. Local services for people with mental illness or a learning difficulty (mental handicap) should replace long stay mental hospitals. Changes in primary health care, to some extent stimulated by the new general practitioner contract, have led to a greater focus on anticipatory care, disease prevention, and health promotion. There are also opportunities to alter the roles of all groups of professional staff by a better understanding of the mix of skills and by challenging established professional practices.

Other changes are running in parallel to developments in professional practice. The aspirations of patients continue to rise. For example, many patients want a genuinely participative relationship with their doctor rather than one that conforms to the more traditional paternalistic model. Patients and their relatives have views about the standards of care provided and will express their disappointment and criticism if these standards are not met. They should be involved in the growing debate about health outcomes. Although the initial emphasis has often been on the non-clinical aspects of care – namely, the environment, manner of professional staff, and organisational issues – patients are becoming increasingly knowledgeable about health care.

There are good examples of areas of health care in which the power relationship has begun to shift. In maternity services women have asserted their status as healthy rather than sick people and as partners in care rather than subordinates. They have challenged entrenched positions on place of birth and on the style of delivery, from shaves and enemas through to position and element at the time of delivery. In doing so they have exposed conventional medical wisdom for which empirical evidence was insufficient for professional preferences to outweigh women's wishes.

Managing uncertainty

Some of the greatest changes in the culture of medical care have occurred where uncertainty is greatest. For example, in HIV disease doctors have faced an unusual constellation of factors: the disease is new and its natural history only partly understood; there is no medical approach to prevention and no cure – only more or less unpleasant therapeutic interventions which can ameliorate the course of the disease; and the patients are fairly young and, as a group, unusually articulate and influential. Those HIV services which are highly rated by the users have recognised the need to develop an approach which acknowledges the extent of medical uncertainty and

deals with it by involving the patient. Patients are invited to participate in key decisions; the medical role is to enable this participation by presenting information in a way which empowers them.

Medical uncertainty is particularly clear in HIV disease but is also present in many other aspects of medical practice. When there is no clear cut answer patients may have different priorities and make different choices from their doctor. This was shown in choice of treatment for symptoms of benign prostatic hyperplasia, in which patients in the United States were more risk averse than medical staff and more likely to “watch and wait” than to opt for early prostatectomy (J E Wennberg, twentieth annual meeting of the Institute of Medicine, United States, 1990).

Involving users

Purchasers and providers alike will be increasingly interested in what users think of the services provided. Patients' views of the effectiveness of health care should be the concern of all practitioners and encompassed within an approach to assessment of health outcome; the outcome of health care must be judged on the views of patients at least as much as on those of professionals. Patients may need additional support to enable them to become more participative. Advocacy schemes have been implemented in those services whose patients are most vulnerable and least able to articulate their needs and preferences – that is, people with learning difficulties, people with mental illness, disabled people, and elderly people.

Assuring provision of good quality health care

There is a new emphasis on postgraduate and continuing medical education; medical or clinical audit has been introduced within both primary and secondary care; and early experience of audit suggests that it can provide a vehicle for achieving improvements in clinical practice. Increasingly, the focus needs to be on health outcomes and building effective interfaces between the educational and management processes. With increasing shifts across the interface between primary and secondary care there will be greater professional interaction between general practitioners and hospital doctors, again a development which can be fostered by a constructive approach to audit.

Chief executives will take a growing interest in the quality of health care because the unit will thrive by providing high quality, value for money services.

Assuring purchase of good quality health care

Purchasers will want to contract for services of demonstrable quality and are seeking representative and measurable measures of quality, in addition to those of volume and cost. The purchaser will build alliances with user groups and also with other groups and individuals in the community to assess their

views of services and their future priorities.

By conventional medical standards much of this discussion could be dismissed as naive. For example, determining how much weight to put on variations in case mix can be difficult. In many branches of medicine there is no clear consensus, and users' views need to be interpreted in the context of the present state of professional knowledge. The discussions will be difficult and challenging. However, this debate is beginning, and clinicians should welcome the implications. There are many benefits for medical and other clinical professions if the managerial focus increasingly encompasses clinical quality as well as the more conventional measures of finance and activity.

Putting the jigsaw together

Purchasers need to open up a forum for debate with providers if contracts are going to be challenging and achievable. This series on the providers' view of purchasing for health will be especially helpful in drawing together the best information available, diagnosis by diagnosis. Expert providers from a range of clinical disciplines have been asked to state what they would require if they were purchasing care for the condition on which they are experts. Each article will make explicit those aspects of clinical practice in which effectiveness has been shown, those in which there is doubt, and those which are "redundant." Advice will be offered to providers and purchasers on how to improve the quality of health care.

Purchasers require good background information about issues which constitute good quality care as well as understanding about case mix and the trade offs which may need to be made. They will need to be able to assess the cost not only of assuring quality of care but of assessing it. The changes taking

place in the medical profession and other clinical professions are leading to a culture in which critical assessment of quality of care is becoming an integral part of clinical practice. This is crucial if quality and not financial expediency is to remain the central aim of purchasing. In 1991–2 the quality dimension of contracts has been limited, but the aspirations for 1992–3 are higher.

Clinicians need to be more prepared to change their practice. Existing patterns of care may be shown to be ineffective (absolutely or relatively); new techniques may be more appropriate; and service users may have strong preferences that should be taken into account in reshaping clinical policies. The developing agendas around education and audit must be harnessed to ensure that the need for change is recognised and that health professionals are enabled to continue to develop and enhance their skills.

This series will go beyond individual medical interventions and will encompass the range of professional contributions which together result in the delivery of better health care and thus better health. Both purchasers and providers should find the series helpful in identifying key areas of understanding around clinical standards and quality.

- 1 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health*. London: HMSO, 1987. (Cm 249.)
- 2 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cm 555.)
- 3 Secretaries of State for Health, Social Security, Wales and Scotland. *Caring for people, community care in the next decade and beyond*. London: HMSO, 1989. (Cm 849.)
- 4 Secretary of State for Health. *The health of the nation*. London: HMSO, 1991. (Cm 1523.)
- 5 Department of Health. *NHS research and development strategy: guidance for regions*. London: HMSO, 1991. (EL(91)117.)
- 6 Department of Health. *NHS research and development strategy: research for health*. London: HMSO, 1991. (EL(91)118.)