The contracting round: achieving health gain or financial balance?

Mark McCarthy

Summary

In the 1991 National Health Service reforms, health authorities became responsible for the health of their resident population, and they contract for health services from NHS providers – trusts and primary care services. A case study in Camden and Islington, an inner London health district, during 1996–1997 shows that contracting was directed more towards achieving financial balance than health objectives. Reasons include the inflationary effect of competition within an internal market, the power of administrators in decision-making within the health authority, and lack of adequate financial accounting in the NHS to relate costs to health outcomes. The introduction of programme budgets for districts would provide more cost-effective use of the nation’s resources.

Keywords: health planning, programme budgets, contracting

Introduction

On 1 April 1996, 100 new health authorities were formed in England and Wales, taking on the functions of the former district health authorities and family health services authorities, and some functions of the abolished regional health authorities. The new authorities were the final step of the ‘purchaser-provider split’ initiated in the 1991 National Health Service reforms. Under these arrangements, district health authorities control almost all the NHS resources for health care to their geographically defined population, and make contracts with both primary care providers (general practitioners (GPs), pharmacists, dentists, opticians) and secondary care providers (NHS trusts). Most health care resources are spent through annual contracts with local providers, but some funds are also available for ad hoc episodes of care from more distant secondary care providers as ‘extra-contractual referrals’ (ECRs).

District health authorities are the main publicly accountable administrative body of the NHS. Authorities have the duty to protect and promote the health of their resident population through NHS contracts and alliances with other agencies (including local authorities), whereas hospitals and GPs have more direct responsibilities for prevention and care. Health authorities are responsible for choices on the use of NHS resources at local population level, working within guidance of health policies and priorities but with considerable local autonomy. In the 1974 NHS reorganization, consultants in public health medicine transferred from local authorities into the NHS; since 1996 the Director of Public Health has become a statutory executive member of the health authority. Public health consultants take medical responsibility for the health of their population collectively, as hospital consultants and GPs take responsibility for their individual patients.

Approximately 6 per cent of gross national product in the United Kingdom is spent on health care. International comparisons do not give clear evidence of what the ‘right’ level of health expenditure should be, nor whether the United Kingdom should spend more. NHS funding has risen broadly in line with growth of the country’s economy in recent years, although the increase in allocation in 1996–1997 was relatively small. Demographic growth and population ageing appear to be less important factors in increasing demand for health care than technology change and rising expectations. A report on priority setting has suggested three levels of decision-making on the use of resources. National allocations between districts are made by central government; allocations between different health programmes are made by health authorities; and decisions on the use of resources for patients are made by clinicians.

This paper describes how one inner London health district, Camden and Islington, decided on the use of its resources for the financial year 1997–1998. It indicates how the authority assessed the actual resources available to it, the role of contracting, and the place of public health advice on achieving health gain in this process.

The annual commissioning round

Camden and Islington Health Authority is sited in inner north London. It has a population of 370 000 and relatively high levels of deprivation. There are several large hospitals, serving both the local population and also providing regional and national services. The former Camden and Islington District Health

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Authority (DHA) and Camden and Islington Family Health Services Authority (FHSA) had been coterminous since 1993 and were combined through a single executive team since 1995; 1996–1997 was the first year of a new single authority and an integrated budget.

Finance

The budget for Camden and Islington in 1996–1997 was approximately £280 million. Most of this was the allocation from the national capitation formula, but it also included direct funding for services such as those related to HIV–AIDS and ‘transitional’ subsidies to some local services. In creating its budget for 1996–1997, the outgoing former District Health Authority negotiated contracts with a balanced budget, while retaining a ‘contingency reserve’ of £2.5 million. The Authority continued its five-year programme, initiated in 1993, to transfer each year £1 million from secondary to primary care. No funding was allocated to new service development.

Financial planning for 1997–1998 started with the Health Authority’s Commissioning Intentions, published in September 1996. Camden and Islington had been one of two districts nationally (with Central Manchester) that received no growth in resources for 1996–1997 beyond increases for inflation. The financial forecast for 1997–1998 predicted that resource growth would again be either nil or very limited. As in previous years, the Authority was required by the Treasury to ensure that providers made ‘cash releasing efficiency savings’ (CRES), but proposed a ‘flexible approach’ to the Treasury’s 3 per cent target.

The actual 1997–98 financial allocation proved more favourable to Camden and Islington than expected. Nationally, there was a 2.5 per cent increase for inflation and districts were given a further 1.3–1.8 per cent (although less than the national level of economic growth for 1996–1997). Camden and Islington was given 1.3 per cent growth funding, plus an 8 per cent increase on the ring-fenced HIV–AIDS budget. The Department of Health also announced £15 million extra funding nationally for mental health services, to be allocated to districts against bids.

Following publication of the district allocations, Health Authority staff created an initial ‘financial framework’ which set out, in simple headlines, proposals for use of the allocation for 1997–1998. The financial framework focused on the marginal funds potentially available for redistribution, or new programmes.

(1) A ‘contingency reserve’ of approximately £2.5 million had been included within the Health Authority’s 1996–1997 budget, but had not been allocated during the year. At the end of the year, there were two claims on this reserve: one Trust had provided more care than required in the annual contract, and was thus overspent; and the Authority had itself overspent on extra-contractual referrals. The higher level of activity in the Trust had been predicted: in the previous year’s contracting round negotiations (in March 1996), the Trust had raised its contract prices beyond inflation levels, and the Authority had agreed a contract with fewer ‘episodes’ of care (finished consultant episodes, FCEs) than in the previous year. But, in fact, the Trust’s FCEs continued at the level of the previous year, and thus higher than contracted. Authority officers chose to use the contingency reserve to fund these two activity ‘cost pressures’, and also to continue this spending in 1997–1998.

(2) The main body of funds identified for distribution was £8.4 million. This included £3.1 million new growth and £5.3 million CRES. The allocation of these funds proposed was £4.1 million towards further ‘cost pressures’, £1 million for primary care developments, and £3.3 million to create a new contingency reserve. The ‘cost pressures’ were categorized broadly – £2.8 million for acute contracts, £300 000 for extra-contractual referrals, £100 000 for specialist services, and £900 000 for mental health services (held to match the bid to the Department of Health for new ring-fenced mental illness funds). The ‘contingency reserve’ included £1.3 million held against the possibility that Trust pay awards were greater than planned.

(3) Two new areas of funding were the extra allocation of £1.9 million for AIDS–HIV, and an extra £1.3 million that was agreed with the Department of Health for mental illness services. This £3.7 million extra funding is not technically part of the district’s main allocation. It was expected that the Health Authority would support the new mental health services from its normal revenue after an initial three year period.

(4) A fourth area of allocation was £0.7 million new funding for ‘general medical services’ (primary care). It was estimated that almost all of this funding would be needed to finance normal annual growth in primary care services.

Contracting

At the same time as the Authority’s Commissioning Intentions were published, the Trusts provided ‘first’ prices for 1997–1998. Following publication of the national allocations, and taking into account the Commissioning Intentions, the Trusts proposed revised prices and entered into negotiation about the ‘activity’ (FCEs) to be agreed for 1997–1998. Trusts were reluctant to agree efficiency savings (CRES) leading to reductions in income; instead, they sought to maintain or increase income through claims for ‘cost pressures’. These included costs of drugs, perceived increases in emergency admissions, funding to expand consultant and specialist registrar medical staff, and other aspects where NHS inflation costs were higher than the national average. Some of the ‘cost pressures’ were also related to AIDS treatment and mental health services, for which extra funds had been announced. In
The 1994 Health Strategy - including the Health of the Nation - was discussed by the executive directors in March 1996. A comprehensive population health needs assessment had been prepared for the Authority in January 1993, and a Health Strategy had been agreed in October 1994. The draft public health report for 1996, setting out the financial situation, broad health objectives and the programmes needed to meet them, was discussed by the executive directors in March 1996. A shorter Public Health Report was presented to the Authority in January, and a Health Authority response to the Public Health Report.

At each of its public meetings during 1996–1997, the Health Authority received a report on the local situation for each Health Authority public meeting in January discussed the planned shifts in health care between in-patient and day care elective care. This information, made available to contract managers in their negotiations with Trusts, showed that admission 'pressures' were perceived rather than real, perhaps, for example, because of the normal tendency of emergency admissions to rise in winter.

The initial increased claims of Trusts over their 1996–1997 contract levels gave a 'gap' on paper of up to £15 million. Some of this included expectations of new finance for HIV-AIDS and mental health services. However, in contract negotiations during February and March there was convergence between Trust claims and Health Authority proposals. For example, in February two Trusts were requesting funding increases of over £6 million each (including new HIV funding), whereas by mid March (excluding new HIV funding) the 'gap' was less than £1 million each. As in previous years, there was strong pressure from the Department of Health for Trusts and Health Authorities to agree final contracts early in April.

### Table 1: Hospital ‘finished completed episodes’ for Camden and Islington residents

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Emergency</th>
<th>Maternity</th>
<th>Elective</th>
<th>Day</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994–1995</td>
<td>32638</td>
<td>4895</td>
<td>13500</td>
<td>17132</td>
<td>6048</td>
<td>68165</td>
</tr>
<tr>
<td>1995–1996</td>
<td>33098</td>
<td>4371</td>
<td>13098</td>
<td>18061</td>
<td>5765</td>
<td>68628</td>
</tr>
<tr>
<td>1996–1997</td>
<td>31867</td>
<td>4685</td>
<td>11094</td>
<td>17797</td>
<td>5559</td>
<td>65443</td>
</tr>
</tbody>
</table>

Their negotiations, the Trusts did not present to the Health Authority opportunities for making savings in clinical services, for example by stopping ineffective clinical practice, or transferring care from in-patient to day or out-patient care.

An analysis was made by the Health Authority of trends in total admissions over the three years 1994–95 to 1996–97 (see Table 1). This suggested that there had been no overall increase in FCEs: emergency admissions had been stable, and there had been a modest transfer between in-patient and day case elective care. This information, made available to contract managers in their negotiations with Trusts, showed that admission 'pressures' were perceived rather than real, perhaps, for example, because of the normal tendency of emergency admissions to rise in winter.

The contracting round has replaced the annual planning cycle since the NHS reforms. Formal guidance requires the health authority's annual commissioning intentions to be based on health needs assessment, past trends and planned shifts in investment. Although, in principle, the separation of purchasers and providers should allow the health authority to consider each year how to maximize health gain through the reallocation of its resources, in reality contracting is driven by the aim of achieving financial balance. As a Director of Public Health of another health authority wrote in December 1996: 'Health authorities have been working hard on developing health strategies and health programmes. Much of this work can come to naught. Towards the end of the financial year the contracting process takes over. Large sums of money are exchanged between purchasers and providers without explicit or detailed cognisance of the health strategy or programmes.'

### Public health

A comprehensive population health needs assessment had been prepared for the Authority in January 1993, and a Health Strategy had been agreed in October 1994. The draft public health report for 1996, setting out the financial situation, broad health objectives and the programmes needed to meet them, was discussed by the executive directors in March 1996. A shorter Public Health Report was presented to the Authority in January. The September Commissioning Intentions included the Authority's response to the Public Health Report.

At each of its public meetings during 1996–1997, the Health Authority presented a report on the local situation for each of its key areas and other more local concerns - were reaffirmed. The Health Authority public meeting in January discussed costed proposals for specific developments across health strategy areas based on policy recommendations that had been considered and agreed at Health Authority meetings.

At a seminar in February 1997, Health Authority members played a simulation game, allocating priorities to broad health care groups based on their valuations of disease prevalence, treatment effectiveness, and equity. Existing budget allocations were then compared with allocations based on this order of priorities. The exercise showed significant differences between existing and simulated spend, and assisted Authority members' understanding of programme budgets.

The final contract negotiations, however, were not organized according to health programmes but by provider. In one contract, there was discussion on improving diabetes shared care between hospital and GPs. Increased expenditure on certain high cost drugs was agreed, for example, recombinant therapy for treatment of haemophilia, although the extra benefit over existing treatments was contested. Within the ring-fenced allocation for HIV-AIDS, all the extra Department of Health funds were allocated to pay for combination retroviral therapy, although there was again debate over the evidence of health gain for these new treatments - and disagreement in clinical advice as to which patients should be given treatment, for how long, and for what benefit.

### Discussion

The contracting round has replaced the annual planning cycle since the NHS reforms. Formal guidance requires the health authority's annual commissioning intentions to be based on health needs assessment, past trends and planned shifts in investment. Although, in principle, the separation of purchasers and providers should allow the health authority to consider each year how to maximize health gain through the reallocation of its resources, in reality contracting is driven by the aim of achieving financial balance. As a Director of Public Health of another health authority wrote in December 1996: 'Health authorities have been working hard on developing health strategies and health programmes. Much of this work can come to naught. Towards the end of the financial year the contracting process takes over. Large sums of money are exchanged between purchasers and providers without explicit or detailed cognisance of the health strategy or programmes.'
Three factors can be considered in explanation of this distortion of the aims of the NHS reforms: failure of competition as a substitute for planning, priority for administrative objectives and lack of adequate accounting information.

Failure of competition

Although the original aim of the NHS reforms was for an 'internal' market imitating the private sector, real competition in the NHS has been impracticable because prices are not true costs and quality is not measured. Even in London, where the opportunities for choice are greatest, contracts for acute care are based on geographical patterns of referral by GPs to hospitals, rather than 'competition' through prices, quality or outcomes. Equally, services for children, elderly people and mental illness need to be coterminous with local authority boundaries and provision.

Moreover, competitive contracting between trusts and health authorities may be inflationary, and reduce efficiency. Trusts prefer to raise their prices and pass their perceived 'cost pressures' on to health authorities rather than make savings themselves. Trusts are able to revise their initial prices in the light of the published district allocations – that is, tailor their 'bid' to the funds expected. Ellwood, in a behind-the-scenes study of finance and contracting in two trusts, stated that: 'evidence of extensive cost-shifting and price manipulation was found. Published prices are a starting point; the overall contract value is subject to negotiation, and the providers inevitably have long-term relationships with their purchasers.'

Health authorities cannot make significant changes in the flow of patients within the time-scale of the contract negotiations, and probably would not want to do so on the basis of price alone. In practice, when trusts raise their prices, the main options for health authorities are either to provide more money or to contract for fewer episodes of care. Health authorities do not want their trusts to go out of business, and – as in the case study – may subsidize an overspending trust to maintain existing levels of performance. Some health authorities overspent by millions of pounds in 1996–1997 because of higher costs from trusts. When health authorities spend money they do not have, and trusts use resources above their contracted income, the use of NHS resources is distorted away from planned priorities.

Priority of administrative objectives

The 1996 Camden and Islington public health report drew attention to the relative deterioration of local death rates compared with national levels and recommended improvements in services (both treatment and prevention) and intersectoral policies to reverse this pattern. However, apart from the ring-fenced allocations directed at centrally determined priorities, few of the public health proposals for use of local funds were accepted by the Authority's decision-makers.

The new funding for general medical services, along with other primary care funds, was left in an indeterminate pool for later consideration, rather than being allocated at the beginning of the year to specific health-related developments. Similarly, the contingency reserve was held against 'overspending' rather than being allocated as purposeful investment for health.

Ensuring a balanced budget is, of course, an important responsibility of a health authority. But contracting by provider, rather than by care group or health programme, ensures the predominance of administrative objectives over health objectives. The health authority allocates resources in response to 'pressures' reported by contract managers from meetings with providers, rather than by a plan to maximize health gain. And NHS trusts have every incentive to increase the 'activity' to imply 'pressure' on their resources. For example, although extra money has been centrally directed since 1991 to pay for extra operations to reduce NHS waiting times, the number of people on waiting lists has not fallen but increased – providers have accepted more patients onto waiting lists in response to increased resources for activity. The clinical benefit of these extra operations has not been defined.

Programme budgets

One approach to linking NHS finance to health gain is to ring-fence funding. Traditionally, the higher tier (formerly the Regional Health Authority and now the Regional Office of the Department of Health) has assisted the development of new services. For 1997–1998, for example, the Department of Health ring-fenced extra funding for HIV–AIDS drugs and mental illness services. Because of 'competition', however, this concept has been lost at district level – but it should be revived. Working within a balanced budget, the 3 per cent Cash Releasing Efficiency Savings would provide several million pounds for negotiation in reordering priorities within contracts each year, and growth funding gives further opportunities.

A more comprehensive approach to choice and priorities is programme budgeting. In a speech to the Association for Public Health in April 1993, Dr Brian Mawhinney, then Minister for Health, asked: 'Have you established where your current expenditure goes, not just in terms of institutions but disease area by disease area?' However, the existing NHS accounting system does not provide financial information by disease group, but only links finance with 'activity'. Contract 'negotiations' concern levels of health service 'episodes of care' irrespective of the health priority to be given to the activity. Programme budgets at district level have been described and offer the way forward for linking resource decisions with health outcomes; but they have been developed by public health doctors and health economists, rather than NHS accountants, and few senior managers in the NHS have experience of them.

The new Labour Government is committed to maintaining the separation between purchasers and providers in the NHS, and thus the unique population focus that health authorities
have. The Government also wishes to reduce administration and increase the numbers of doctors and nurses in the service, and there is broad public support for the view that doctors should lead in setting priorities in health care decisions. However, it is not clear whether primary care led contracting will lead to more rational resource use. Evaluations suggest that fundholding has produced relatively little improvement in efficiency except in control of pharmaceutical costs; and fundholder savings have mainly been invested into practice premises, in the long-term benefiting GP incomes, rather than better health care. A saving in administration costs, especially finance staff, will be achieved if the fictitious internal market pricing system is abolished; and funds need to be allocated to providers according to health gain outputs as well as activity. But significant improvements in population health will depend on strategic, publicly supported, choices on the use of resources through collaboration between health authorities, clinicians, local authorities, other agencies and the public.

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