Health policy: a new look at NHS commissioning

With NHS reforms seemingly having gone full circle, it is time for the government to break out of the loop

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The NHS is being restructured to make health service commissioning the engine of change. However, the model that has been developed builds on a legacy of weak incentives and lack of imagination. It has focused on modifying existing organisations and changing boundaries based on geography. It does not tackle the fundamental flaws inherent in the system created in the 1990s or respond to some key questions that most other healthcare systems have confronted over the past 70 years. This paper challenges the basis on which the NHS is developing commissioning and suggests five areas for further thinking.

Current strategy

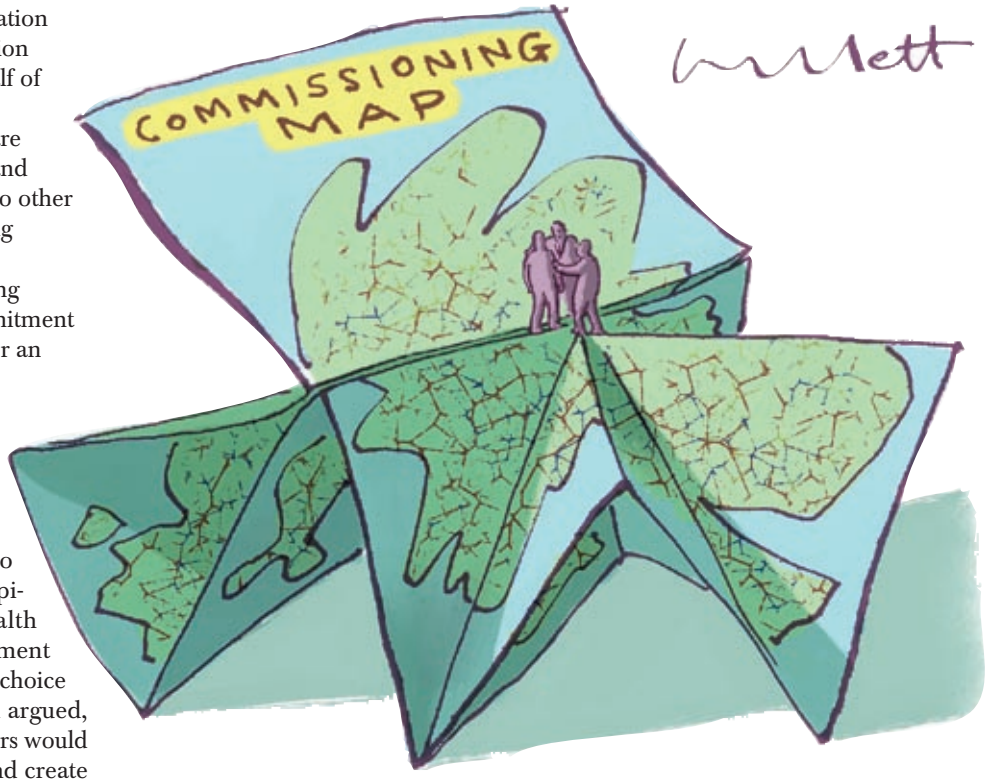
The annex to *Health Reform in England: update and commissioning framework*[1] published in July 2006 sets out the vision for commissioning in England over the next few years. Although some new techniques are proposed, the plans described are essentially more of the same and provide little reassurance that commissioning really will be given the levers to secure appreciable improvements in health or health services. Five assumptions in the current thinking need to be challenged:

- That patient choice should primarily be about choice of provider rather than commissioner
- That commissioning organisations need to be defined by geography and resident population
- That purchasers can and should commission on a population basis rather than on behalf of individuals
- That general practitioners and primary care trusts should be the only commissioners and that delegating commissioning functions to other organisations necessarily means privatising commissioning
- That developing specialised commissioning organisations would undermine the commitment to a tax funded NHS and pave the way for an insurance based model.

Choice of provider or commissioner?

The original idea for a purchaser-provider split in the NHS came from Alain Enthoven in 1985.[2] He argued that the NHS was gridlocked and that there were no incentives to improve efficiency and quality. He championed the "internal market model" of health care, adopted by the Conservative government in the late 1980s, which encouraged patient choice of provider but not of purchaser. Enthoven argued, however, that competition between purchasers would ensure greater responsiveness to patients and create real incentives to improve the quality of purchasing and provision. General practitioner fundholding did allow patients to move between practices, if they wished to change commissioner, but few did so.[3] Recent evidence suggests that little has changed; loyalty to general practitioners remains strong and the barriers to exercising choice are high.[4]

Experience from other countries suggests that developing competition between commissioners can really empower patients as well as create incentives to improve needs analysis, responsiveness to patients, cost effectiveness, better information, and choice. People in Belgium have been able to choose their sickness fund for many years, and recent health reforms in Germany and the Netherlands have increased choice.[5] In Germany the proportion of people switching funds rose from 9.3% in 1998 to 23.4% in 2003.[6] There are certainly potential disadvantages to choice of commissioner (such as funders "cream skimming" or choosing the healthiest patients). The experience in other countries shows that it is wealthier people who tend to exercise choice, and in the Netherlands, patients have given higher priority to choice of provider than commissioner. Nevertheless, commissioners elsewhere have created dynamism in healthcare markets, and the experiences are worth examining.



The English proposals are inward looking, at a time when market changes will have a profound effect. It is possible, for example, that as the NHS develops spare capacity, other European countries may look to purchase NHS services. In future foundation trusts will have incentives to sell their spare capacity overseas. Although this may currently be a marginal activity, commercially astute trusts will look beyond national boundaries for their patients—as many mainland European providers already do. Commissioners will no longer operate in a relatively predictable and managed domestic market but will face challenges from outside the NHS.

Should commissioning be based on geography and residence?

One of the most puzzling aspects of the new commissioning arrangements, if viewed from a non-NHS perspective, is that commissioners must be defined by geography and by resident population. Commissioners in other countries can be organised around communities of interest (such as employment based health plans), but there is no automatic assumption that they would serve a geographical catchment area. The same should be true in the NHS. The debate about the configuration of primary care trusts and coterminosity with local authorities has been based on their provider function more than their commissioning function (though some argue that coterminosity will help to focus energy on health and health inequalities).

There is no reason, in principle, why a commissioner based in Hastings could not purchase services in Halifax for a subscriber who lived there. As more and better information about clinical services and their outcomes becomes available across the country, the case for working only through traditional, local, patterns of referral is weakened. Many patients may continue to prefer to receive their care close to home, but that is different from arguing that their commissioner should be based locally too.

Commissioning for populations or individuals?

Since the purchaser-provider split was first implemented in 1991, it has been argued that a key role in purchasing was to assess population needs and then to commission services to meet those needs. Neat circular diagrams were devised, showing needs assessment as the first stage in the cycle and a logical series of steps towards the satisfied patient. Indeed, just such a diagram appears in the latest Department of Health publication.[1] However, there is little evidence that district health authorities, primary care trusts, and others had the skills or the data to commission services for their local populations or that they made a significant difference to the quality of provision or to the reduction of health inequalities.[7 8] When changes did begin to happen it was often by aggregating the needs and preferences of individual patients through fundholding or similar mechanisms.[9] As Smith and colleagues observed in 2004, the evidence suggests that primary care led commissioners had yet to develop any mechanisms to promote patient choice.[7] Failures of the population based approach in the past weaken the argument for tying commissioning to geography in the future.

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Commissioning by public sector agencies

The imaginative plans that Thames Valley Strategic Health Authority developed in October 2005 for contracting out commissioning functions were heavily criticised and rapidly squashed. The authority intended to tender for the provision of management services to Oxfordshire primary care trusts, on the grounds that current trust leadership was not adequate for the new tasks, and it invited competition from other parts of the NHS and the voluntary and private sectors.[10] Thames Valley's chief executive said that this "did not mean privatisation of the NHS,"[11] but the proposal was rejected by the Department of Health.

These kinds of opportunities to delegate functions to bodies other than a local primary care trust or general practice should be re-examined. If the geographical ties were broken, there is no reason why one trust or practice should not commission on behalf of others (indeed this already happens with specialist and lead commissioning arrangements). Equally, some local authorities have become very sophisticated purchasers in recent years and have the skills to commission both health care and social care for residents and non-residents. The same would be true of some voluntary organisations. Moving commissioning responsibilities beyond their traditional boundaries does not automatically mean privatisation, and the expenditure of public money could still be managed through public sector bodies on behalf of patients.

Competition between commissioners in a tax funded system

A shift to competition between commissioners would necessarily be the first step down the road to an insurance funded health service. It is true that in other countries where such competition exists, the healthcare system is typically funded through social or private insurance. However, it is important to distinguish between the type of funding and the organisational arrangements that are in place for purchasing and commissioning health care. It would be possible to

SUMMARY POINTS

The way in which commissioning is being developed in the NHS raises serious questions
The current approach is unlikely to achieve real change
Geographical restrictions on commissioning should be reconsidered
Public, voluntary, or private agencies could also be allowed to commission
Patients could then choose their commissioner on the basis of the services provided

have a tax funded NHS, as now, with a variety of public sector commissioners.

What should intelligent commissioning look like?

Reorganising commissioning along the lines suggested would have several consequences. Firstly, it would give patients a much stronger voice in the NHS. Patients would express their preferences more directly through their advocates—the commissioners. They would choose their commissioner on the basis of clear information about the services on offer. Secondly, the conflicts of interest inherent in practice based commissioning (where general practitioners are both commissioner and provider) would be eliminated. Commissioners would have only one role and would build up expertise to do it effectively. Commissioners might develop strong niche markets—commissioning health and social care for people with mental health problems, for example.

Thirdly, the debate about what the NHS can offer and what is clinically effective would be accelerated. Patients would subscribe to a health plan of their choice, with a commissioner of their choice. The options available to them would become explicit. All other European countries have for some years been having a public debate about what should be in the publicly funded health basket. The UK has avoided this and has maintained that there is no "right" to any particular clinical treatment and that it is a matter of judgment. This is why ad hoc decisions are made about new drugs like trastuzumab (Herceptin) and why there is no clarity about where decision making should lie.

Finally, intelligent commissioning would rapidly drive a demand for better information about treatment options, clinical outcomes, and cost. There would be strong incentives to provide good information to the public and to facilitate real choice for patients and their families.

Although we are well down the road of developing a different model of NHS commissioning from the one described here, we cannot avoid addressing some fundamental questions. If we do not challenge the assumptions behind the planned model now, they will simply come back to haunt us later.

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A former colleague?

"I am sorry, but he does not speak English," his wife said at the breakfast table. I had approached to ask him if we had worked together. I apologised and left our London hotel to walk to the conference on a bright and cool autumn morning. I scolded myself for being a stupid old fool ("It was 25 years ago, man") and forgot about him for the rest of the day as academia filled my brain.

That evening the thought of him crept back—"It's him all right." We had worked together for six months on a senior house officer rotation in the north of England. Although I had never heard of or seen him since, we got on very well and had loads of laughs. An inveterate people watcher, I reminded myself of the features that had brought back the memories—the sallow complexion, black hair (albeit greying), his height, big Chelsea boots, the way he adjusted his spectacles, the timbre of his voice (though speaking fluently in a foreign tongue), and his gait. But his hands were unmistakable: he had large, expressive hands with long fingers and a big scallop betwixt forefinger and thumb.

I do not remember his name, and, although he had spoken English with a strong regional (London?) accent, I had wondered (though I never asked) if he had an Indian or Mediterranean ancestry. I hope he is not in trouble and having to hide from persecution. I would prefer that he simply has not told his wife and family that he had a previous life. I was pleased that he seemed happy.

After leaving the breakfast room the next morning with his and an accompanying family (too many for the small hotel lift), he returned alone past our table, heading for the stairs, and said, "Morning," and smiled broadly.

I returned his greeting, and my wife said, "There, he's forgiven you." I shrugged, resigned to my renewed doubts and finished my breakfast. Later, in the quiet of the museum, hindsight gave me a slap. I had missed his cue: I should have left the table and followed him to the stairs. How I would love to hear his story.

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