The international evidence base for healthcare commissioning

According to the Department of Health (2006) “ healthcare commissioning is more than just procurement of services. Effective commissioning is about care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all the sections of the society”. The following essay focuses on the international evidence base for healthcare commissioning, explaining the healthcare commissioning of Finland, Sweden, Europe, New Zealand, Arizona and United States and the challenges for healthcare commissioning within the context of economic recession and the ways in which these challenges might be addressed.

The fundamental aims of healthcare commissioning includes service improvement, decreasing costs wherever feasible, better patient outcomes, and NHS priorities should be taken into account for all commissioning activities (InPharm, 2010). The cycle of commissioning is fragmented into 3 segments: Strategic planning (the beginning of the cycle), procuring services and monitoring and evaluation. Various NHS tools for supporting the PCT’s are available like Better Care Better Value indicators, NHS indicators etc. By restructuring the patient pathway at the first time, we improve clinical quality, decrease expensive readmissions, better staff and patient satisfaction and in turn generate savings which can be used for various services (Peskett, 2009).

After the NHS reforms in England, the PCT’ were considered as the main commissioners of healthcare (Peskett, 2009).. In addition to the NHS providers and NHS Foundation Trusts (FT’s), the independent and third sectors were also considered as the main healthcare commissioners. The Operating Framework (Department of Health, 2007a) of 2008/2009 focused

mainly on world class commissioning which defines the commissioner’s skills and competencies for commissioning healthcare successfully from a variety of providers.

According to Ham (2009) market like mechanisms has been applied to the health reforms in England. In the emerging market it will be of critical importance for the commissioners of care to manage equivalent with the providers. The government has laid down plans for establishing ‘ world class commissioning’ but evidence shows that commissioning is not done consistently in any of the systems. World class commissioning if developed might not be successful because of lack of potential in absence of other modifications in the making of reforms like payment modes and autonomous providers. An alternative to this would be to develop competing integrated systems. World class commissioning (WCC) is metamorphosing the means through which services are commissioned, resulting in improved health consequences and reducing health inequalities adding life to years and years to life (NHS: Department of Health, 2009). The Department of Health along with the NHS launched WCC in December 2007 which aims to develop World class commissioners of NHS-funded services.

The NHS in England had designed a 10 year program of reform to handle long standing weaknesses in performance which they are halfway through (Ham, 2008). The commissioners of care play a critical role in negotiating similar terms with providers and use the resources efficiently for improving the health and performance of health services. In the early 1990’s commissioning was a weak link in the internal market and it is risky if the history is repeated again. Many countries worldwide have drawn attention

towards healthcare commissioning for bringing reforms. The traditional systems which have integrated financing and planning of healthcare (eg the UK, New Zealand and Sweden) have experienced the detachment of commissioning from provision since the early 1990’s. The roles of insurers and providers have been strengthened due to traditional partition like Germany, Netherlands and US.

Experience of commissioning in Europe: (Ham, 2008) It was found that commissioning in Europe had substantial diversity in context to organization that do purchasing. The type of organization like the central or regional government, municipalities that can act as purchaser, market concentrations and the way of interaction differs from country to country. Variations are also observed in their funding sources and jurisdictions. The function of the purchasers was merely carried out in the challenging surrounding despite of the tangled European health policy debates because of the market based reforms. Figureas and colleagues stressed that a fundamental lesson from European experience is that a broad systems approach for purchasing and various components are required by policy makers.

Experience of commissioning in Finland: The Healthcare Commissioning system in Finland is micro level, non-competitive and within the local government (Benson, 2011). For an average of 11, 000 populations there are about 448 municipal councils which are responsible for purchasing. Each of these 448 councils is valid for a period of 4 years and an executive board is appointed which leads to democratic linkage between the citizens and health commissioners. The councils are authorized to commission secondary or

tertiary services of their choice themselves or by merging with other councils.

Experience of commissioning in Sweden: The Swedish healthcare system comprises of 3 levels of government: the central government, county councils and municipalities (The Commonwealth Fund, 2010). The local government is responsible for the ways in which services are delivered considering the local conditions and precedence whereas the central government accounts for the overall goals and regulations of the healthcare system. Thus at local level the delivery system varies because of this decentralization. The central and local taxation is held responsible for public funding of healthcare services. The financing of prescription drug subsidies is provided by the central government. It also provides funding by grants apportioned using a risk adjusted capitation pattern to county councils and municipalities. Financing of primary and mental healthcare and specialist services is provided by the 21 county councils whereas home care and services and nursing home care services are provided by the 289 municipalities. The private sector covers about 5% of the population and it provides easy access to care for patients. The 21 county councils are responsible for the organization of primary care services. For residents within a devoted geographical area, the primary care is provided by the health centers. But there have been significant changes in the model and now the residents can choose their provider and physician. A new law holding an alternative for the population and primary care privatization has been implemented from January 2010. The various modes for payment of private primary care providers are taxation, topped up with fee-for-service and

targeted payments. The residents can now directly go to the hospitals or the private specialists.

Experience of commissioning in New Zealand: There was a separation of purchaser and provider roles in New Zealand's healthcare system from 1993 to 2000 (Ham, 2008). From a recent study both the positive and negative side of purchasing and contracting in New Zealand were highlighted. The drawback was that it was difficult to co-relate provider's performance and negotiate contracts because of insufficient data on cost, volume and quality. An antagonistic environment was appreciated because of legalistic approach to contracting. It was difficult to sustain long term contracts or conjunctive relationships because the competition law concerns were not even whereas on the positive side because of purchasing the purchasers and providers focused more on costs and volumes of services and specified the categories and levels of services supplied. According to the providers written contracts would encourage them to focus on improvement of quality of care. Ashton and colleagues have summarized the New Zealand healthcare as: contracting has amended the provider's direction on costs and volumes, increased the clarity of services and greater emphasis on methods for improving quality. New Zealand's healthcare faces the challenge whether the profit of contracting maintained with simultaneously declining the transaction costs.

Experience of commissioning in United States: In United States, indemnity insurance was used for financing and delivery of healthcare (Ham, 2008). Patients selected their providers and the providers charged the insurers by paying fees for services. Hence the patient had a flexible choice and the

providers prevailed. Because of increase in healthcare ‘ managed care’ approach was developed in the US in the 1980’s and 1990’s which was based on the funding authority playing a significant role as commissioners. Evidence suggests that managed care temporarily curbed the increasing healthcare costs in the US. But managed care led to fee-for-service providers. In spite of the evidence, a reinvention movement known as ‘ consumer directed healthcare’ movement took place in the health insurance industry.

Experience of commissioning in Arizona: The healthcare commissioning system in Arizona (USA) known as Arizona Healthcare Cost Containment System (AHCCCS) was launched in 1982 (Benson, 2011). Arizona had two tier arrangements: AHCCCS covers about million Medicare and Medicaid from a number of purchasers. The purchasers are liable to commission health services operationally for 35, 000 to 200, 000 people known as ‘ members’ or ‘ lives’ and they purchase services from various providers. In order to sustain the contract or win, the AHCCCS has to produce detailed bids every 5 years and not all the health plans covered under AHCCCS are for profit organizations.

The Department of Health’s (2007d) recently published documents suggests that the world class commissioners will (Peskett, 2009):

Run the NHS locally

Function along with the community partners

Both patient and public involvement will be there

Merge with clinicians

Organize and assess knowledge and needs respectively

Accelerate the market

Enhance innovation and improvement

Draw upon some sound financial investment

Supervise the local health system

One of the ways of addressing one end of the spectrum is PBC which challenges the PCT's for having the proper governance arrangements and bringing awareness about absolute clarity between responsibilities and boundaries.

CHALLENGES FOR HEALTHCARE COMMISSIONING:

According to Le Grand (1999), commissioning problems were due to very weak incentives and very strong constraints (NHS CONFEDERATION, 2010). History says that commissioning had failed in the internal market in the 1990's and hence there is risk if repeated again (Ham 2008). Weak commissioning is because of the tendency to focus less on PCT's and PBC and giving importance to national, specialized and joint commissioning. Healthcare commissioning has become weak because of the following reasons:

In publicly financed systems purchasing of health services is quite difficult

Inability to control the referrals and activity of GP's in general

Insufficient power against the number of providers, especially the Foundation Trusts (FT's) for shaping the market

Curtailment of clinical engagement and base for decisions related to healthcare commissioning

Lack of ability to comprehend an issue and perform in analysis of requirement and demand, managing budget, risk taking etc.

There is hardly any evidence which suggests that commissioning has made a symbolic or strategic impact in secondary care services (Smith, et al., 2004).

Healthcare commissioning is perplexed and postulating and requires both technical as well as managerial skills (Peskett, 2009). Ham (2008), quoting Mays and Hands (2000) defines Healthcare commissioning as complicated, unclear, not exhibiting information symmetry between buyer and seller, lengthy training mandatory and is based on long term relationships between patients and professionals. Often there is misunderstanding among the commissioners and providers, clinicians and managers, and sometimes between the primary and secondary care commissioners which builds up stress, hence a prominent degree of competence and communication skill is mandatory.

The challenges for healthcare commissioning were revealed by the UK's Department of Health Independent Sector Program, particularly for assessment of governance arrangements and identification of high standards of healthcare providers (Peskett, 2009). A successful care pathway commissioning requires an acquaintance and proficiency of the clinical

intakes, turnouts and consequences as well as organizational skills for process management and patient journey. Pertinent inter and intra-organizational governance arrangements should be verified.

Evidence suggests that healthcare commissioners will need not only time but also stability and persistence of management and organization, if a sustainable progress is required for betterment of local services (Smith, et al., 2005). The recently developed primary care commissioning organizations focuses internally in their initial stages and in future with the secondary care and other providers. The factors which facilitate effective commissioning may also pose to be the greatest challenge. One of these includes – for engaging the GP's a set of incentives is created, for patient with long term conditions new forms of seamless services being developed and eventually making an absolute effect on the broader healthcare system, which was difficult for the primary care commissioning to achieve.

From a survey conducted recently a conclusion was drawn that about 50% of GP's did not show interest in commissioning budget (Smith, et al., 2005). The GP's would thus have power and would play the role of managers but the power was not distributed equally among the doctors. It has been suggested that an important incentive within fund holding and total purchasing would lead to changes and might improve the services as well, if there were profits during the practice process. In order to engage all the GP's into budget commissioning more strident incentives would be required. If a new NHS market is developed then it will offer sharper incentives so that the GP's and nurses can become practice based commissioners. Hence services could be purchased from new providers of primary care and diagnostics by a

commissioning budget. For the non NHS providers, there arises a possibility that the primary care should demand increasingly for budget commissioning and thus become equivalent to the NHS GP’s and nurses.

(Peskett, 2009) Separation of managerial and clinical goals led to failure with no clinical leadership. Negative targets had detrimental consequences and if the financial flow encouraged efficiency and not effectiveness it leads to failure of service. A culture of collaboration would be helpful rather than competition with command and control ethos. The managers and the organization should be responsible enough to provide commercial expertise, infrastructure and information and the clinicians should provide specialist and knowledge related to healthcare. Weak and ineffective engagement of clinicians of primary and secondary care would lead to crucial Primary Care Trust Commissioning. Commissioning fails if there is lack of resources, capacity and capability and an ability to sustain long duration relationship. Commissioning organizations also require robust governance system in business transactions for ensuring no conflicts of interests. Lack of time, personnel, resources and difficult long term relationship were the challenges that Healthcare commissioning had faced (Checkaland, et al., 2009).

The four major challenges faced by healthcare commissioning are (Boyd, 2010):

Ameliorating the health of the patients

Assuring a high quality standard of care in healthcare arena

Supervising costs and savings. It includes preventing and managing falls, assessment of risk and saving tax payer’s money.

Managing the transition to clinical commissioning

(Boyd, 2010)The key responsibilities of healthcare commissioning includes buying high quality services throughout the care pathway in order to meet the needs of common people and making decisions for not purchasing services. The detailed information regarding organizations engaged in pathway, from primary care to tertiary care is available to the commissioning team and their aim is to fit together all the parts of care pathway to provide a holistic care. Foundations for effective commissioning are as follows: improving outcomes, patient empowerment, evidence based practice, community mobilization and sustainability (Royal College of General Practitioners, n. d.). If these foundations are not taken into consideration carefully then it might lead to difficulty in commissioning health services.

Payment by Results (PBR) plays a massive role for achieving efficiency gains in commissioning decisions (InPharm, 2010). A key challenge to an efficacious healthcare commissioning is that there is an absence of general/global, apparent/definite commissioning procedure for the NHS. Several factors are taken into consideration for establishing a business case and introducing it to the decision makers for authorization. These factors includes financing the services, route of commissioning – whether the prevailed services be improved or put a tender, assessment of both the NHS and patient needs and views of patient. According to Baird, et al. (2010) one of the various challenges that the healthcare commissioning had was the

size and performance in commissioning organizations, both in the NHS as well as internationally. It was concluded that small commissioning organizations would struggle more if they took the responsibility of commissioning the entire spectrum of healthcare and there was negligible relationship between performance and size of commissioners.

The providers would also face a number of challenges (NHS CONFEDERATION, 2010). These include:

Handling the PCTS’s during their transition phase

Making commitments for the next 2-3 years about services and financial plans

Understanding the new GP consortia and their managers

Making arrangements for contract with multiple consortia behaving individually and in networks

Ascertaining that the PCT’s vital statutory activities are being taken into account even during a major organizational transition.

The challenges of Healthcare commissioning might be addressed by focusing more on clinical leadership (NHS CONFEDERATION, 2010). For the local needs and services, the consortia will develop a real, risk adjusted, capital budget. The consortia will be held responsible for economic risk, service execution and health outcomes. Amongst the local system, the consortia will have an outstanding position. Therefore it should be capable of attracting a powerful management and have clout. Gray (2001) says that these

challenges are difficult to address because it is not possible to decrease hospital care expenses and divert it into budgets of primary care drugs. Accessibility to diagnostic service costs might be prohibited which is subjected internally within the provider unit and not to external contracts. Savings within the hospital can be redirected to hospital care by professionals in any other service.

Conclusion:

Healthcare commissioning personifies the improvement in quality of healthcare and it is responsible for publicizing the national healthcare standards, assessing the organizations performance and comparing it with other organizations, solving the problems when it is not possible to resolve it locally and looking into severe service failure. According to Sobanja (2009) commissioning is defined as " the act of committing resources, particularly but not limited to the health and social care sectors, with the aim of improving health, reducing inequalities, and enhancing patient experience". Many countries throughout the world are now concentrating on healthcare commissioning. Experience and evidence available from Europe, United States and New Zealand suggests that commissioning is not done systematically in any of the systems. There have been innovations in all the systems but again there are illustrations of barriers and limitations of effective commissioning. Commissioning tends to be difficult may be due to the nature of healthcare and the expectation of the healthcare commissioners to have a high level of technical and managerial skills. Payment system, incentive, market organization and regulation influence the impact of commissioners. The concluding point to stress is that there is only

one element called commissioning in the health reforms and its impact will be affected by how different elements are carried forward. Hence it can be concluded that even if world class commissioning is enhanced it may not reach the standards and fall short of its potential due to lack of variations in system design.