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Strategic purchasing – the UK experience

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Proposed approach



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- Review the reform picture across the UK with an emphasis on the position in England.
- Consider the position of 'commissioning' within the reform agenda
- Speculate about the development of commissioning into the future and the tools needed for success

The case of the UK



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- **Scotland has bet on professionalism**, reducing layers of management, replacing them with clinical networks, and increasing the role of professionals in rationing and resource allocation.
- **England has gone for markets**, hoping that competition between independent trusts (similar to private firms) and between trusts and privately run treatment centres, will drive up standards and efficiency.
- **Wales has relied on localism**, integrating health and local government to improve coordination of different forms of care at local level and to raise standards.
- **Northern Ireland has resorted to permissive management**, in and out of devolution, concentrating on keeping services going in tough conditions.

(Greer, 2006)

Background in England



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- After a long period of underinvestment the UK is moving to a position of funding healthcare comparable to that within Continental Europe.
- The Government commissioned the Wanless Report published in 2002 which looked at long term health trends and the resource requirements to deliver high quality healthcare (Wanless, 2002).
- We are now six years into a ten year programme of reform which began with the NHS Plan in 2000.

Systems Reform



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'The Prime Minister's got religion about this'

(Peter Mandelson, ex Government Minister)

2008; what does it all mean?



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- Wanless:

– 2002/03	6.8% real growth
– 2007/08	7.1% (fully engaged)
– 2012/13	4.4% (-:-)
– 2017/18	2.8% (-:-)
– 2022/23	2.4% (-:-)

Office for Public Sector Reform (2002)



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- 'Citizens.... have a right to... proper standards of reliability, choice, courtesy, and accountability; to know if these standards are being achieved and to identify who is responsible if not'
- 'These things will not be met by... a one size fits all service'
- 'Innovation and efficiency are much more likely to be achieved when people are given the incentives to do so at local level'



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- 'Foundation Hospitals....open up the options for greater community accountability'
- 'Devolution is not an easy goal. Nor is it risk free. Yet it is an essential part of the reform of public services'
- 'Reducing bureaucracy, incentives for front-line staff, and inspirational leadership and management'

Creating a Patient-led NHS, (2005)



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- 'Our main focus since 1997 has been the acute sector, incentivising it to reduce waiting times and improve its services. It has responded magnificently to this...'
- 'But there is a clear risk that a strong, vibrant, incentivised hospital sector will suck all investment into hospital care unless it is balanced by an equally strong and vibrant commissioning function'



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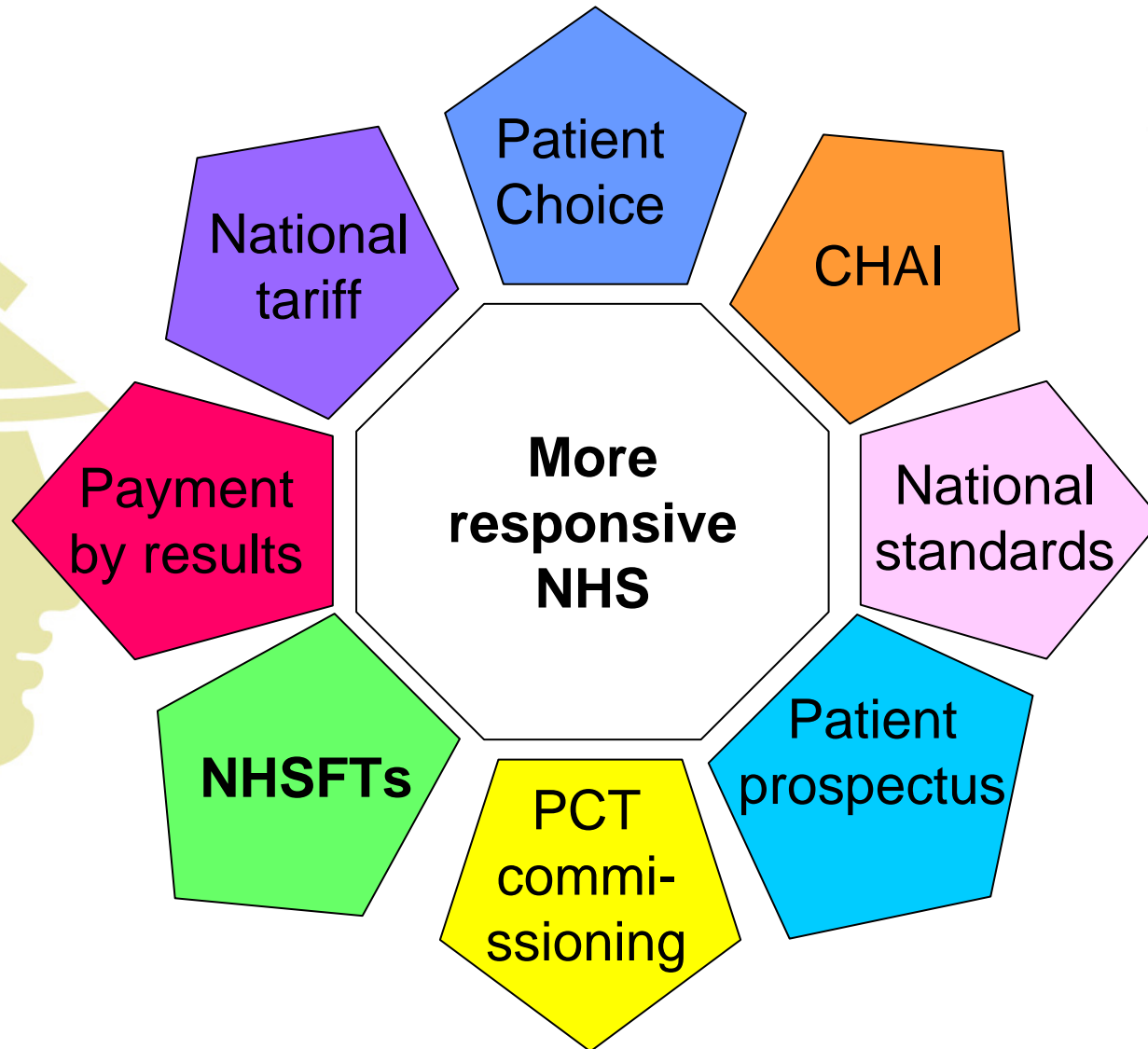


- 'This commissioning function will represent patients, focus on prevention and public health, and management of hospital providers to ensure good value for money'
- '..a Patient-led NHS focuses... specifically on the importance of expert, imaginative commissioning...'

Reforming the NHS



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- As a result the NHS in England is in transition from public monopoly insurer and provider of healthcare....
- Governed from Whitehall....
- To an insurer with devolved commissioning from a mixed market of providers.

The spectrum of model choice



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- One extreme is a wholly market-based health system where competition rules, regulation is light-touch, with basic consumer protection. Plurality of provision may be a feature along with commissioning with strong incentives
- Or one which is a nationally planned, owned and provided service, governed from the centre.

The other extreme....



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- So how far will the Government go?
 - The values and ideology of the Prime Minister
 - How the reform programme is led and managed
 - The level of political support for the change
 - The impact of reforms already underway
 - Public perceptions of reform and the services offered
 - Evidence of improvement of quality of care
 - Satisfaction of the public with health services when compared to other developed countries.

What is the definition of 'Commissioning'?



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- “Commissioning is the means by which we secure the best value for patients and taxpayers. By ‘best value’ we mean:
 - the best possible health outcomes, including reduced health inequalities;
 - the best possible healthcare;
 - within the resources made available by the taxpayer.”(DH, 2006)
- Or a ‘sophisticated and strategic process of assessing health needs, developing new services or providers..., contracting for services, and undertaking a range of strategic efforts to improve population health’
(Ovretveit, 1995)

Or.....



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- Conscience - setting out “how things should be” -what the system aims to achieve and how;
- Eyes and ears - observing and reporting on “how things are” - what the system is currently delivering;
- Brain (having processed information from both sources) - identifying and implementing the optimal solutions for delivering stated objectives.

(Wade et al, 2006)

SHAs - *3 FUNCTIONS (populations of millions)*

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Strategic leadership

Organisational and
workforce development

Ensuring local systems
operate effectively and
deliver improved
performance

PCTs - *3 FUNCTIONS (populations of hundreds of thousands)*

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Engaging with its local population to improve health and well-being



Commissioning a comprehensive and equitable range of high quality responsive and efficient services, within allocated resources



Directly providing high quality responsive and efficient services where this gives best value

Practice based Commissioning



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- A response to the limitations of two different approaches to how resources are used, and what services are provided and to whom:
 - One is driven by individual consumers and competition between providers
 - And the other based on decisions by Government in the form of centralised bureaucracy
 - Is it the 'Third Way', enabling informed GP's to improve health services by directly influencing the content and location of their care?


Factors facilitating effective commissioning by primary care




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- Stability in health organisations
- Time for clinical engagement
- Policies supporting choice for patients
- Policies to shift resources between providers
- Incentives for GP's to develop new forms of care
- Effective management support and information
- Regulations to minimise conflicts of interest from GP's being commissioners and providers

(Smith et al, BMJ, vol. 351, 2005 (1397-1399)).



Question 1: How are PCTs to achieve financial balance when they have little influence over the volume of activity that they must pay for, and when they have to pay the full tariff for most of the elective activity provided?



- In particular, how will PCTs achieve targets when they have weak levers to manage hospital referrals?
- NHS trusts and FT's argue that there is a quasi-market, and that they should be free to use available capacity to provide more patient services if patients choose them.

Question 2: How are PCTs to shift funding from existing hospital providers to support provision of new services closer to home?



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- The new Commissioning Framework (2006) recognises the need to fund providers of new services closer to home (and, in some cases, to offer them incentives), but does not address the fact that PCTs can only do this if they can be sure that spending on hospital care will be reduced.
- PCT's cannot expect any help from hospital trusts because this will make it even more difficult for them to achieve financial balance. To address this dilemma, PCTs need stronger instruments to bring about a shift of funding from hospital care to new services closer to home.

Question 3: How are PCTs to deliver the commissioning priorities that they identify in their strategic plans for the medium term?



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- The Commissioning Framework clearly envisages a strategic commissioning role for PCTs, deciding priorities in collaboration with local stakeholders, and then shaping the structure of supply to ensure that the pattern of expenditure reflects those priorities.
- However, with the current weak commissioning regime, PCTs do not have effective instruments to achieve this.

(Palmer, Kings Fund, 2006)

Developing strategic commissioning ?



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- Creating longer-term contracts than annual
- Only pay full tariff for contract volumes; marginal cost thereafter (perhaps set at 50% to continue to incentivise providers)
- Shares risk between Commissioner and Provider
- Allows redirection of resources to community care
- Stimulates greater patient choice

Advantages?



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- Commissioners have real 'teeth' through ability to shift resources
- Providers would be more likely to support closer to home agenda as their ability to expand beyond contract becomes muted
- Medium term contracts provide greater certainty for providers
- Less destabilising for both provider and commissioner as marginal cost less impactful
- Incentives on providers to improve efficiency would be greater because of marginal income from extra workload

Objections?



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- These things should be left to the market
- Lower marginal price for above contract volumes reduce the incentive to expand supply.
(Palmer, Kings Fund, 2006)

What might this mean for the 'new' commissioners'



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- See themselves as the public's health insurers not as commissioners, and be assertive
- Be clear about what you want:
 - Integrate health into partnering with users
 - Encourage thoughtful use of healthcare
 - Emphasise prevention
 - Catch and manage disease early (Berwick et al, 2004)



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- See your population as your shareholders
- If your shareholders are your customers you need to do huge amounts of marketing
- Why not pay for outcomes not outputs
- Negotiating skills development
- How will you facilitate choice by your customers:
 - Information, advocacy
 - Market entry, market 'warming', market exit
 - How will you put together specifications and then tender
 - What incentives will you use for innovation, partnering etc.



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- Concentration on expenditure excellence
- Stop being a provider
- Ask yourselves the question:
 - If people had a choice of commissioners would they choose us?
 - After all they may demand choice if they compare you with other commissioners

What might this mean for the 'new' providers'



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- Your patients are your customers
- You need to market and sell
- You need to collect information that describes your quality against specification, and ideally beyond specification
- How will you become professional at responding to tenders and specifications
- Negotiating skills
- Concentration on cost management excellence

Still to come



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- Further annexes due in December 2006 covering commissioning of primary medical services, health and well-being, long term conditions as well as joint commissioning with local authorities
- Determination on the feasibility of community NHS Foundation Trusts
- Tariff revisions:
 - To provide incentives for best practice
 - Unbundling to support care closer to home
 - Rewards to investment in innovation
 - Rewards to the providers of the most specialised care

Conclusions



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- Strategic commissioning as a concept is still immature and vexed by political vacillation on the consequences of the reform agenda, and interference in organisational structures.
- Current incentives will not speed the reform agenda fast enough for the impact of Wanless to be managed successfully.
- Clinical (or provider) engagement is key to success.



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Care Homes in the UK

(with thanks to Paul Timperley, East Midlands Strategic Health Authority)

Very Controversial Area – should State cover Social Care Costs?

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Royal Commission 1999 –

- Three principles:
 - Responsibility for provision shared between state and individual
 - Any system of state support should be fair and equitable
 - New system of state support should be transparent
- Government did NOT accept main conclusion around social costs splitting to living cost, housing costs and personal care (latter being state funded)

Types of Health Care



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1. 'Acute' -

Hospital

Primary Care

2. Intermediate Care
(Intensive Rehab Therapy)

Community
Hospitals

At Home

Supported by Primary
Care

In a Care Home

Supported by Primary Care

3. Long Term Care/Discharge home or Care Home

Who Needs Residential Care?



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- Older frail (including dementia)
- Acute Physical Disability
- Learning Disability
- Terminal Care
- Respite Care for Benefit of Carers

Type of Residential Care



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- Care Homes (Primarily Social Care)
- Care Homes with Nursing (Have a qualified nurse on duty)

Care Home Statistics 2006 ⁽²⁾



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Care Home	61%
Care Home with Nursing	28%
Local Authority Homes often specialist area eg learning disability	10%
Source the information centre	

Nature of Care Home Market



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- Private/3rd Sector, traditional/state provision now rare
- Fragmented: Myriad of larger and smaller companies involved.

(In an Office of Fair Trading survey, half the homes were owned by individuals mostly owning one home, the other half by companies with up to 200 homes)

- Size of market unregulated
- Quality of care assured by:
 1. Minimum Standards (Care Standards Act)
 2. Inspection through Government Agency (CSCI)

Total Size of Market: 2004 UK



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People in Care Homes	410 000 people
Care Homes	15700 Homes
Value	£8 billion
Office of Fair Trade Data 2005	

UK Care Home Statistics 2006 (1)
NB Only Local Authority Supported People in these
Figures



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- Total number of People Supported
= 259200 (reduction of 3% on previous year)
- 70 000 Admissions
- 78% of admissions are over 65

Source The Information Centre

Current Government Policy for England



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- Social Care Funded by Individual with limited state safety net
- Health care provided free by State
- Maximise care in community settings as close to home as possible
- Intermediate Care gives:
 1. Acute hospital admission avoidance
 2. Active rehabilitation post acute phase to support effective discharge
 3. Minimise the patients loss of ability following a care episode to reduce admissions to care home
- Increasing active managed care/'community matrons'
- Its different in Scotland!

Funding



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- NHS funded care package is totally free and paid by the NHS for people whose primary need is for health care (very few outside terminal/hospice care)
- The nursing element of a care home cost is paid by the NHS (typically £85-£133pw).
- Residential care costs are paid by the client dependent on a capital 'means' test set around £20,000. For unsupported clients fees are privately negotiated
- For clients whose family are unable to make arrangements and/or have a capital of less than c£20k Social Services make the commissioning arrangements and contribute towards the fee on a sliding scale
- Average Weekly cost of a place is £322pw from a Local Authority topped up by £65 from the client

The Indicative Trent Position (part of the country in the East Midlands and where the University of Lincoln is based)



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December 2002 Care Home Census

Fully Funded by NHS (NB March 2006) :

Long Stay	445
Terminal Care	910
Total	1355

Issues



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- Families unhappy as cost of care home provision increasingly eats into family capital (Inheritance)
- Families left to negotiate fees at a very stressful time leads to very variable place costs even within the same home
- Lack of regulation has led to reports of abuse in care homes (leading to regulation requiring staff vetting and the establishment of a register of abusers)
- Discharge delays as patients wait for a home of choice place to become available (care homes run at high occupancies though relatives do also play the system to defer incurring care home costs)