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Commissioning reform in the NHS: will he who pays the piper ever really call the tune?

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ABSTRACT – Since the purchaser/provider split was first introduced in the early 1990s, there have been successive attempts to enhance and strengthen the role of commissioners in the English NHS. Their role is to ensure that health services are planned and delivered in a way that meets the interests of patients and taxpayers rather than healthcare providers. The new coalition government has recently set out its proposals to transfer commissioning responsibilities from primary care trusts to a national NHS Commissioning Board and a set of general practice-led commissioning consortia. It is too early to say whether these reforms are likely to transform commissioning and finally place payers, rather than providers, in the driving seat of the NHS. However they unfold they are likely to have a significant impact on healthcare professionals in commissioning, primary care and specialist roles.

KEY WORDS: commissioning, general practice, NHS White Paper, purchaser/provider split

Introduction

In July 2010, the UK's new coalition government published a White Paper laying out its plans to 'liberate' the English NHS.[1] If fully implemented the policies could lead to profound changes in the roles of central and local government in relation to the NHS, in the relationships between patients and healthcare professionals and in the nature and landscape of health service provision in England.

One of the most prominent and widely discussed features of the proposed reforms is the plan to transfer responsibility for commissioning NHS services from the 151 primary care trusts (PCTs) currently performing that role to a new national Commissioning Board and a set of local general practice (GP)-led commissioning consortia. At the time of writing full details of the new commissioning system are yet to be laid out. But if the legislation is passed and the policy is implemented as the government intends it will be operational by 2012 and PCTs will be abolished from April 2013. Combined with the planned transfer of public health responsibilities from the NHS to local government and the creation of a more open and diverse market of healthcare providers, these changes will alter the culture and structure of the NHS in very significant ways.

And yet although the announcement of this radical reform of commissioning signals an end to the existing regime, it also evokes a distinct sense of familiarity and continuity. For as those working in the NHS will be only too aware, this particular shake-up of the purchaser- or demand-side of the NHS is the latest in a long line of attempts by successive governments to strengthen commissioners' control over healthcare spending and performance by changing the size, shape, remit and leadership of its commissioning bodies.

This paper describes the role of health service commissioners, the rationale behind the purchaser/provider split in the NHS and the model of commissioning that has emerged over the last 20 years. It goes on to consider the government's proposed changes to commissioning policy and practice and the implications of these proposals for frontline healthcare professionals.

Who or what are commissioners?

In the context of the recent history of the NHS, the term 'commissioner' refers to the role of those individuals and organisations responsible for prioritising, securing, funding and monitoring all of the health improvement and healthcare services provided in a defined geographical area, or for a specific group of individuals.

More specifically, it indicates that this role is carried out on behalf of the people actually using or benefiting from those services and independently from the organisations providing them. Hence commissioners are sometimes referred to as the 'third-party payers' within the healthcare system, and the NHS is described as having a 'purchaser/provider split'.

The appropriateness of such terminology has been subject to much discussion over the years,[2] and there are important differences between the concepts of 'purchasing', 'paying for', 'procuring' and 'commissioning' healthcare. To summarise rather than unpack the detail here, commissioning is perhaps best described as an ongoing process or cycle in which purchasing, procurement and payment are important elements or stages, but which also involves a much broader set of activities.

This commissioning cycle or model has been depicted in many different ways,[3] but all versions begin with an assessment of the health needs of a defined population and agreement of health improvement objectives for that group of people. This is followed by a sequence of actions including prioritising and specifying the public health interventions and healthcare services considered necessary to meet those identified needs and priorities; procuring these services from appropriate providers; monitoring the volume, quality and outcomes of the care delivered and reimbursing providers accordingly; reviewing the extent to which the

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original health improvement objectives are being met; and (returning to the beginning of the cycle) reassessing needs, priorities and service requirements accordingly.

In other words, NHS commissioners do not simply purchase or pay for whatever healthcare professionals and providers choose to offer but actively define, seek out and evaluate the services they believe their patients want and need. Furthermore, they are not only responsible for procuring healthcare services, but also for taking broader action to improve the overall health status of their population and to reduce health inequalities. Crucially, as the overall budget for the NHS is cash-limited commissioners in turn have a finite budget with which to carry out their roles, hence the need to prioritise what services and activities get funded.

In 2007, the Department of Health (DH) published a comprehensive description of the role of NHS commissioners, and a process for assessing the skills and competencies considered necessary to perform it well – the World Class Commissioning (WCC) Framework.[4]

The WCC programme has since been subject to significant criticism from some quarters, not least because of its rather grandiose title, and the industry of data-collection, reporting and assessment that it generated. Supporters, on the other hand, argue it was the first genuine attempt to provide NHS commissioners with a clear remit and mandate, and was beginning to generate real improvements in their competence and performance.[5] It will now be impossible to tell what its impact could have been, as the programme has been suspended by the new coalition government.

If nothing else, the framework provides as good a summary as any of the complex, wide-ranging and unique set of activities that came to make up the job of NHS commissioners during the last era of NHS policy.

In recent years this job has been performed by PCTs which in their current configuration (151 organisations with similar geographical boundaries to top-tier local authorities) date from 2006. Although these PCTs are the statutory commissioners of most NHS services, many more organisations are actually involved in the commissioning task. While the commissioning cycle may be neatly drawn or described on paper, in reality it is not a contained, coherent set of activities that can be performed or controlled by a single body.

Most significantly, GPs and their primary care colleagues play a pivotal role here. In the UK healthcare system where independent contractors have responsibility for the holistic care of a registered population, and act as the gatekeepers and guides to the rest of the NHS, a general practice is in effect a micro-level commissioning organisation. A PCT can evaluate the health status of its population based on epidemiological data, develop care pathways and protocols based on nationally agreed standards, and disseminate information about the quality of different healthcare providers. But on a day-to-day, patient-by-patient basis it is GPs and their practice teams who assess individuals' healthcare needs, decide or advise what services they need, and help to identify the most appropriate provider of that care. For this reason, these 'practice-based' commissioners have been encouraged to work with PCTs to agree and implement local commissioning plans so that their respective micro-level and strategic commissioning decisions are complementary, although the success of this policy has been variable across the country.

At the other end of the spectrum, there are some macro-level commissioning activities that groups of PCTs come together to perform. This may be in order to pool specialist expertise and financial risk, for example to commission very high-cost low-volume services through specialised commissioning groups. It can also be to achieve economies of scale by outsourcing 'back-office' functions, such as data collection and analysis, to commercial or business support units.

Thus in reality NHS commissioning does not adhere to a single model, but rather consists of different patterns of overlapping and interdependent activities performed simultaneously at various levels of the healthcare system.

Before the existing PCTs were established these activities were carried out by a succession of different bodies operating on their own version of this commissioning continuum, with the structures changing as governments themselves changed or simply became frustrated with the pace of improvement in the NHS. Earlier forms included the first 'waves' of PCTs introduced from 2001, and reach back through their predecessor, primary care groups, the total purchasing pilots and multifunds that evolved during the mid-1990s, to the district health authorities and GP-fundholders introduced as the prototype commissioners at the beginning of that decade.[6]

Why do we have commissioners in the NHS?

All this begs the question why? Why has the NHS created and re-created this complex set of commissioning organisations and structures? Why does it need separate, 'third-party' commissioners at all? Does the government or DH not set priorities for, and allocate resources to, the NHS? Are healthcare professionals working in hospitals, GP practices, and community health teams not best placed to decide what and how services should be delivered?

The rationale for commissioning lies in the belief that neither central government nor individual healthcare providers are likely to make optimal decisions about the use of the NHS's limited resources.

When the then conservative government first introduced the purchaser/provider split in the early 1990s it was in an attempt to make the NHS more responsive to both its own needs for cost control and to patients' demands for faster access to higher quality services. As Mays and Hand explain, the broad concern motivating reformers in the UK and other countries facing similar challenges 'was a belief that public hospitals and other provider organisations faced few if any clear incentives to operate efficiently or responsively and that patterns of resource allocation tended to be driven by providers' interests rather than by the needs of patients or the strategies of planning authorities'.[7]

In other words, when it came to the NHS the government felt that although it was paying the piper (with taxpayers' money) it was certainly not calling the tunes. Furthermore, commentators that influenced policymakers at the time, notably the US economist Alain Enthoven, counselled that this was unlikely to change as long as incumbent healthcare providers retained their monopoly status and controlled local resource allocation decisions.[8] At the same time, however, for both practical and political reasons it was considered neither possible nor advisable for a national department of health to take all such decisions itself.

Thus, the answer lay in assigning budgets and decision-making responsibilities to organisations operating at a regional or community level but separately from the providers of hospital and community health services in that patch. These new purchasers were set up to act as the local custodians of taxpayers' money and as advocates for patients and members of the public in their area. Not only would they assess health needs and determine spending priorities more objectively than those involved in running health services, they would encourage providers to improve their quality and efficiency by making them compete for contracts and patients, and by publishing details of their costs and performance.

As described above, over the subsequent 20 years numerous attempts have been made to refine and improve this model, but the underlying premise that a separation of functions is required has continued to drive English health policy and to shape the structure of the NHS during this period.

Is the concept of health service commissioning fundamentally flawed?

Of course the fact that there has been a consistent thread running through NHS policy for some time is not to say that everyone accepts the argument. Many critics of recent NHS reforms believe that the assumptions on which the original purchaser/provider split were based, and in particular the idea that introducing competition between healthcare providers would improve quality and efficiency, are wrong. They argue that this approach sets different parts of the NHS against each other, undermines professional ethos, diminishes the sense of collective responsibility for a national health service as a public good and ultimately leads to fragmentation and inefficiency.[9]

Others do not have a problem with the idea of competition per se, but believe that in the current system commissioners have essentially been set up to fail. When considering the prospects for PCTs and World Class Commissioning in 2008, Chris Ham concluded that without spending substantial resources developing their own capacity, expertise and information systems (and possibly even then), third party healthcare commissioners would always find it extremely difficult to negotiate with their providers on equal terms, hold them to account for their performance or substantially influence their behaviour.[10] In other words, the pipers have continued to play their own tunes regardless of the preferences and demands of their payers, and are likely to carry on doing so.

Rather than continue to fight what he suspects is a losing battle, Ham's proposed alternative is to develop competing integrated delivery systems, in which many of the roles that are currently divided between commissioners and providers are recombined. Some form of strategic commissioner would still oversee the performance of these integrated groups, but would not attempt to design or specify the services they should provide or set rules as to how they should be organised or secured. Instead, the groups would be left to build networks of care involving primary care teams, specialists and social care providers, who would jointly plan and deliver a full range of services for a registered population. Their incentives to maintain and improve performance would be that individual patients could choose to register with a different integrated group if they were not satisfied with the services they received, and that they would be financially liable for any failure to manage their budgets.[11]

In reality it is impossible to tell whether the analysis of the existing commissioning model as fatally flawed is correct or, whether given more time to develop their capacity and expertise, PCTs would have been able to exert real control over local health systems and deliver the objectives they set out to achieve.

Either way, the coalition government has made clear its intention to dismantle the current system, and grow its own new breed of strong, effective healthcare commissioners.

The coalition government's commissioning reforms

In the consultation document on *Commissioning for patients* that was published with the July 2010 White Paper,[12] the government set out its plans to establish new GP-led organisations to commission most NHS services, including elective hospital care, rehabilitative care, urgent and emergency care, most community health services and mental health and learning disability services. Every individual GP practice will be required to be a member of one of these 'commissioning consortia'.

The GP-led consortia will receive their funding from a national NHS Commissioning Board, which will have overall responsibility for allocating and accounting for NHS resources, promoting quality improvement and public and patient engagement, ensuring the development of the consortia and holding them to account. It will also directly commission certain services including primary care and specialised services.

The anticipated number, size, structure and organisational form of the commissioning consortia was not set out in the proposals, but the central argument for their creation is that as clinician-led organisations they will be more efficient custodians of tax-payers' money and more effective advocates of patients' rights than the existing 'bureaucratic' PCTs.

While the consortia will commission NHS services, the function of joining this up with social care commissioning and health improvement activity will fall to new Health and Wellbeing Boards to be established by local authorities. Both GP consortia and the NHS Commissioning Board will have a statutory obligation to participate as members of Health and

Wellbeing Boards and to collaborate on the delivery of their functions.

Commissioning for patients: what are the implications for healthcare professionals?

At the time of writing (November 2010) the government has not even published the outcomes of its consultation exercise, let alone begun the process of translating its proposals into legislation and policy. Therefore views on the likely outcomes of this process and the implications for practitioners can only be speculative.

Nonetheless, there has already been a great deal of discussion of this subject in the press, on the ground, and between the professional bodies, politicians and policy analysts. Unsurprisingly, these discussions have tended to focus on GPs, and specifically on those who may seek and obtain leadership roles in the new commissioning organisations.

For a small number, taking on such roles is likely to mean a substantial change to their day-to-day work, and the need to develop new business, management, leadership and communication skills. Although large numbers of GPs have experience of running their own practices, as medical directors and professional executive committee (PEC) chairs for PCTs, and as leaders of practice-based commissioning groups none of these positions confers the degree of responsibility that will fall on the accountable officer of an organisation responsible for millions of pounds of taxpayers' money.

These new organisations could therefore provide welcome opportunities for GPs and other primary care professionals seeking a career structure and development path that allows them to use their clinical skills in a more strategic role. However, individuals considering such roles will no doubt first be seeking clarity about the relationship between their status as a clinical consortia leader and that as a healthcare professional. Would failure in the former role have any implications for the latter, or could the GP leaders of a struggling consortium, for example, simply return to routine clinical practice without consequence?

The majority of GPs and practice staff are unlikely to get involved in the day-to-day running of commissioning consortia or take direct responsibility for its performance. Nonetheless, if the consortia are actually performing their intended role effectively, all GPs are likely to feel the impact in some way. Again, the new arrangements should provide opportunities for clinicians to develop their skills and interests and to influence the design of services for their patients. At the same time, however, they may experience more oversight and scrutiny of their practice and performance by colleagues working for the consortia, and pressure from peers to follow agreed referral and treatment protocols.

Some concerns have been expressed that GPs' enhanced role in commissioning and, in particular, their collective responsibility for managing commissioning budgets, could interfere with individual doctor–patient relationships. If patients believe that their GPs have a personal interest in controlling healthcare expenditure, will they become suspicious of the motivations behind doctors' advice and treatment decisions, for example. And in a small number of cases, might this suspicion be justified? The governance, payment arrangements and incentive mechanisms will have to be carefully designed if actual and perceived conflicts of interest are to be avoided.

For specialists and other clinicians working in hospital and community settings the implications may be less direct but could still be significant. For example, the scenario set out in the White Paper is that the transfer of commissioning responsibilities from 'PCT managers' to GPs will promote better dialogue and partnership working between commissioners and providers, as they will be able to engage as clinicians to clinicians.

On the other hand, specialists may find their capacity to work with commissioners is spread more thinly. If, for example, there are more GP-led commissioning consortia than there are currently PCTs, or if their boundaries and constituencies differ, specialists' may find that they are invited to participate in multiple clinical network meetings, local strategy groups, and training and development activities with their various commissioners. Furthermore, there could be more variation in the services and quality standards commissioners expect from providers, which could encourage providers to offer more tailored, personalised care, or could result in lengthy and complex negotiations with multiple commissioners when their different demands cannot all be met.

It is possible, however, that the other aspects of the government's health policy proposals will, in the end, have a much greater impact on providers than the actions and behaviours of local GP commissioners. As well as reforming the commissioning system, their intention is to generate more competition between NHS and non-NHS providers driven by the publication and dissemination of detailed information about their practice and performance, and to give providers greater freedoms to innovate, and incentives to develop, high-quality services. These proposals present both risks and opportunities for existing providers. While 'liberation' from top-down targets and strategies may be welcomed by many, it will come with much greater scrutiny of the performance of organisations, services and individual professionals, and with fewer buffers to support and sustain providers when this performance is less than ideal.

In a system driven in this way by data, patient choice and competition, it is not actually clear to what extent commissioners will actually take decisions about the shape and form of local health systems in future. With an increasing emphasis on making the market work rather than guarding against failures, instead of strengthening the hand of commissioners these reforms may in fact signal a shift away from the idea that a third-party representative or advocate is required at all.

It is yet to be seen whether these reforms will represent a transfer of existing commissioning responsibilities to a new set of organisations operating within a broadly familiar framework, or if a radical change in our understanding and experience of the NHS will transform the healthcare commissioning role beyond recognition, or even make it obsolete. Whether in either

event such changes would finally place payers, rather than providers, in the driving seat of the NHS is even less clear.

What does seem likely is that all healthcare professionals will feel their impact in some way over the coming months and years, whether they take on new roles leading the vanguard of reform, or simply find the people and organisations they work with and for change around them as the next era of NHS policy unfolds.

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