

Cancer care commissioning, information and choice in England: a commentary

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Abstract

The National Health Service in England has focused on improving cancer services over the last decade, following indications from the international EUROCARE study that cancer services, and survival, were behind other comparable countries. New managerial structures and processes have been created to encourage service specialization by cancer type, develop coordination between hospitals and improve access times for patients. However, within the NHS in England as a whole, the government has been encouraging market ideas that contrast with this centralist direction. To improve patient 'choice', an improved information system, drawing on timely clinical and administrative data, is needed for cancer care commissioning.

Key words: cancer, healthcare services, commissioning, information, choice

Ten years' national cancer agenda

Cancer has been a focus of attention for the National Health Service (NHS) in England since a report by the Chief Medical Officer in 1995 [1,2]. Although cancer mortality has been decreasing, except for tobacco-related cancers [3], recorded incidence is rising, especially for breast, bowel, prostate and skin cancers. The international comparative study EUROCARE [4], suggesting that survival for many cancers was lower in the UK than in other comparable countries in Europe [4], has been an important stimulus for successive governments to improve cancer services in England.

To implement the Chief Medical Officer's 1995 report, the NHS was required to designate hospitals as either specialist referral 'centres' or hospital treatment 'units', and for these to be linked together in service groupings. Also, advisers developed national guidance on services for breast and colon cancers. After 1999, the new Labour government launched a programme to develop cancer services [5], appointed a Director of Cancer Services as both the Government's senior civil servant for cancer policy and also to head a Cancer Action Team responsible for NHS implementation, and published a National Cancer Plan [6]. Funding for the service developments was helped by the Prime Minister's decision at that time also to raise total NHS spending up to average of other European Union countries. This so-called 'Modernisation' programme was aimed at raising staff levels, improving hospital equipment and increasing expenditure on newer pharmaceuticals.

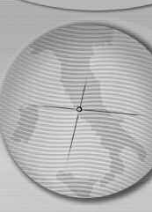
From 1974, the NHS had been organised with a local tier of decision-making, the health authority,

which had held most of the funds for a local population at a single point. In 2001, the Minister of Health introduced a structural reform called 'Shifting the Balance of Power within the NHS' [7], which abolished this tier and changed the funding to be held both centrally and locally. This allowed the government to control NHS funding directly to hospitals. The government also piloted a scheme to assist better administrative practices at local level, particularly to achieve government-set targets: this Cancer Services Collaborative [8] was soon expanded across the whole country.

The government's primary target for cancer services was neither a reduction in mortality, nor an increase in survival, but a service delivery indicator - waiting times. Each cancer centre and unit was required to achieve a target - that new patients urgently referred to hospital by a general practitioner should not wait more than two weeks to be seen. Accompanying this main target, the Cancer Plan developed clinical services guidance within a Manual of Cancer Services [9], devised and measured 180 service standards at acute hospitals, promoted cancer clinical trials through local services, created 34 cancer networks to coordinate the cancer centres and cancer units, and encouraged tumour-specific multi-disciplinary teams across these linked hospitals.

Politics of choice

The government's proposals in 'Shifting the Balance of Power' were presented as devolving 'power' away from central government. But holding funds centrally, setting national targets and creating national organisations including the



Modernisation Agency, the National Institute for Clinical Effectiveness and the regulatory Healthcare Commission, have all increased central government direction. The government also abolished Community Health Councils, created by a Labour government thirty years before to provide non-specialist advice and advocacy to local communities, and introduced patient advisory bodies for Foundation hospital trusts – making local voices less politically potent.

But the Labour party is driven by the electoral politics of appealing to majorities. It has linked ideas of promoting faster ‘access’ with the supposed greater ‘responsiveness’ of competitive markets and private healthcare providers. It has been a strong advocate of being against ‘one-size-fits-all’, and of increasing ‘choice’. However, competition, privatisation and selective access is at odds with Labour’s ideology of a National Health Service to achieve a fair distribution of limited national skills and resources according to need, and to promote high standards by professional collaboration rather than commercial competition. For cancer care, in particular, market solutions are problematic.

Patient choice is the corollary of service deregulation into competing markets. Patient choice is expected to increase the sensitivity of services and to encourage innovation. But the theory of consumer preference breaks down quite quickly, however, for health care, since it is well recognised that health is not a ‘perfect’ market. Within the National Health Service, where funds are collected through taxation and distributed through Parliament, clinicians must offer choices to patients within controlled resource limits. With provider competition, hospitals will want to take on more patients to increase profits, while the contracts that are made with the hospitals are limited by the NHS funds available.

Cancer information

Improvements in cancer care, through management and choice, depend on information. For cancer networks, information is drawn mainly from local Trusts. Patients, in contrast, draw from a range of sources, including GPs, patient-led charities, friends and published resources (including internet). Any choice, however, depends on comparison, and information needs to be provided in ways that allow reliable interpretation.

We made a study of information for cancer networks [10]. We undertook field interviews with staff members of four selected networks, and followed this by seeking telephone interviews with staff the manager, clinician and information

officer of the networks. We found that staff at present focus mainly on issues of data collection, in particular seeking to improve data for the waiting times standard. The networks had limited experience in making comparisons of performance, presenting data to their boards or and providing information for patient choice.

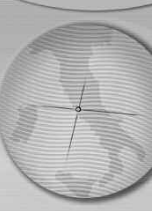
We also made analyses of the aggregate data sets at network and hospital trust levels. There were statistically (and practically) significant differences in rates across the country for survival, patient experience, waiting times, cancer standards, hospital provision and in-hospital mortality. We found that these differences were not uniform – that is, for example, the ranking of a hospital may differ significantly between different tumour types, and also across the different range of data measures recorded. Moreover, some, but by no means all, of the hospital characteristics recorded showed statistical associations with outcomes of survival and patient experience.

It is thus a complex task to make a choice from data alone which cancer network or hospital to attend for cancer care. A rational ‘choice’ would depend on matching different priorities against personal preferences, leading to minimisation of negatives. But this is really hypothetical. Most people who need cancer care are referred to their nearest hospital by their own GP, or they are found to have cancer during an investigation of less specific symptoms, or another disease.

Does this mean that comparative data sets will not be of value for cancer? Not necessarily. There remains a growing demand for comparative information for patients, sometimes to understand how their service compares with others, sometimes to provide an objective view about another possible service at a particular stage in the course of treatment. Certainly people don’t make choices simply on statistics alone. It is well known, for example, that ex-President Clinton chose to go to the hospital in New York State with the lowest success rates for his heart surgery [11]. On the other hand, data can provide public evidence of the current situation. In the inquiry into children’s heart surgery in Bristol, data were available to professional colleagues that were not made available to the public: accountability was lacking [12].

Cancer care commissioning

In 2007, the government will introduce standard prices for the National Health Service to pay public or private hospitals by clinical episodes, so that different ‘providers’ can compete according to their own costs. The system does not control for quality, and it will be for the managers of local



commissioning to determine whether they are getting value for money. Cancer forms a substantial part of the disease burden of a population, and will therefore be a significant concern for commissioning. Also, cancer patient pathways differ by tumour type, and different services are needed at different times in the pathway.

The government is also proposing to devolve NHS funds to be controlled by GPs, who are then expected to make 'market' choices for their patients. GPs will be expected to know which are cost-effective services, and to be able to discuss options with their patients — while also managing the emotional turmoil of the diagnosis and treatment of the disease. However, with most activity for cancer being initiated and controlled by hospitals, how will GPs know how to best allocate the funds provided to them, and will they best support patient choice?

An improved cancer information system is needed. Measures of cancer services, drawn from existing national data and covering service structure, process and outcome, are available at network and hospital trust level; and a wider set of information can be drawn together covering prevention (health promotion activity and screening) and financial information at population level. If choice is to be based on comparative performance, these data will be needed for rational decisions.

Where performance of local services is below comparators, the commissioning group will be able to discuss or negotiate service improvement. Holding financial control may not be a very strong card for the commissioners, because of the relative inflexibility of the market. Where hospitals propose better quality at the cost of higher prices; commissioners cannot quickly move a contract to another provider if there is no spare capacity. So markets may both decrease the efficiency of cancer services, because unused capacity is needed, and change clinical incentives from higher-quality care to higher-cost care.

The underlying logic of commissioning is strong: on behalf of the public, an informed commissioning group seeks to ensure the best cancer care service. Individual choice is converted into collective decisions. Good information will be prerequisite, providing the basis for objective decisions for cancer services. Such evidence will protect (at least to some extent) against corruption, and also provide a continuing set of measures for service evaluation and assessment of the benefits of service change or investment.

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