For Debate

Contracts and quality of care

Anthony Hopkins, Robert Maxwell

What conditions should be included in contracts between hospitals and district health authorities to safeguard the quality of patient care? The white paper *Working for Patients* outlines (para 4.13) that "in future, each DHA's (District Health Authority) duty will be to buy the best service it can from its own hospitals, from other authorities' hospitals, from self governing hospitals, or from the private sector."[1] Hospitals for their part will have to satisfy districts that they are delivering the best and most efficient service. Working paper 2[2] expands these concepts and gives guidance on pricing block contracts, cost and volume, and cost per case contracts (paras 2.10 to 2.19). The only reference to quality of care in these contracts is in working paper 2 (para 2.20) that "it will be the responsibility of those placing contracts to monitor the performance of hospitals in providing agreed services. In order to ensure that patients' personal as well as clinical needs are being met, health authorities will wish to monitor patient satisfaction by such means as the systematic use of questionnaires and follow up surveys. As a quality control measure, contracts could require the hospital to provide reports on all complaints received and the action taken to remedy them."

The competitive market that is likely to be introduced when the white paper is enacted means that without adequate safeguards performance within the contract is likely to be driven by price rather than quality. In 1982 a prospective payment system was introduced in the United States, after which payment for hospitalisation of the Medicare population was linked to diagnosis (diagnosis related groups (DRGs)). There is evidence that after the change in contractual arrangements patients were discharged "quicker and sicker."[3,4] We are concerned that similar changes may occur in the United Kingdom and also by the emphasis on patient satisfaction as the sole measure of quality mentioned in the white paper. Although we agree that monitoring patient satisfaction and complaints is an essential feature of quality assurance, satisfaction is clearly only one dimension of outcome and does not necessarily reflect the quality of technical aspects of care—badly treated patients with poor medical outcomes may still feel satisfied. Admittedly, official thinking is taken a step further in a later working paper, *Contracts for Health Services: Operational Principles*,[2a] which recognises (in para 4.11) the importance of quality measures of appropriate care and clinical outcome as well as of patient satisfaction. As the working paper goes on to say (para 4.12), "It will take time to develop a range of quality measures. . . ."

In the light of the primitive audit systems presently in place in the United Kingdom, one safeguard of the quality of care is that future contracts between hospitals and district health authorities should specify relevant and realistic measures of quality so that performance under the contract may be monitored. Interestingly, there is already considerable experience by district health authorities of placing clinical contracts, but in a recent survey only about a 10th of such contracts included any specific definition of quality of performance.[5] We hope that this paper will open discussion on what contracts should specify. The first step is to identify conceptually what we should try to assess. Until dimensions of quality of care have been identified discussion about the methods to be used and appropriate measures is pointless. In our discussion we draw on some of the previously reported arguments by one of us (RM)[6] and on the work of several authors, notably Donabedian.[7]

Perspectives in drawing up health contracts

What do patients need to know?

What should authorities ensure?

What do surgeons and physicians need to know about the contract and their patients?

How can referring general practitioners or hospital doctors be satisfied with patient care?

Contracts will be made for a population, comprising either all residents within the boundaries of a district health authority or patients requiring an identical procedure such as coronary angiography or hip replacement, and several perspectives must be considered (box). Firstly, what do patients need to know about the contracts being made by a district health authority on their behalf? Secondly, what should the authority ensure on behalf of its resident population? Thirdly, what do the surgeons and physicians working in the contracting hospital need to know about the contract and the patients whom they treat? Finally, how can referring general practitioners or hospital doctors be satisfied about the quality of care that their patient receives in the contracting hospital? Here we shall consider mainly the patient's perspective and other perspectives only fleetingly, partly because we must start somewhere and partly because meeting patients' legitimate concerns provides a prime touchstone of quality for all partners to the contract.

Perspective of patients

Measures that individual patients might like to see specified in a contract for a service—for example, coronary bypass surgery, a procedure for which specialist hospitals are likely to be keen to tender to

Research Unit, Royal College of Physicians of London, London NW1 4LE
Anthony Hopkins, *director*

King's Fund, London W2 4HT
Robert Maxwell, PHD, *secretary/chief executive*

Correspondence to:
Dr Hopkins.

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maximise volume of patients relative to high fixed costs—probably include the following:

- Length of time on the waiting list and for the procedure will not be too long
- An explanation will be given as to what exactly is to happen, and there will be an opportunity to ask questions, initially and as treatment progresses
- Someone with appropriate skills will perform the procedure
- They have chosen to undergo the procedure after informed consideration of the inherent risks
- Their care will be of a high standard technically
- Postoperative pain will not be excessive
- Care takes place in a reasonably pleasant environment
- They leave hospital as soon as possible but only when feeling well enough to do so
- The family doctor will know what to do when they return home
- Their original symptoms (say, angina) are improved after the operation, and they will be able to lead a fuller life as a result.

This list of presumed patient interests may provide a framework for considering some contractual specifications of quality (see summary box). We will discuss each heading in turn.

Main considerations of quality in drawing up hospital contracts

Access to services—temporal
—geographic

Communication—between clinical staff and patients and vice versa
—between hospital and family doctors after discharge

Technical safety and effectiveness—technical skills
—mortality and morbidity
—relief of pain and discomfort

Hotel services
Discharge aftercare
Patient outcome

Plus (for patients collectively): equity, relevance to need, and value for money

ACCESS

Contracts for a defined population within a district health authority for a particular procedure should specify a time limit from referral before which the procedure will be carried out on, say, 95% of those for whom the procedure is appropriate. We are particularly concerned that changes occurring after introduction of the white paper should deal firmly with what might be termed the "tail end" of the distribution of waiting times; contracts should be able to control this, and horror stories of patients on waiting lists for five years or more should become a thing of the past. A contract between a hospital and district health authority might specify financial penalties if a patient in the district's population has to wait more than, say, one year from referral for a procedure. Clearly, a much shorter waiting time should apply in life threatening, urgent situations. We are simply suggesting a reasonable maximum figure for any serious procedure. Rather than pay the penalty a hospital may choose to divert more resources to fulfilling the contract or to buy in a similar degree of skill from another hospital, although this would of course have to be agreed with the referring authority. For outpatient services, which some general practitioners will be purchasing, patient access should be monitored similarly, although the simplest recourse for general practitioners dissatisfied about outpatient waiting times may be to shop elsewhere.

Contracts might also specify the period of warning normally to be given before admission to avoid calls at short notice, except when agreed with the patient. It should be unacceptable for patients to be sent home (as sometimes happens) because a bed is unavailable. Although waiting times for the procedure once patients are in hospital might also be specified within a contract, the occurrence of emergencies means that it is sometimes necessary to shuffle operating lists. Furthermore, there will in future be strong economic incentives to get on with the procedure once patients are admitted on a fixed price contract, and specifying that a procedure should be carried out within a defined time from admission is probably unnecessary.

In addition to access to hospital within a reasonable time, geographical accessibility should also be considered when the contract is placed. For a major procedure such as coronary artery bypass surgery patients are likely to accept travelling some distance to adequate technical skills. For some procedures or types of care there may be more than one contracted provider, offering some choice and the opportunity to compare performance, and patients should then be able to express their preference. As with all medical care, appropriate consent must be obtained from the patient, but we must not forget the family and its support. We, believe that if contracts are made with district health authorities some distance away, they should specify that the hospital will, through an appointed accommodation officer, give advice about reasonably priced locally available accommodation.

COMMUNICATION

Patients should be informed of the name of the consultant who is responsible for their care. We support the view expressed in the *Patients' Charter*, published by the Association of Community Health Councils, that all patients have a right to "be informed about all aspects of their condition and proposed care (including the alternatives available) unless they express a wish to the contrary."[8] Yet culpable failures in communication are among the commonest adverse findings by the Ombudsman. We believe that the contracts should spell out the requirement for adequate communication and should emphasise that patients have at all times the right to seek information about their diagnosis and progress and about the results of tests from their consultant and his or her junior colleagues. As most patients are diffident about bothering busy staff and may see their consultant infrequently they should be told whom to ask in the first instance (for example, the house officer, whose duty would be to call on others as necessary). For some procedures it may be appropriate to specify that patients receive a well written pamphlet before their admission, describing what will happen to them in hospital. Patients have the presumptive right to have the risks of the procedure explained in straightforward language; the risks of not doing the procedure and of alternative procedures and medical treatment must also be clearly explained in such cases, along with the patients' option to decline treatment. This option could well figure in general terms in any explanatory pamphlet sent to patients before admission. Communication of information and the sensitivity and interpersonal skills with which information is given are

aspects of quality that might be monitored by interview or questionnaire.

TECHNICAL SKILLS

The contract must specify that a procedure is to be carried out by a doctor with appropriate training or, if by a doctor in training, that there will be proper supervision. In undergraduate teaching centres the contract should specify that medical students may be involved in some aspects of patient care but remind patients that, as currently, they have the option to decline being "taught upon" and that this will not affect the quality of their care. The contract should specify that records are made of all individuals performing procedures, as in the present operation record; these records will then be available for subsequent audit during the contract and when it comes up for renewal.

MORBIDITY AND MORTALITY

Although a primary concern of patients having a procedure is that they survive, we do not believe that contracts can realistically specify a perioperative mortality or morbidity (such as wound infections) that cannot be exceeded. Rather, these are outcomes that should be audited during the term of the contract which may influence its renewal.

RELIEF OF PAIN AND DISCOMFORT

Although it is hard to see how relief of pain and discomfort can be specified in a contract, except in platitudinous terms, accessibility to adequate postoperative pain relief is one topic of interest for audit, and patients' accounts of their care may be of great value here.

HOSPITAL ENVIRONMENT AND HOTEL SERVICES

Hospital environment and hotel services are items likely to be considered when a district health authority places a contract for a procedure, although not requiring spelling out. It is worth noting, however, that cleanliness of a hospital ranked equal third as a component of patient satisfaction (components related to nursing care ranked first, and those related to medical care second); aspects of the hospital environment and hospital food, rather than medical care, may determine patients' response to whether or not they would be prepared to return to the same hospital (A G H Thompson, proceedings of the fifth international symposium on quality assurance, Madrid 1989). The quality of environment and hospital services are again open to audit by surveys of patient satisfaction. Although a considerable amount of work has been carried out on questionnaires designed to measure patient satisfaction, there is an urgent need for their standardisation so that results can be compared across districts.

DISCHARGE, AFTERCARE, AND LIAISON WITH FAMILY DOCTOR

We quoted above some evidence from the United States that introduction of diagnosis related groups resulted in premature discharge from hospital[3] so that cost could be kept within a reimbursement limit. The contract must specify that a patient must not be discharged unless she or he is clinically ready and that further care has been arranged. The contracting hospital must perform its duties well and expeditiously under the terms of the contract; equally, however, the contracting hospital may legitimately require the referring family doctor, hospital doctors, and district health authority to have in place appropriate systems of aftercare so that patients can be expeditiously and safely discharged. In practice this means that a referring district authority will on occasion have to take into one of its own hospitals a patient who no longer requires the technical services of that hospital but whose domestic circumstances prevent return home at the usual time. For patients whose course is complicated by some unforeseen clinical setback there are two alternatives. The hospital undertaking the procedure could keep them until they are fit to leave and then carry the financial loss. (Clearly costs will have to be calculated on the basis of a proportion of patients whose care is not straightforward.) Often it will be more appropriate, however, for them to return to the district health authority hospital near home, and contracts then will have to specify how the costs of this aftercare will be shared between the referring district health authority and the contracting hospital.

It is commonplace for patients in the United States to sign a chit stating that they feel ready to be discharged. In some hospitals this chit lists the treatment at discharge, and patients have to sign that they understand how to take it and that they also understand the arrangements for their further care. Without being so naive as to believe that signing a list of drugs means that a patient really understands what to do, we think that this openness has much to commend it.

A district health authority should, in our opinion, specify to the contracting hospital that discharge must be associated with adequate communication with the family doctor, usually by a discharge note handed to the patient or posted at discharge. The note should be followed by a discharge summary containing adequate information, which should be sent within a (specified) reasonable time. The appropriateness of the content of the discharge summary[9] and the interval between discharge and receipt of the summary by the family doctor should both figure in a contract made between district health authorities and hospitals. A district might, for example, insist that a summary should always be received by the general practitioner within 10 days after discharge. This can readily be audited. Specifying such a requirement in a contract may increase awareness by hospital administrations of the need to pay adequate salaries to attract the secretarial help that hospital doctors in the United Kingdom so sorely lack at present.

RELIEF OF SYMPTOMS AND IMPROVEMENT IN QUALITY OF LIFE

We do not believe that relief of symptoms and improvement in the quality of life can be contractual matters. We would like to think, however, that these fundamental outcomes of care are results that can be audited. There are many criteria of state of health, either specific to one disease or as measures of "general health."[10] They are, however, essentially research tools, and, as yet, few generalised indicators of the outcome of care can regularly be applied routinely. A priority area for research is the evaluation and refinement of available simple indicators of outcome and their adoption nationally so that outcomes of care can be audited and compared in different district health authorities and regions. An almost equal priority is the refinement of available measures of severity of case mix because without this comparing information among units can be dangerously misleading: apparently good results may stem from refusing difficult cases, and vice versa.

Perspective of district health authority

We have referred more than once to aspects of care that cannot reasonably be specified in a contract but can be audited. We believe that contracts should

specify that a hospital must have an adequate audit system to ensure that it operates in such a way as to safeguard quality. A district health authority will undoubtedly wish to see audit reports from previous years before placing a contract. It will have to consider the question whether the supplier's audit is something of a decoration or whether it is serious and leads to action. In short, there is increasingly a need to audit what is actually going on under the name of audit. In addition to this institutional system, a district health authority should, we believe, specify that a contracting service within a hospital should collect data that will permit audit of the variables, such as waiting times, discussed above. Finally, there should be patient orientated systems of audit specified within the contract. A district health authority might require that the service concerned join it in, for example, reviewing all perioperative deaths in that service. The district health authority should also monitor patient satisfaction by receiving copies of all complaints made to the contracting hospital and by its own surveys, some of which should be carried out after a sufficiently long interval to ensure that the focus is on outcome rather than process.

The interest of the district health authority in quality—and its responsibility—must extend beyond the performance of any one contract. Whereas the contractor is bound to carry out his contractual obligations or suffer the consequences these obligations are unlikely to include such crucial questions as whether access to care is equitable and whether access is related to need, not to influence or expressed demand. These are the business of the district health authority in the first instance, not those of the contractor. Similarly, whether a particular procedure or service is worth buying is primarily a matter for the district health authority as the purchaser to judge. On the other hand, the contractual relation will be strongest and will stand the test of time when the district health authority and the contractor work on questions like these together, even though their perspectives and responsibilities necessarily differ.

Perspective of referring general practitioners or hospital doctors

The main concern of referring general practitioners or hospital doctors will be that patients are referred appropriately—in other words, that they need the service in question—and that they are properly looked after. So the referring family doctor and hospital doctor will want to be satisfied in advance about the contractor's competence to provide care of the requisite standard and that the end result will be satisfactory. Probably they will be rather less concerned about the overall pattern of results than the district health authority because they may not be concerned with such large numbers of patients, but they will want to keep closely in touch with how their own patients fare.

Referral patterns at present depend largely on considered judgments about quality as perceived by the referring family or hospital doctor, who will preferentially refer to a colleague in whom he or she has confidence. Confidence is likely to be based on respect for technical skills and personality. In short, the consultant is expected to produce good results and to communicate well with this particular patient, and some account will also be taken of waiting times. We believe that a district health authority should consult widely among local family and hospital doctors and in the local community before trying to alter established patterns of referral; doing otherwise would not be sensible when the established patterns are mostly based on conscious and informed judgment.

Perspective of the physicians or surgeons in contracting hospitals

We believe that virtually all doctors want to do the best possible job for their patients, regardless of the route of referral. Under the new system doctors will become professionally responsible for contract performance. It is essential therefore that the professionals contracted to undertake the procedure are fully involved in discussions about the contract and that they have sufficient resources to undertake their contractual responsibilities safely and well. They will also wish to be reassured that there are no pressures for inappropriately early discharge and that adequate aftercare has been arranged for their patients. An agency providing a service under contract will do so episode by episode so continuity of care will depend on cooperation between clinicians in the unit concerned and the referring district health authority.

In addition, senior medical staff in contracting units will need good information about resource utilisation and costs. In a competitive situation it is only too easy to obtain business at what turns out to be unrealistically low prices because somebody was too optimistic about an essential element in the bid. No unit within the NHS is likely to have much fat to absorb mistakes of that kind, which implies a dramatic and quick advance in information about unit costs, including the effect of changes in volume.

Conclusions

Currently, there are widespread doubts about the desirability of the emphasis in the white paper on contracts. Our purpose is not to argue this one way or the other but to highlight the central importance of proper attention to quality. Unless contractual relations take account of quality from the start they will be driven by financial considerations, with the false assumption that quality can look after itself. It cannot. Much hard thinking needs to be done about how quality can be specified, monitored, and controlled in a wide range of clinical services. Our purpose has been to share our thinking at this stage to stimulate others to take these ideas forward.

Many readers may be alarmed at how complicated the simple notion of contracts can become. This fear may be justified because the notion of quality in health care is itself complex. We also need to recognise that contractual arrangements will have a force of their own: once a contract has been made people will ultimately work to its terms. This does not necessarily mean, in our opinion, a highly detailed specification of quality measures in the contract, but there must be acknowledgment of the central importance of quality, agreement about how it will be monitored, and provision for what to do if there is any suspicion of failure.

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