# Purchaser/Provider Split: Passing Fashion or Permanent Fixture?

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It seems incredible that the term 'purchaser/provider split' was introduced into common parlance a mere two or three years ago. It has come to pervade the health and social services at every level; and whether you are a purchaser or provider seems to be the issue of the moment. But is the concept going to fall out of fashion as quickly as it appeared, or is it here to stay?

There are many who feel very uneasy with the concept, and who see it as Thatcherism's Parthian shot at the welfare services which form the heart of the nanny state. They may believe that now there has been a change of leadership, the purchaser/provider split will go the same way as the poll tax. After all, the NHS reforms are almost as unpopular and politically threatening, so why not a U-turn here as well? Surely this particular fashion will disappear, as the free enterprise 1980s give way to the more caring 1990s, with many people depending on such a change sitting tight in the hope that their style of management will come back into vogue without them having to do anything, much as those who never change their wardrobes hope that their old clothes will one day swing back into fashion.

I can understand this approach from directors of social services who are in serious danger of being overwhelmed by change. And I have much sympathy for those who feel reluctance towards what appears to be a system that treats dependent and vulnerable people as commodities, to be traded through contracts in the market place.

But I do not think that we can ignore the purchaser/provider split in the hope that it will go away. What I shall try to do is unpack the ideas behind this concept to see if they are likely to endure, or to disappear as fashion moves on.

**What does the concept mean?**

In our media-dominated age, we live in a world of 'sound bites' – short, pithy phrases which encapsulate complex concepts rendering them digestible for mass consumption. They are very useful as a way of fixing important concepts that otherwise get lost, but they carry the risk of over-simplification. The term 'purchaser/provider split' is one such sound bite given greater prominence by the added allure of alliteration. But if we look under the label, we find not a single neat concept at all, but a complex mix of professional, managerial and political concepts that have become intertwined.

We have the professional concept of shifting from a service-dominated regime to one that puts users' and carers' needs first; we have certain managerial concepts such as care management; and we have economic and political concepts such as the mixed economy, competition and privatisation.

The professional concepts of making services more responsive to individual needs and helping people to fulfil their potential are perhaps the best place to start. They are the most deep rooted, and can be traced back to the Mental Health Act 1959 and beyond. Institutional services tend to be very paternalistic, doing things to and for people. For a long time now there has been an increasing realisation that people, however disadvantaged, want to do more for themselves and to live as normal a life as possible. To deliver this form of care we need considerable flexibility to tailor services to individual needs.

But when we look at the way the caring organisations have been set up, we find that they are out of step with this helping approach. It is a basic principle of management that 'forms should follow function'. This particular sound bite means that we should first identify what we are trying to do, and then decide how best to organise to do it. Just as an engineer designs a structure or a machine to fit the load placed on it, so we must engage in 'organisational engineering' to ensure that organisational structures can deliver professional goals and aspirations. Current arrangements lock money up in services in a way that makes the kind of flexibility required for a helping service

impossible to deliver – and force caring people to behave in a paternalistic fashion.

**Funding and flexibility**

Money is at the root of the problem (as usual). But the issue is not the total amount of money (this is an important but entirely separate issue) but the way money flows within the system. At present it flows directly to services in a top-down way. Both health and social services budgets are service-dominated with most of the money committed at the start of every year. This top-down approach inevitably means that service providers – whether they be doctors or day centre managers – are in positions of control. No matter how caring the people concerned, inevitably they see things from their own point of view and perpetuate their own interests without seeing the wider context. As many of you know to your cost, it can be very traumatic closing a service once it has been set up, and even changing its way of operating can be enormously difficult.

Even when the original purpose has disappeared or moved on, somehow that service adapts and finds some new niche to fill, and carries on much as before, choosing people who fit its chosen regime. Thus the top-down method of funding inevitably reinforces the status-quo, with paternalism built into the very form of a service funded in a top-down way. It militates against planning – since there is no point in planning when the budget is already committed. Planning is at best relegated to the margin of the few percent of the total budget freed up each year. This is one key reason why joint planning and the cooperation between health and social services has been such a disappointment. There may be some adjustment to meet changing needs, with training centres becoming 'social education centres' for example, but how real is this change? How many are *still* undertaking contract work? And how often have resources been released to promote totally new ways of working which undermine existing vested interests but meet *real* needs – employment schemes, for example, which do not rely on centres at all.

But how else can money flow in services that are centrally funded? The main alternative is the bottom-up approach with money given directly to users. The social security system works in this way, and is at least as important a way of financing care as the centrally-funded health and social services. Invalid care allowance, for example, costs

twice as much as all local authority social services for adults, and attendance allowance is well over £1 billion. Income support for residential and nursing home places is rapidly increasing, and is expected to top £2 billion a year before 1993.

The bottom-up approach has the enormous merit that it directs money straight into the hands of users and carers for them to choose how to spend it. But there are some problems. First, there is no guarantee that money will go on a suitable form of care at all, and tax payers have a right to expect their money to be spent effectively. Second – and this is the real killer – benefits cannot be cash limited, so that control of expenditure is lost. This particular version of a bottom-up approach is thus unfocused, expensive and wasteful.

We could perhaps tackle the first problem through vouchers, which could only be cashed in for the correct form of care. But how can we ensure that vouchers are for the right amount and the right care? A voucher system is far too rigid and inflexible, and in any case it does not address the cash limiting problem.

The greater flexibility required can be introduced if we interpose a 'broker' who can work out what each person needs (within a policy framework) instead of a fixed voucher; and cash limiting can be imposed if we devolve a total budget direct to the broker rather than fixed payments to individuals. The introduction of such a broker is a compromise, since we cannot expect her or him to truly represent the needs of users and carers, especially with one eye on the limited budget. But at least the broker is moved a step closer to users and carers, and the self interests of the service providers are pushed to one side (Exhibit 1). Hence, while not ideal, the introduction of a broker provides (at least in theory) a form which can match the professional aspirations of a helping service better than directly funded services. This is of course the concept of care management. Thus the shift in *professional* objectives from a looking-after service to a helping service requires a number of new *management* requirements – care management, commissioning and devolved budgets. Each of these new management requirements triggers a need for a new system for assessment, contracting and for controlling budgets, which in turn will throw up *political* choices (Exhibit 2). But it is important to keep in mind that these management changes and political choices are *caused* by a change in *professional approach* – not the other way around! If we approach it in this way, seeing political choices relegated to the

Exhibit 1

Exhibit 2

end of the process, then many of the worries expressed at the beginning of my talk can be put into perspective. Let us consider these management requirements in turn.

**Management requirements**

Care management and assessment must be carefully organised if the needs of users and carers are to be addressed. Many different models of care management are being tried. But some sort of hierarchy will be needed if care managers are to focus on the needs of more dependent people (Exhibit 3). A new role of 'screening' is required.

Under the new arrangements, authorities must be much more articulate about who is to be eligible for support, and, equally important, who is not. In the past, authority members have made decisions about services while fieldworkers have made decisions about rationing. Under the new arrangements this situation is (quite properly) reversed, with members required to make the political choices about eligibility criteria. The screening of people for help, applying these criteria sensitively, will become a very skilled job – at least as skilled as care management. People who do not qualify for direct help under the criteria but who still have problems can be helped through advice. In future, the giving of advice (on services available in the private sector, welfare rights, housing, etc) could become the most important role of social services – both softening the blow for those not qualifying for help, and extending the role of social services to include the whole community – not just those at the margins as now. If developed properly, this role could give social services a much wider appeal while meeting far more need than at present. The internal budgets would show greater expenditure on field workers (and training) and less on direct service provision. Acceptance of that shift will require political will.

Commissioning will require contracts – the very thought of which is causing much alarm. But in fact if the approach is used properly money can be released for more creative purposes. Different sorts of arrangements are possible depending on whether money is paid as a block or individually through spot contracts; and the degree of specification can vary from highly detailed to virtually nothing (Exhibit 4). This 'decision space' contains current arrangements for specific grants (block contracts with few specifications) but it adds a range of other possibilities – widening choice, rather than forcing

Exhibit 3

Exhibit 4

authorities down particular paths. But political choices are still required about how much this possible freedom should be exercised, and some may be tempted to impose politically inspired restrictions.

Finally, devolved budgets, while giving greater flexibility locally, will require tight controls if they are to work properly. Forward commitment accounting systems will be required, giving care managers projections of how much of their budget is committed if the current pattern of services continues for the current caseload without change.

But, more significantly in the short term, arrangements will be needed to fund services at the same time as funding care managers' budgets. If care managers buy current services, there will be no problem. If they do not, then double funding will be required. No authority can afford to risk either the expense, waste or destabilising influence of such an eventuality. Money will have to be devolved gradually, with big block contracts persisting for a period (although with size of these contracts reduced year on year). Care managers could start by receiving a small proportion (5 per cent) of the budget in the first year. As funds are gradually transferred from social security, much of this money could then be devolved to care managers, while the total proportion of service budgets covered by block contracts are gradually reduced. Eventually services would need to win more and more of their funding directly from care managers – but only after a time to establish proper systems, giving people time to adjust. Political decisions will be required on just how fast and how far to proceed.

## Conclusions

In summary, political decisions will be required about eligibility criteria, about the form contracts should take, and about the speed of progress and the balance during the implementation period between purchasers and providers. But seen from the point of view of users and carers, these decisions should enable the service to grow and develop in a positive way. Inevitably, some people will try to force particular political models, with all services privatised in some authorities, while, in others politicians will refuse to grasp the nettle of setting eligibility criteria. But these political positions are likely to be the passing fashions, while a system more friendly to users and carers based on a purchaser/provider split becomes established as a permanent fixture.

Many of the political issues are being magnified at present, but this phase will pass. It is a bit like looking at the problems through a telescope (with Exhibit 2 providing the framework). Look at them from the political point of view and they become magnified. Look at them from the *other* end through the lens of the users' and carers' point of view (as Tessa Jowell puts it), and they look much smaller and altogether more reasonable. The challenge of implementing the new way of working is enormous; but if we think of it from the point of view of the users and carers it all becomes worthwhile. We are not asking our staff to die on the barbed wire of some political creed to which they may not have subscribed in the first place. We are asking them to work phenomenally hard to improve the choice and quality of life for disadvantaged people – which is what most of them are doing already anyway.