Accounts Commission for Scotland

Expanding on contracting

1

Health board commissioning: contracts & contracting

BULLETIN

AUGUST 1997

Health board contracting in Scotland

The Government has announced plans to abolish the internal market in the NHS in Scotland. This bulletin summarises the Accounts Commission's review of contracting over the last three years in each of the 15 Scottish health boards. The information it contains on how contracting has worked in practice provides a useful background against which to develop a new mechanism for planning and delivering health services.

- There is significant variation between boards, both in their approach to contracting and in the costs of the process. However, there is little formal evaluation of these practices, and scant evidence of boards sharing experiences and spreading ideas which have proved successful.
- Planning and delivering health services within the internal market remains predominantly a local affair. In the main, contracting is a process of agreement between a board and its local NHS trusts. The management cost of a patient receiving care outwith local contracts is disproportionately high, and any mechanism which replaces contracting should recognise this.
- The advantages of letting longer term contracts are well known by the NHS in Scotland. However, their implementation is constrained by annual funding and a serious lack of confidence in the information used for planning.
- There is strong evidence of a considered trend back to the basic contract types and away from more sophisticated models such as cost and volume. This reversal of the once generally accepted direction for contracting is in part a realistic response to the lack of accurate measures of service provision and cost. However, the NHS in Scotland suffers from poor information and imprecise plans for future health services. There is a danger that reverting to simpler contracts will hide these problems, since they provide few incentives for overcoming them.
- The contracting process does not provide robust information on the quantity, cost and quality of services delivered and it is not possible to assess value for money. No matter how health services are managed after the abolition of the internal market, this is an issue that needs to be addressed at a national level. At local level, service by service reviews seem to offer the most promising and practical way forward, with the good practice principles identified being rolled out to new service areas.
- Half of all contracting management costs are spent on monitoring, and only a quarter on preparing to contract. The Accounts Commission believes that this balance is wrong, and recommends that boards increase their preparatory work in collaboration with providers. This should help to ensure clear and explicit agreements which are related to strategies and commissioning intentions.

These issues are fundamental to the effectiveness of contracting, and they should also inform the debate on a mechanism to replace contracting in the planning and delivery of health services. The Accounts Commission believes that the highest priority is to address the lack of robust data on activity and cost. Widespread consultation with the NHS in Scotland would provide an opportunity for boards to share their experiences and successes; reinventing the wheel in fifteen separate areas of Scotland is a costly and unnecessary approach.

Introduction

In 1996/97, Scottish health boards were allocated some £4 billion to improve the health of their populations. About £2.8 billion (70%) of this money was used to purchase services by means of contracts under the 'internal market', introduced by the NHS and Community Care Act 1990. Contracting is a key means by which health boards meet their statutory obligations. Drawing up, agreeing and monitoring these contracts has been a major area of work for both boards and trusts. It is essential that the contracting process is managed effectively, to avoid tying up money which could otherwise be used to improve patient care.

The new Government has announced plans to abolish the internal market, although a separation seems likely to continue between boards, responsible for planning health care, and trusts, responsible for providing it in line with those plans.

The Accounts Commission is studying the way in which health boards are carrying out their role as commissioners of health and health services. This bulletin, the first in a series, reports the findings of the first phase of that study, focusing solely on the contracting aspects of the 'commissioning cycle'.

We believe that our review of how contracting has worked in practice provides a useful background against which to develop a new mechanism for planning and delivering health services.

The study was developed by the Commission and undertaken by local auditors at all Scottish health boards during 1996/97.

A report detailing local audit findings has been produced for each board. These local reports contain an action plan to address areas for improvement and development. Complementary research was carried out by the Commission's national study team, which included interviews with key staff at health boards and a postal questionnaire to NHS trusts.

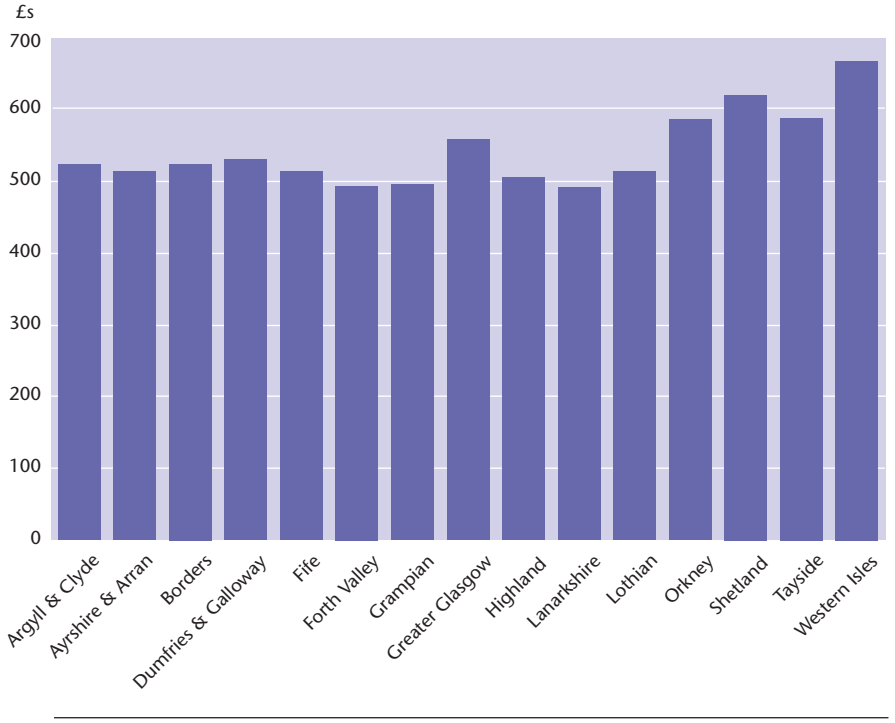
This bulletin provides information on the changing use of contracts between 1994 and 1997, and highlights important national trends. It also describes contracting practices, which vary significantly between boards. Subsequent bulletins will cover good practice in contracting, the information needed to contract effectively, and the changes which health boards are making in the light of the Shields Report on their roles and responsibilities.[1]

The contracts map

The value of contracts which a board lets is related to the size of its population and the number of GP fundholders in its area. Reflecting the boards themselves, there is wide variation across Scotland. Overall, the total value of contracts let by the 15 health boards ranged from £12 million to over £500 million in 1996/97, a forty-fold variation. Six health boards are responsible for 70% of all contract expenditure in Scotland, while the largest two boards alone account for about one third of the total.

Contract expenditure per head of population, weighted for age, sex and morbidity, ranged from £491 to £667. The three island boards spend most per head of population; the highest expenditure for a mainland board was £588 per head.

Exhibit 1: Contracted expenditure per head of weighted population

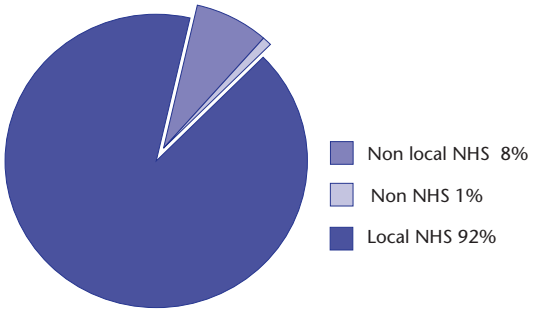


The variation in total contract expenditure is primarily related to the size of the boards' populations, but the number of contracts let by each reveals major differences which cannot be explained completely by their size or geography. The largest boards do not necessarily let more contracts. Overall the trend is upwards, with most boards letting more contracts for hospital and community health services now than in 1994/95. Between 1994/95 and 1996/97, the number of these contracts rose from 311 to 398, an increase of 28% over 3 years. Only one board let more than 30 contracts in 1994/95, but by 1996/97 this had grown to six boards.

Island boards let fewest contracts, an average of twelve per board in 1996/97 compared to an average of 30 for mainland boards.

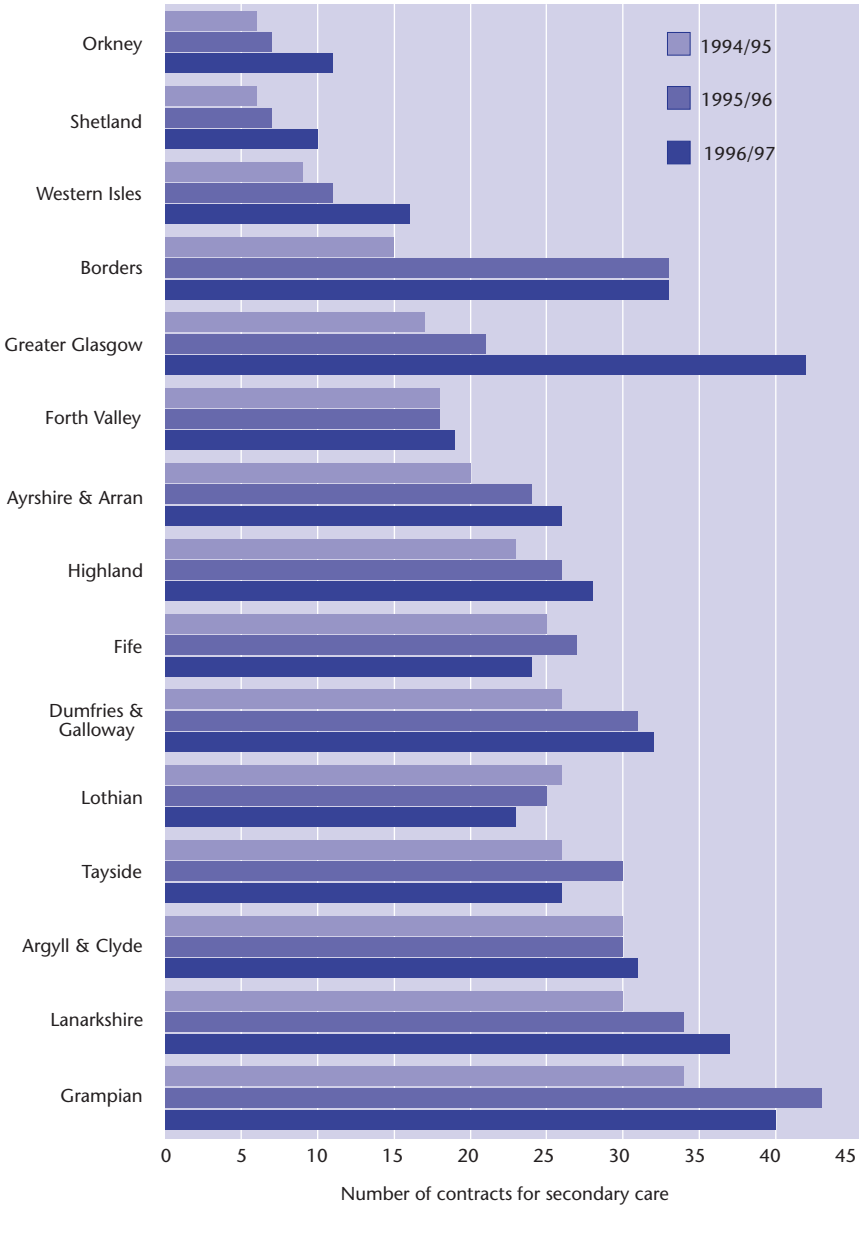
Many contracts are for relatively small amounts of money. Of the 398 contracts let in Scotland in 1996/97, 80 (20%) were between host boards and their local NHS trusts. These contracts account for more than 90% of the value of hospital and community health services purchased.

Exhibit 3: Value of secondary care contracts by type of provider (1996/97)



Note: percentages have been rounded

Exhibit 2: Total number of contracts let 1994/95 - 1996/97



In addition to the cost of managing large numbers of small contracts, these figures demonstrate that contracting is a very local affair. Even for the three island boards, only around one fifth of total expenditure is accounted for by contracts outwith their area. Three mainland boards (Argyll & Clyde, Borders and Lanarkshire) have contracted to spend a similar proportion of their resources outwith their own area, but the average for Scotland as a whole over the last three years is less than 10%.

The value of these out-of-board contracts for hospital and community health services has increased by 1% over the last three years, indicating that the internal market has had a minimal impact on boards' choice of health service providers.

Contracts with non-NHS providers are very small in scale. In 1996/97, the total across Scotland was £40 million, which represents less than 1.5% of the total. For individual boards this ranged from zero to 5% of contracted expenditure, with 10 boards contracting less than 2% of their total expenditure outwith the NHS[2].

Types of contracts

The four most commonly used contract types are:

- simple block
- sophisticated block
- cost and volume
- cost per case.

These contract types are used to varying degrees by all health boards. However, they have been adapted (and in many cases renamed) by a number of boards, so that the distinction between some contracts (especially sophisticated block contracts and cost and volume contracts) is often unclear. In some boards it is not possible to distinguish easily cost per case contracts from extra-contractual referrals.

In 1995 the Healthcare Financial Management Association (HFMA) also commented on this, reporting that ' the boundaries between contract types are increasingly being eroded, variations on a theme have emerged'[3]. The HFMA also highlighted the danger that increasingly sophisticated contract types might increase the cost of contracting without adding value to the process. The Accounts Commission is encouraged to report that all Scottish health boards are aware of this danger. Auditors found evidence that boards have considered the utility of different types of contracts before adopting them.

The history of contracting in Scotland reveals a period of development and experimentation, between 1991 and 1995, followed by a year of consolidation. This is perhaps best shown by the move away from more sophisticated contract types, and more importantly the overall increase in the use of simple block contracts.

This increase was quite dramatic. Between 1994/95 and 1995/96 the total amount committed to block contracts rose by 49%; between 1995/96 and 1996/97 it rose by a further 82%. In the same year the value of all other contract types fell by more than 10% (exhibit 4).

The increasing importance of simple block contracts is illustrated further by the proportion of health care expenditure which they account for (exhibit 5).

- **Simple block:** Under this form of contract the purchaser pays the provider an annual fee in instalments, for access to a pre-defined range of services. No specific activity levels are set, with the contract being agreed on the basis of total cost or level of provider inputs. Simple block contracts are suitable for services where the recording of activity is historically too poor to set an activity baseline. They are also suitable if it is difficult to record actual activity or where demand/need fluctuates or is uncertain.
- **Sophisticated or indicative block:** This form of contract operates as a block contract; however activity 'ceilings' and 'floors' are determined (e.g. plus or minus 5%) called 're-opener clauses' or 'activity thresholds'. If activity exceeds or falls below these levels, the contract entitles the provider to additional resources (if above ceiling) or a reduction in resources (if below floor). A contract with threshold/ re-opener clauses is suitable for containing activity and covering provider costs through income.
- **Cost and volume**: This contract involves the provider receiving a sum of money in return for treating a specified number of cases. Like the sophisticated block, there will also be threshold or re-opener clauses. This type of contract is most suitable where the activity can be reasonably accurately predicted by the board. Within a cost and volume contract the board can be more specific about the expectations they have of providers.
- **Cost per case:** This involves the payment of a fee for a particular service for an individual patient, the frequency and number of which may not previously have been agreed. It is most suitable to use this type of contract when the level of service required is very small. Cost per case contracts can also be effective if this level is expected to vary significantly.

Exhibit 4: Use of block contracts

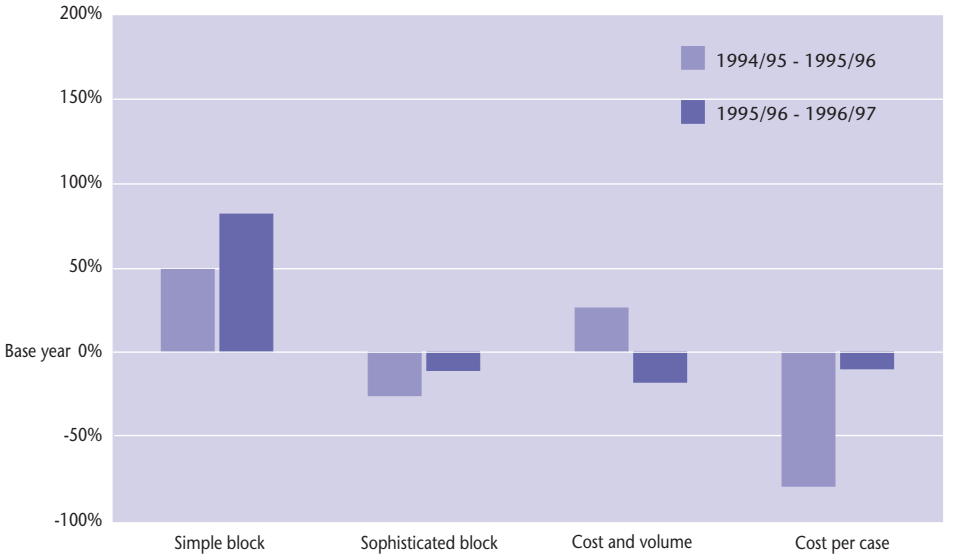
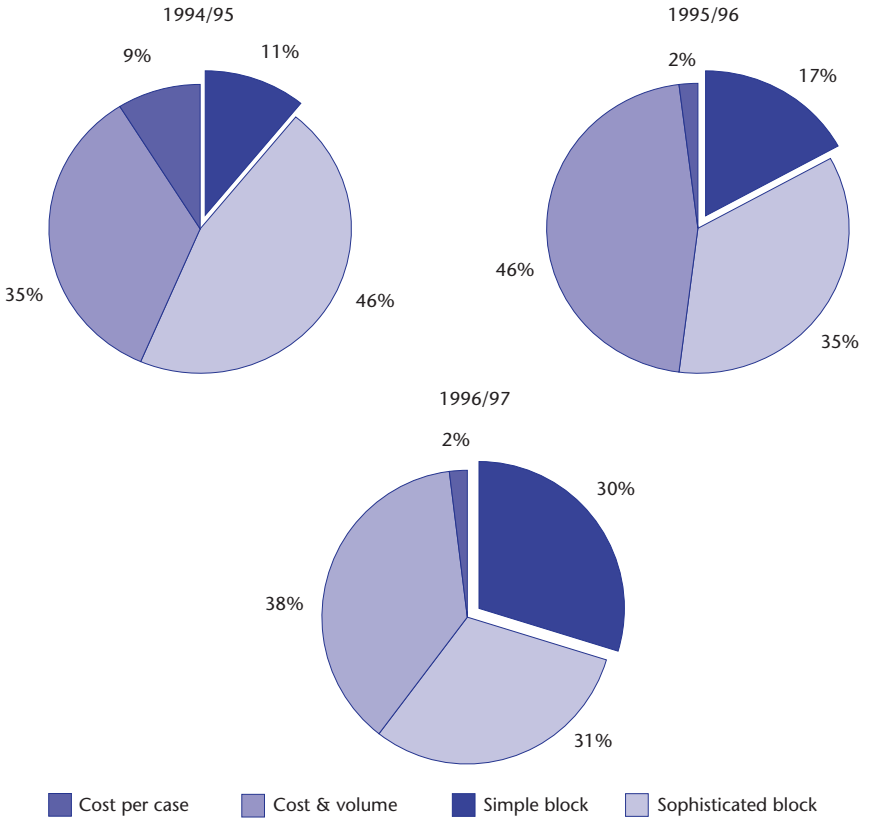


Exhibit 5: Contract types used by value 1994/95 - 1996/97



Note: percentages have been rounded

In 1994/95 only 11% of all contracted expenditure was committed through simple block contracts. By 1996/97 this had increased to 30%. Auditors reported that eleven boards increased their use of block contracts between 1994/95 and 1996/97. The remaining four decreased their use of this contract type, but by less than 10% of contract value.

Across Scotland, cost and volume contracts account for 38% of total expenditure, although one board uses this contract type exclusively.

In spite of the perceived dangers of this type of contract, boards actually incurred little additional expenditure as a result of their use. For example in 1995/96, when almost half of contracted expenditure was tied to cost and volume contracts, Scottish health boards had to provide approximately £10 million to cover additional expenditure, or 0.5% of the original contract value.

For only two boards did additional expenditure exceed 1% of the original contract value; Grampian at 3% and Orkney at 11%. Both these boards reduced their use of cost and volume contracts for the subsequent year. Moreover, a number of other boards have tightened up the thresholds and ceilings, and many contracts now specify that reaching the ceiling will trigger negotiations and not, as in previous years, automatic payments for additional activity.

The clear trend back to block contracts across Scotland hides the experimentation of individual boards with different contract types. For example one board let only 1% of its contracted expenditure by means of block contracts in 1994/95, but this had risen to 98% in 1996/97. Another board, experimenting with cost and volume contracts, moved from no contracts of this type in 1994/95 to one third of contracted expenditure in 1995/96, abandoning them again in 1996/97.

The year 1996/97 seems to mark the beginning of a period of consolidation in contracting. Boards offered 5 key reasons for reverting to less sophisticated types of contracts:

- an acknowledgement that the board could not afford to pay for additional activity reflected in more sophisticated types of contract
- the need to ensure that the contract type did not provide 'perverse' incentives to providers to carry out additional unplanned work
- the lack of robust and comparable pricing mechanisms
- the lack of information to inform sophisticated contract types
- the value of block contracts in assisting the board and its main providers to agree and implement strategic changes to services.

Scotland is not unique in its diversity. Studies in English and Welsh health authorities found great variety in the form and content of contracts[4,5]. It is, however, surprising that practice varies so much between the 15 Scottish health boards. There was little evidence of boards sharing contracting experiences, or spreading ideas and processes which proved successful.

Contract periods

Traditionally NHS contracts have covered a twelve month period in line with the financial year. However, over the last two years, longer contract periods have been encouraged by a number of influential reports, including:

- the Shields Report on the roles and responsibilities of boards
- NHS Priorities and Planning Guidance 1996/97 and 1997/98
- the report of the Joint Review of the Contracting Process by Board General Managers and Trust Chief Executives.

Longer contract periods offer the opportunity to strengthen partnerships between boards and trusts, reduce end of year pressures, allow boards a better chance to implement strategic change and reduce the bureaucracy of contracting.

So far only two boards have let contracts with NHS trusts which cover more than twelve months; one contract for three years, another for 18 months. A third board had a ten year contract with an independent provider which expired in 1996/97. Three boards, having completed a review, decided not to let longer term contracts, while three more are still considering their utility.

All boards agreed that the potential for longer term contracts is severely constrained by the annual system of financing. Many boards are unwilling to enter into contracts where their ability to fund the agreed sum beyond the first year is uncertain. Boards also reported that the lack of robust data on activity and price further reduced their confidence in longer term contracts.

However, nine boards have let a number of 'rolling contracts'. These are typically for three to five years, with activity levels and price subject to an annual review. Although they will reduce year end pressures on boards and strengthen the implementation of longer term strategies, it is not clear whether they significantly reduce the cost of contracting. Our research suggests that most problems with contract negotiation centre around activity and price, and these are not affected by the introduction of rolling contracts.

Some boards are considering staggering the end dates of their rolling contracts. This would spread the contracting process more evenly throughout the financial year, but again does not eliminate the need for negotiations on activity and price every twelve months.

Most boards base their contracts on what was actually purchased in the previous year. This means that the vast majority of the services they contract for remain unchanged from one year to another. This study suggests that many boards could benefit by focusing their attention on individual service areas. Ayrshire and Arran Health Board plans to introduce longer term contracts on completion of individual service reviews. This, they anticipate, will provide greater confidence in the services being commissioned, and allows the board to enter into longer term contracts based on a thorough review of needs and services.

Contract currencies and price

A key issue in contracting for health services is the use of contract currencies and the specification of contract price. A currency is the term given to the unit by which a service can be described, or measured, for example occupied bed days. Most currencies do not relate directly to the way in which prices are specified. This creates particular management and value for money issues for the NHS in Scotland. Moves towards describing (and therefore paying for) what services achieve (outcome) and not what they do (occupy beds) are evident, but are constrained by limited and inaccurate 'currencies'.

A detailed review of contracts for the last three years clearly demonstrates that traditional contract currencies are still being used by most boards. Overall, both contracts and planning documents were found to be imprecise and phrased in very general terms. This does not help boards to achieve value for money, and disguises a lack of information about what services are being purchased, and at what cost and quality.

The problems surrounding the definition, measurement and costing of NHS services are well documented elsewhere[6]. The Accounts Commission found a good deal of dissatisfaction with contract currencies and price bases. The main concerns were:

- different approaches to costing services by providers
- broad and inconsistent definitions of services
- different units of measurement
- inaccurate measurement.

Both trusts and boards felt that their ability to refine contract currencies and therefore set meaningful price bases at a local level was limited.

Most contracts for secondary care are phrased in terms of four contract currencies:

- occupied bed days
- in-patient discharges
- out-patient appointments
- day cases.

A number of contracts are set in terms of the specialty, defined as an unspecified combination of in-patients, out-patients and day cases. This is a very imprecise currency, which can hide significant variations in the pattern and cost of care provided.

One of the most specific contract currencies identified was individual procedures; in 1996/97 seven boards used this form of contracting, representing 10% of the total contract value.

Only one board reported using care packages as a contract currency. Greater Glasgow Health Board contract for 'packages' of drug rehabilitation services. Care packages are one of the few examples of a service description matching the price base.

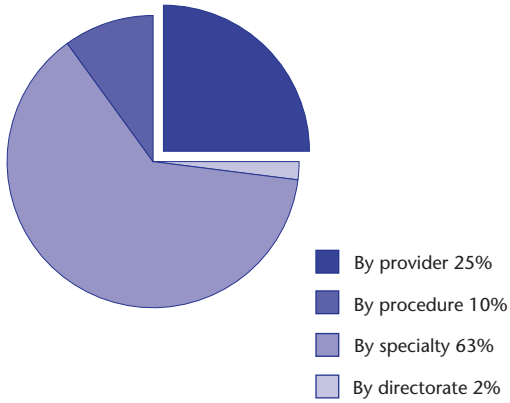
Another example of this is Healthcare Resource Groups (HRGs). The methodology for HRGs improves the sensitivity of currencies by linking procedures together which may 'consume' a similar level of resource. NHS Trusts have produced some tariffs based on HRGs. The NHS in Scotland has operated a national costing project over the last five years. This promotes costing methodologies within providers, but has had no mandate over boards' use of the tariffs. By 1997/98 the NHS Management Executive expected that all boards would have addressed the contracting implications of HRGs and used them in some contracts. Between 1994/95 and 1996/97, no contracts used HRG currencies.

There are alternative approaches to the issue of linking currency to price. One reportedly favoured by clinicians is the grouping of diseases, diagnoses or procedures.

Only four price bases, used to specify the amount of money to be paid, were found in contracts:

- by provider
- by directorate
- by specialty
- by procedure.

Exhibit 6: Value of contracts by price specified 1996/97



The most significant of these is the specialty level, which accounted for 63% of all contracted expenditure in 1996/97. Contracts set at procedure level are increasing; in 1996/97 10% of all contracted expenditure was specified in this way. However, around a quarter of all the money spent through contracts is still specified by provider, which is strongly reminiscent of the pre-reform mechanism of allocations from boards not tied to any specification of activity, cost or quality.

The limited specification of contract volume and value which does exist is rarely presented within the contract document itself, which in most cases contains only aggregate figures of activity and cost. This explains in part the high use of broad price bases reported here. However, an accountable and open NHS needs to ensure that its decisions are made explicit. Subsequent bulletins will report on boards' production and use of purchasing intentions, and the level of detail found in these documents.

Regardless of the mechanisms used for commissioning health services, it is vital that the NHS in Scotland has robust information on the quantity, cost and quality of services provided. The current contracting process does not provide this information, and it is impossible to measure value for money in all but a few better-researched services, such as some cancer and stroke treatments. This is an important issue that needs to be addressed at a national level, however health services are to be managed after the abolition of the internal market.

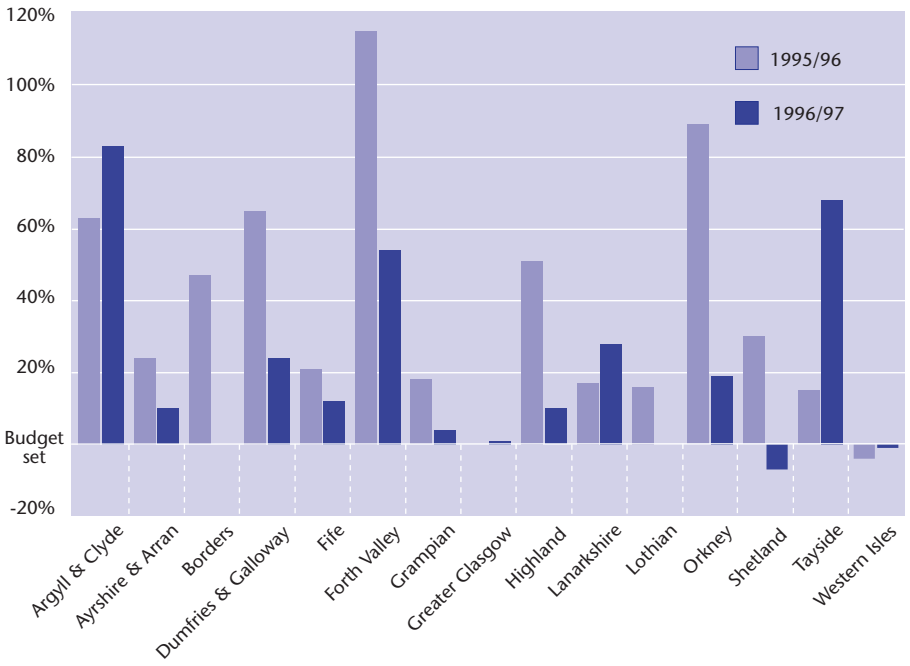
Extra-contractual referrals

Not all health services required by a board's residents can be anticipated and covered by a contract. When a resident requires a health service the board has not contracted for, this service is arranged through an 'extra-contractual referral' (ECR). The level of ECRs for each board is comparatively small, compared to contracted activity, but the system is a good indicator of efficient contracting processes.

In 1996/97 boards spent around £30 million on ECRs, representing 1% of total expenditure. This is a small proportion of board expenditure, but the number and value of ECRs are increasing, and the cost of managing them is disproportionately high. On average it costs ten times more for each pound spent on an ECR than on routinely contracted activity.

Since 1994/95 the total budget assigned to ECRs has increased by a quarter. Significantly, the total actually spent on ECRs has increased by more than the budgeted provision. Very few boards have contained their ECR expenditure within budget over the last three years.

Exhibit 7: ECR expenditure compared to set budget



Across Scotland, ECR expenditure exceeded the budget by 31% in 1995/96 and 23% in 1996/97. Two boards exceeded their ECR budgets by significantly more in 1996/97, at 68% and 83% respectively. The level of overspend in Scotland seems to be higher than in England; a survey of 80 English health authorities found the highest overshoot to be 40%[7].

The cost of contracting

So far, this bulletin has focused on how boards have managed the contracting process, and what changes have resulted from it. This section moves on to examine the cost of the contracting function, including:

- preparing to contract
- negotiating contracts
- monitoring contracts
- managing ECRs.

Contracting is only one health board function. The Shields Report contained proposals intended to refine the contracting function, in the context of boards developing as 'commissioning' bodies. In response to this report mainland boards were asked to limit total management costs to £10 per head of weighted population.

Another bulletin in this series will discuss in more detail how boards have responded to the Shields Report; here the focus is upon the estimated cost of contracting.

The approach used to determine these costs was originally developed by Grampian and Lanarkshire Health Boards. For this study all boards identified the number and cost of staff working on the four elements of contracting, together with expenditure in other areas such as support services. The result is the best estimate available of the cost of the contracting process across Scotland.

From local auditor work and national research it is clear that many, if not all, boards are unable to identify accurately the cost of their contracting work. For many boards this has become more difficult with the decline of traditional functional structures and the growth of matrix management. The evidence also suggests, however, that boards may not have used cost information to prioritise areas for cost reduction, but have instead concentrated on

reducing management costs overall. This has serious implications for the future evaluation of the effectiveness of boards' new structures.

In 1996/97 the total cost of managing contracts by Scottish health boards was £5.7 million. This figure is around £1.1m less than that reported for 1995/96 and represents less than 0.2% of all contracted expenditure. Individual board expenditure varied between 0.2% and 0.6%. This level of expenditure is equivalent to just over £2.10 on contract management for every £1000 of contracted expenditure.

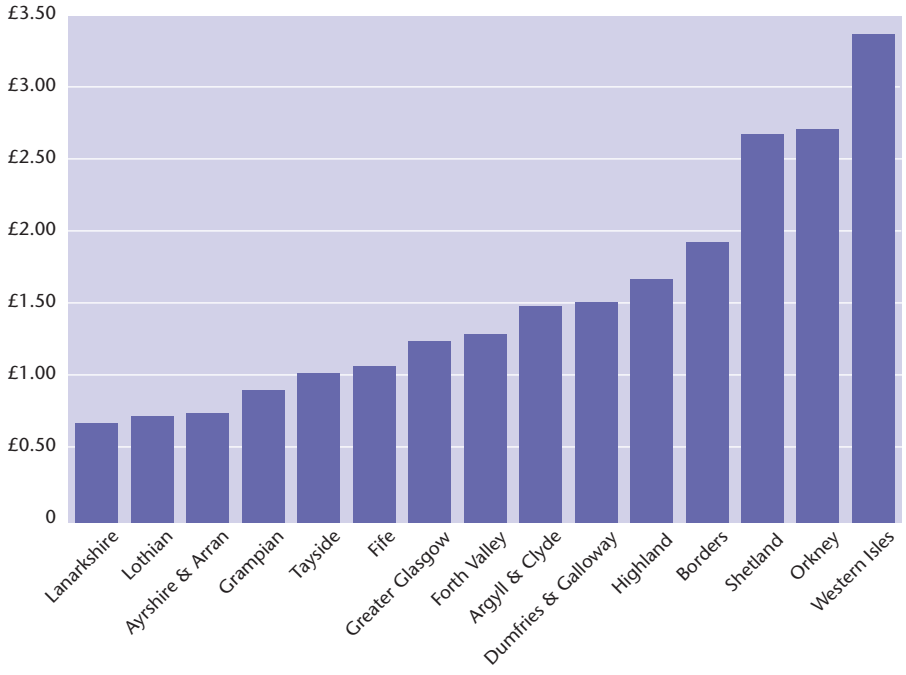
It is generally accepted that boards should strive to keep the cost of managing contracting as low as possible, since it consumes resources that could otherwise be used to fund patient care. Comparisons between boards offer one method of identifying potential areas for improvement. Other methods include comparisons with: the cost of other functions within a board; the value of total contracted expenditure; or per head of population, weighted for age, sex and morbidity.

Using the weighted population figures for 1996/97 the cost of contracting range identified was more than four-fold. The lowest spend per head of population was £0.69 compared to the highest, which was over £3.00 per head (exhibit 8).

A key factor which appears to influence this range is the geography of the health board area. Island and more rural boards all estimated higher costs per head of weighed population.

As expected the cost of contracting also rises in line with the value of contracts let (exhibit 9). However most of the boards with greater contract values have achieved some economies of scale.

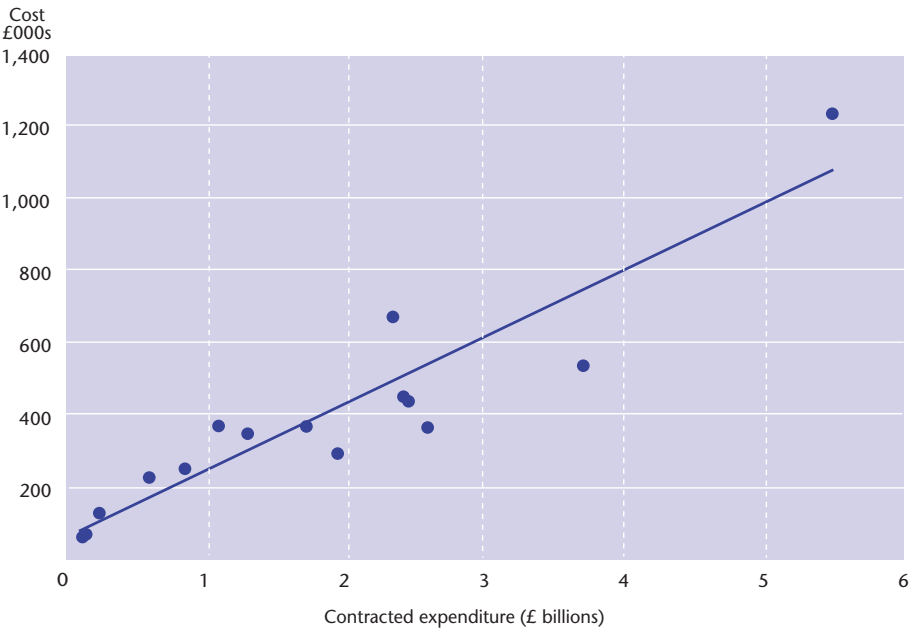
Exhibit 8: Estimated cost of contracting per head of weighted population



Many trusts, surveyed in the course of this study, indicated that the cost of contracting to them fell disproportionately on the administration of low value contracts (GP Fundholders, contracts with other health boards and also ECRs).

The discussion which follows uses only health board staff costs of the contracting function, since these are both the most significant and the simplest to identify.

Exhibit 9: Cost of contracting by value of contracted expenditure



The management cost of contracting consists of three main tasks:

- preparing to contract
- contract negotiations
- contract monitoring.

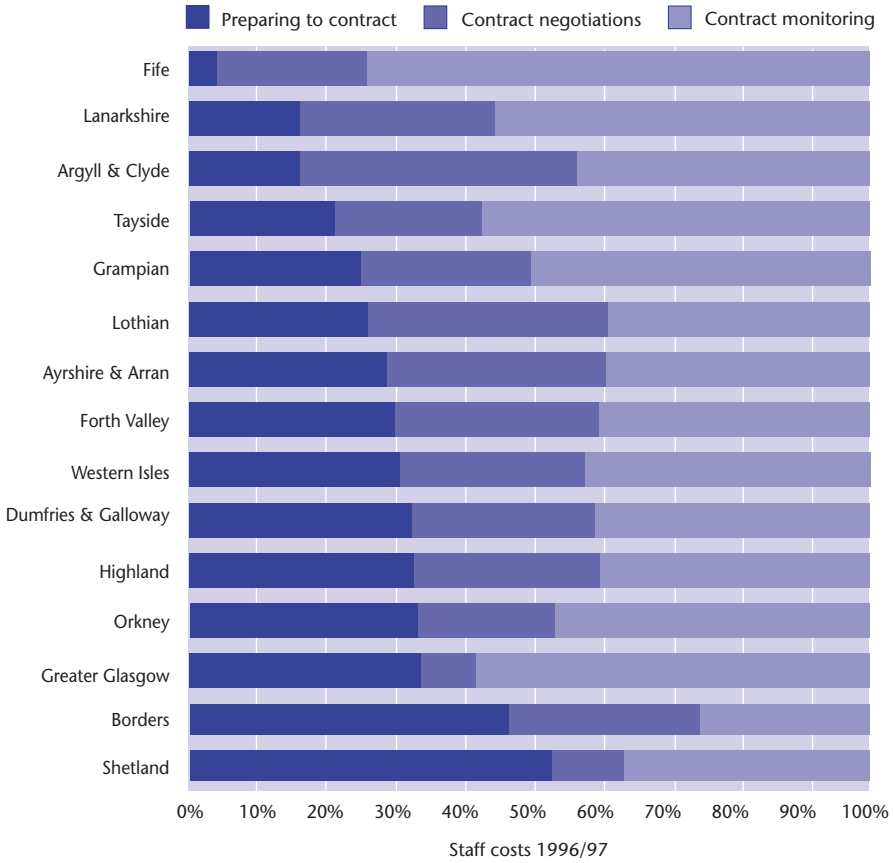
Across Scotland, boards put more effort into monitoring the services they have contracted for than into preparing and negotiating contracts (exhibit 10). Half of all contract management costs are associated with contract monitoring. The other half is split equally between preparation and negotiation. These proportions changed little between 1995/96 and 1996/97.

Exhibit 10 illustrates the varying approaches to contracting within the 15 health boards. For example, contract monitoring accounts for nearly three quarters (74%) of one board's contracting function, yet only one quarter (27%) for another board.

Preparing to contract is the most significant element of contract management for only five boards (ranging from 33% to 53%). For one board it accounts for only 4% of the cost of contracting.

The Accounts Commission believes that the balance between contract preparations and monitoring is wrong, and recommends that boards increase the scale of their preparatory work. This should help ensure clear and explicit agreements which are related to strategies and commissioning intentions.

Exhibit 10: Estimated proportional spend on contracting functions



The management cost of ECRs

The Accounts Commission's costing exercise confirms that ECRs are an expensive way of arranging service delivery. Although overall ECRs represent only 1% of the total expenditure on services, they account for around 10% of the total cost of contracting. For individual boards the cost ranges from 5% to 19% of the total cost of contracting.

The cost of managing ECRs is also costly when compared to the value of the sums involved. On average, the management of ECRs costs 2.8% of the total involved, compared with 0.2% for the management of contracted expenditure. In cash terms, it costs Scottish health boards more than £20 to administer £1000 of ECR expenditure. This is ten times higher than the equivalent of just over £2.10 per £1000 of contracted expenditure.

Island and rural boards find it more costly to manage ECRs. The five most rural boards account for 10% of ECR expenditure in Scotland, but 20% of the total ECR administration costs.

Tayside Health Board have one of and lowest ECR management costs but can demonstrate savings achieved by their administrative procedures. These savings exceed their ECR management costs by a factor of ten, and provide a good indication of some aspects of ECR procedures.

Further bulletins in this series will develop this and a number of the other issues summarised here.

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7 'Its all in the balance', Dixon and Klein, Health Service Journal, 5 June 1997.

If you would like more information about the study or additional copies of the report please contact:

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The Accounts Commission for Scotland

The Accounts Commission is a statutory independent body which through the audit process assists the NHS and local authorities in Scotland achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies.

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