Neurology in the market place

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Abstract

The White Paper, "Working for Patients", led to a change in the way in which hospitals were funded from April 1991. The changes will have profound effects on the future shape of health care in the United Kingdom. Neurologists will need to understand the new National Health Service if their patients are to benefit from the changes. If neurology is to survive as a specialty separate from general medicine it will have to show that it can provide quality care which is accessible, relevant, efficient and effective, at a price which Districts can afford.

The White Paper "Working for Patients"¹ which outlined the United Kingdom government's proposals for change in the provision of health care, was published almost two years ago. It was followed by a series of working papers, circulars and directives from the Department of Health which provided more detail and a timetable for the introduction of the changes. From 1 April 1991 the ideas of the white paper became the framework for health-care in the National Health Service (NHS).

For the hospital service the paper contained two main changes; the opportunity "to apply for a new self governing status as NHS hospital trusts" and the switch from direct funding of hospitals to funding of each district "to buy the best service it can from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector". Districts are to be funded on a capitation basis adjusted for expected morbidity in the population resident in that district.

Whilst it is the first of these proposals which has received most comment it is the second which will have the greater impact on patient care. Districts will be funded only for their resident population. As the population moves from city to suburb so will the funding. Hospitals will be totally dependent for their income on gaining contracts from districts for the provision of a specified service for residents of those districts. This funding process leaves districts (purchasers) free to choose where to place contracts and to define the service they wish to purchase. To receive income, hospitals (providers) will have to meet the terms of the contracts or lose both the work and the income. Through this contracting process, purchasers on behalf of their resident population, will control the volume, scope and quality of the hospital service.

In the White Paper two brief paragraphs deal with specialist services including designated regional and supraregional units. Working Paper two² stated that for such units "decisions...should be taken locally but with a presumption in favour of contract funding". Thus regional units may have to win contracts from many purchasing districts to maintain their present income and workload.

The Market

It is a fundamental tenet of the White Paper that "hospital services must be funded in a way which encourages more choice and more value for money". Purchasers will look for the best service for their patients and hospitals will strive to deliver a better service to attract contracts. In large specialties, and in some large cities with alternative providers close together, this could happen but in much of the country with a single accessible provider choice is likely to remain theoretical. Only towards the edge of current catchment areas is there likely to be real choice for patients requiring treatment in small specialties.

The successful market trader knows the cost of his produce and the price of his competitor's goods. He also knows what his customers like and what they are prepared to pay. If he is to survive he must judge the demand, the cost and the competition correctly. Good market research, good financial advice and good information are essential; measures of customer satisfaction and quality control systems make success more likely. Customers will determine success or failure by their decision to buy from one trader rather than another.

While some aspects of this description will apply to the new NHS the market will be limited and managed. Districts will have a finite sum and will not be able to purchase all the health care which will be required. The existence of waiting lists, the complaints of underfunding and the overspending by many authorities suggest that the present provision does not meet demand. In a free market this would almost certainly lead to decreased choice and increased cost. In such a managed market it is likely that discussions between purchaser and provider will be made more difficult by the constraints on the kind of agreement which can be reached.

The contracting process

The most satisfactory mechanism for the negotiation of contracts has yet to be decided. Volume, cost and quality are the most important management issues in the contract and it is

likely that much time will be spent on them. However, the fundamental purpose of the contract is to provide health care. It is therefore important that at least as much attention is paid to the description of the service and the needs of the population. Initial discussions should be between the clinical specialists of the purchasing authority and the providing unit. Unless this framework is established first other negotiations on volume, cost and quality are unlikely to be fruitful.

Three types of contract are described in the White Paper: block contracts, cost and volume contracts and cost per case contracts. Cost per case contracts require detailed knowledge of case mix, work load and departmental costs. Few, if any, neurological units in this country have such information. Without it units would be vulnerable to fluctuations in workload and casemix: districts could likewise find themselves over committed. Similar considerations apply to cost and volume contracts although the vulnerability is reduced.

With current levels of information the only option open to most providers and purchasers is the block contract in which the purchaser agrees to pay a fixed sum in respect of an undertaking by the provider to deliver health care to the resident population. Such a contract would ensure that care continues while efforts to improve the information base continue.

"The move to a contract system and the funding of districts as purchasers from 1991 are above all aimed at improvement in the quality and responsiveness of patient care. The separation of purchasing from provision will require contracts to state in increasingly explicit terms the quality and standard of service which is to be provided."³

The opportunity for providers of care to discuss quality with purchasers should be welcomed. Again it is important that clinical specialists take the lead. Quality of care has to be measured and monitored. Some aspects, not necessarily the most important ones, are easier to measure than others. In the negotiations about quality the tendency to look only at the easily measurable or to dismiss the difficult as impossible must be avoided. An understanding by both parties of the need to develop new ways of looking at quality of care should accompany a commitment to explore the relevance of available standards. Many of the available techniques measure the process of care rather than the outcome. Although there is a tendency to downgrade the value of such information, to the patient the process of care is important even if outcome is seen to be more important.

Initially purchasers are likely to look for evidence of compliance with building and safety regulations, appropriate training, audit and the recording of complications of treatment or investigation. They are also likely to set standards for waiting times, response times and the promptness with which general practitioners receive discharge letters. These aspects of the process are unarguably to do with the quality of the service and thus a legitimate concern of the purchaser.

Purchaser and provider are likely to question

patients on their assessment of the care which they received. This may be done regularly through patient satisfaction surveys or randomly by postal or telephone questionnaires.

Few units currently look at outcome routinely but an understanding on the part of both purchaser and provider that this is needed will lead to the development of more useful ways of assessing outcome. The inclusion in the contract of the outcome initiatives which are already being undertaken, usually with audit or research funding, rather than the imposition of the purchaser's own ideas, will increase the chance that useful measures will be found.

At the end of negotiations between provider and purchasers there will be an agreement which will guarantee a specified service to the purchaser and an income to the provider.

Marketing neurology

Neurological units in the UK range from a single neurologist in a district general hospital to the neurologist practising from a regional centre as one of a large group of neurologists, neurosurgeons, neuropathologists, neuro-radiologists and neurophysiologists. Each faces a different challenge in the new NHS but all must attract contracts. For the large unit there may be contracts with ten to fifteen districts and possibly GP budget holders in addition. Such units are likely to require their own team of negotiators and may well wish to run their own budget in order to be in a position to respond to the opportunities of attracting contracts. Small units are more likely to entrust the management aspects of the negotiating to the base hospital. In both situations, however, it is first necessary for the neurologist to formulate a clinical service plan and to agree this with clinicians in the districts. These preparatory discussions form a basis for clinical cooperation as well as opening the contract negotiations. It is sometimes painful for neurologists to find that other clinicians do not see the neurology service in the same light.

Neurology is a relatively small specialty with under 200 consultants in post in the UK. Hopkins⁴ has shown that only 7% of patients with a neurological complaint are referred to a neurology clinic. Stevens,⁵ Perkin⁶ and Hopkins, Menken and DeFriese⁷ have shown that the neurologist in the UK deals, in the main, with common conditions. To persuade purchasers that they should write contracts with neurologists it is necessary to define what neurologists do for the 7% that is either not done elsewhere or is done less well elsewhere.

Alongside the fact that neurologists see so few of the patients with neurological symptoms must go the recognition that only a small proportion of the total number of referrals from a district are to a neurologist. Compared with services for the elderly or antenatal and perinatal care, neurology is a low priority for most districts. A further complication in the contracting process for neurology is the high proportion of tertiary referrals. The mechanism for funding these is not yet finalised and may not be uniform. Should districts fund the tertiary centre directly or should they fund general

hospitals who may use some of the funding for tertiary referrals?

The first task in marketing neurology is to define a service to be provided which meets an obvious need, can be provided to a high standard and is cost effective. While purchasers may be interested in our ability to recognise the rare and obscure they are likely to put that second to our ability to contribute significantly to the management of common disorders. A series of services designed to give expert care in a few areas, combined clinics with other specialties and more formal shared care schemes with general practitioners or general physicians may be of interest. Links with other disciplines, younger disabled units, rehabilitation centres, community services and the voluntary sector may be more difficult to establish in a contractual framework but will give a distinctive image to project in the marketing process. Large units may well include neurosurgery as well as investigative specialties and neurology. The integrated nature of such units and their potential for cost effective use of resources may be attractive to purchasers. Certainly there will be few Districts wishing to omit neurosurgery from their contracts with providers.

The nature of the service to be provided will vary from place to place. Even within one region it will be necessary to put weight on different aspects for patients living nearer to or further from the unit. Different investigation facilities and different specialties in the general hospital will also alter the nature of the service required.

Describing the service calls for a considerable amount of discussion among neurologists and their colleagues in regional units. The process of setting priorities demands assessments of the value of procedures and the efficiency with which they are carried out. Most large units will have regular meetings to discuss policy but only if they control their own budget are they able to take full advantage of opportunities to change their practice.

When the service is defined it must be costed. This exercise is inevitably approximate with current information but it is possible to derive figures which are sensitive enough to be useful. It is not necessary to wait until each procedure can be costed before using the available financial information. Sandercock, Roberts and Blumhardt,⁸ and Moore and Blumhardt⁹ showed the effects of a change of policy in the Liverpool unit. The savings released in opening the programmed investigation unit financed the epilepsy clinic and an improvement in physiotherapy and occupational therapy in the unit.

In a specialty like neurology the costing of a contract should not be too detailed. The volume of work for any one purchaser is relatively small. In this unit in 1989 the 1500 neurological admissions (consultant episodes) came from 13 regular user districts with only five of them contributing more than 10%. With such small numbers even if accurate diagnostic information were available it is unlikely that any two consecutive years would have a similar

pattern of diagnosis and severity. Because of inadequate diagnostic information and a lack of measures of severity it is not possible to see whether the referral pattern for any given diagnosis varies between districts or with distance from the centre.

A further confounding factor is the absence of detailed outpatient data. As this only accounts for 2% of the expenditure in the centre it is not financially very important. However, in spite of the low cost most neurological consultation and treatment is undertaken in the clinic so that outpatient work is a most important part of the contract. The relationship between clinics in the centre and clinics in the general hospital must be defined if differential costing is not to lead to a shift from one clinic to another or from outpatient to inpatient consultation.

It is conceivable that data giving precise answers to some of these questions could be provided. This would be helpful for some of the unknowns but for many there is no need to find an answer. The collection of data is time consuming and costly; if it does not add significantly to the ability to manage the service the time and effort would be wasted.

When purchasers have been persuaded of the value of the neurologist and are ready to discuss a contract it will almost certainly be a block contract. In those centres with a significant commitment to general hospitals, however, a separate element providing a fee for that service on a sessional basis would be sensible.

Implications for neurology

It is the hope and the expectation of the government that the change in the funding process will lead to an improvement in the quality of care. If targets and contracts are realistic there is a real possibility that this will indeed be the case. It remains to be seen whether the service will be financed to meet the additional demands for information, improved environment, shorter waiting times, and more personal service. If this is not the case conflict rather than cooperation is likely and an already stretched service may not survive.

There is currently little evidence that the necessary skills exist in the NHS to run the new system. Changes have been introduced at a speed which has made the required training too short and hence made success unlikely. The coincidence of these changes with changes in nursing training, junior medical staff training, the public health function, regrading of all technical staff, the new contract for general practitioners and the review of care in the community has led to administrative chaos and loss of morale.

If all these difficulties can be overcome there remain some challenges particularly important to small specialties with multiple purchasers. Strategic planning will be very difficult, yet with the long training programmes and competition for staff this is vital. In a tightly managed market developments of any kind will be extremely difficult and will require the agreement of hard pressed districts before they can be funded. Any increase in efficiency leads

to lower investment from districts rather than increased opportunity for providers. Likewise there will be an increasing temptation to encourage generalists rather than specialists to care for patients if an additional contract is required.

Neurology should be able to meet these challenges with an active and convincing marketing campaign based on well researched facts with accurate costs. Changes in the way the service is provided may be required; neurologists will need the support of colleagues, general practitioners and the general public. It may be necessary to look to regions to set standards for Districts to meet in the placing of contracts with small specialties and regional units. If this is not forthcoming an even more vigorous campaign will be needed.

The White Paper signalled a major change in the NHS. Unlike previous reorganisations it brings a change in the way health care is provided not just a rearrangement of man-

agement structures. Cash limitation will be tight and opportunity for development small. Neurology will only survive to provide care for patients if neurologists understand the changes and take the initiative in solving the problems.

- 1 *Working for patients*. London: HMSO, 1989.
- 2 *Working for patients: Funding and contracts for hospital services*. Working Paper 2. London: HMSO, 1989.
- 3 *Working for patients: contracts for health services. Operating contracts*. London: HMSO, 1990.
- 4 Hopkins A. Lessons for neurologists from the United Kingdom Third National Morbidity Survey. *J Neurol Neurosurg Psychiatry* 1989;52:430-3.
- 5 Stevens DL. Neurology in Gloucestershire: the clinical workload of an English neurologist. *J Neurol Neurosurg Psychiatry* 1989;52:439-46.
- 6 Perkin GD. An analysis of 7836 successive new outpatient referrals. *J Neurol Neurosurg Psychiatry* 1989;52:447-8.
- 7 Hopkins A, Menken M, DeFriesse G. A record of patient encounters in neurological practice in the United Kingdom. *J Neurol Neurosurg Psychiatry* 1989;52:436-8.
- 8 Sandercock PAG, Roberts MA, Blumhardt LD. A prospective audit of the use and costs of myelography in a regional neuroscience unit. *J Neurol Neurosurg Psychiatry* 1989;52:1078-84.
- 9 Moore AP, Blumhardt LD. Value of a programmed investigation unit: an audit study. *J Neurol Neurosurg Psychiatry* 1991;54:269-71.