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**Special  
Supplement**

# Commissioning in the NHS



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## Introduction

Sir Nigel Crisp, chief executive of the NHS, has published two documents this year: *Creating a Patient-led NHS* and *Commissioning a Patient-led NHS*. Norwich Union Healthcare then sponsored the NERA Economic Consulting's report: *Commissioning in the NHS*. Here, the Smith Institute brought together key figures in health services to discuss what effective commissioning means and how it can be achieved.

## Seminar participants



### Pieter Degeling

Professor of health management, and director of the Centre for Clinical Management Development, University of Durham



### Edward Bramley-Harker

Co-author: *Commissioning in the NHS*; associated director, NERA Economic Consulting



### Julian Le Grand

Richard Titmuss Professor of Social Policy, LSE; former No 10 advisor on health policy



### Wilf Stevenson

Chair, director of the Smith Institute

Participants from the audience were: **Rod Griffiths**, Faculty of Public Health; **Lord Harris of Haringey**; **Matt Tee**, Dr Foster; **Richard Lewis**, King's Fund; **Thelma Agnew**, freelance journalist/*Nursing Standard*; **Jim Thompson**, Centre for Mental Health; **David Mallet**, Monitor; **Nicola Golding**, Healthcare Commission; **Howard Cotton**, Royal College of Nursing; **Nick Goodwin**, London School of Hygiene & Tropical Medicine; **Richard Thompson**, College of Physicians; **Jackie Brown**, Basildon Primary Care Trust; **Tim Baker**, Norwich Union Healthcare; **Eddie Saville**, Society of Chiropractors & Podiatrists

### Foreword by Nigel Edwards

When the internal market reforms of the early 1990s were introduced, the Department of Health set up a working group to develop what was then called purchasing. It was called Project 26, giving a clue to how significant this was seen to be. To some extent commissioning has slipped even from 26th place and for many years there was not even a senior civil servant who had it as a key responsibility. A certain amount of confusion grew up about what commissioning was and the recent development of choice and the reintroduction of market mechanisms has added to this.

It is obvious however, that without high quality commissioning, achieving major improvements in population health in the process and outcomes of care and in developing high quality integrated delivery is impossible. Whilst the focus has been on developing high quality entrepreneurial providers an important point has been missed. Whilst a strong and innovative provider function is essential it is hard to be innovative without commissioners willing to take up the challenge of

working with providers to drive the system forwards.

With the relative neglect of commissioning there has also been a missed opportunity to bring a whole new set of tools and techniques to bear. Using epidemiology to identify need is important but we have often missed the opportunity to use new techniques drawn from market research to segment the population in different ways to understand their needs better. The insight that relatively small numbers of patients drive large amounts of costs means that using actuarial techniques and regression models is vital to understanding risk and need. But the NHS employs exactly zero actuaries. Planning and strategy making, vital to driving the success of payers in other health care systems, have often not developed into the powerful mechanisms for changing services. The highly short term annualised approach to planning over the last 10 years, a sometimes naïve view of policy makers that strategy is set centrally and that market mechanisms need less planning has been partly to blame for this. Markets, choice, payment by results and practice-based commissioning actually require more

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planning than a centrally planned system. Only in this way can organisations understand how to navigate an increasingly uncertain world. New techniques for planning, forecasting and strategy building are required by commissioners just as much as by Foundation Trusts.

Practice-based commissioning and the other market mechanisms offer major opportunities to drive change. There has been some speculation that they reduce the importance of commissioning. This is the opposite of the truth. Whilst a few policy makers believe that the actions of large numbers of individual practice commissioners is all that is needed to drive change the evidence of other systems is against them. Practice-based commissioning will undoubtedly drive change but there are limits to how far the sum of the individual preferences of practices can be expected to produce major reconfiguration and step changes in how services are delivered. A reinvented commissioning model offers the opportunity to add real value to the work of practices and other commissioners to move away from the incrementalism that has plagued the NHS to a more radical, bold and imaginative model driving real change that patients and clinicians would both notice and approve.

Nigel Edwards  
Director of Policy, NHS Confederation

### Foreword by **Chris Ham**

The NHS is midway through a 10 year programme of reform designed to tackle long standing weaknesses in performance. The progress made to date in reducing waiting times and raising standards in areas of clinical priority like cancer and heart disease has resulted from national targets, extra investment and aggressive performance management. In the next phase of reform, progress will depend more on systems reforms, including giving patients more choice, extending payment by results, and introducing greater plurality among health care providers.

Of critical importance in the next phase will be the strength of the commissioning function. Commissioning was the weak link in the internal market in the 1990s, and there is a risk of history repeating itself. The government has recognised this by giving practices the right to take on a budget if they wish, and by announcing plans to strengthen contract management and administration. This is likely to happen through the concentration of expertise in contract management and administration, either nationally or through regional arrangements. The number of primary care trusts (PCTs) will be reduced as these arrangements are developed, building on informal alliances and collaborations already in place in many parts of the country (Peck and Freeman, 2005).

Commissioning is of critical importance because the health care market that is emerging will be dominated by health care providers in the absence of an effective countervailing force. The establishment of NHS Foundation Trusts and independent sector treatment centres requires commissioners to raise their game if they are to negotiate on equal terms in a world of legal contracts and business oriented financial regimes for providers. Specifically, commissioners face real challenges in ensuring that payment by results supports patient choice without inflating hospital activity inappropriately, achieving reductions in emergency bed days through a stronger focus on chronic disease management, and using the potential benefits of a contestable provider market to bring about improvement in the quality of care for patients.

The importance of this report is in offering a dispassionate analysis of these challenges and providing the basis for a debate about the role of strategic commissioning in the NHS of the future. As the report makes clear, strategic commissioning could remain a function carried out within the NHS, or it could be taken on by private sector organisations with relevant expertise.

Whether the private sector would be interested in becoming involved in commissioning is an interesting question. The mixed track record of the NHS in commissioning, and the much wider scope of NHS commissioning compared with the management of private health insurance, might act as a deterrent, unless the incentives for involvement were sufficiently strong. As this report emphasises, more work is needed to specify the nature of these incentives, and to construct an arrangement that might bring benefits to the NHS while also being attractive to the private sector. A hybrid solution would be for a public/private partnership to be formed bringing together experience and talent from the NHS and the private sector to take on strategic commissioning.

In view of the difficulties involved in commissioning health care, not only in the United Kingdom but in also other countries (Figueras, Robinson and Jakubowski, 2005), there would be advantages in encouraging pilots to test out different approaches. This now needs to be given priority to ensure that the systems reforms being put in place build on the progress made so far in improving NHS performance. Particularly in the period after 2008, when the NHS budget will increase at a much slower rate than in recent years, the ability of the NHS to sustain improvements in performance will depend on the skills and competence of commissioners. Time is short; action is urgent.

Chris Ham  
Professor of Health Policy and Management,  
The University of Birmingham

# Commissioning in the NHS



**Wilf Stevenson** Welcome, and thank you to Norwich Union Healthcare for its support in this event. Today we are going to discuss the NERA Economic Consulting report *Commissioning in the NHS*, but, as I think we'll learn, "commissioning" is a problematic term, both in its direct application within the National Health Service and also because it has much wider ramifications for public services more generally.

**Edward Bramley-Harker** I'd like to give you a brief introduction to the report, explain why we picked the topic of healthcare commissioning, and then talk about some of the main themes. I'll end my comments with a question that I hope will frame the discussion.

Our starting point was that the commissioning of healthcare is a highly significant and broad task that impacts on many aspects of health service performance. It impacts on how resources are allocated in healthcare and how health services are configured; in short, on how well the health service meets the needs and the expectations of patients. We found it quite hard to define what commissioning was. In the end, we decided that it covered three fairly broad functions.

The first was a planning function. How does the health service identify the needs of local populations, establish

priorities, understand the local health economy and configure local health service delivery?

The second relates to functions around purchasing. How do we identify what care settings we want to treat patients in, which providers we want to contract with, and how we set the contracts and incentives that drive the relations between our commissioners and our providers?

The third was the monitoring function. How do we confirm what's been delivered, monitor quality, and work with the patient to ensure that they're satisfied.

The motivation for the report was three themes that recognise the breadth of those commissioning tasks. The first was that commissioning in the NHS is a specialised and fairly underdeveloped task. This is a real worry. The second was that there are a number of policy initiatives that are going to have important implications on how healthcare is commissioned in the NHS. For example, patient choice can simplify the commissioning process, so that once a GP makes a referral the patient drives the rest of that particular commissioning task. Another is practice-based commissioning. The financial incentives inherent in practice-based commissioning for GPs are an enabling factor that will encourage GPs to think more innovatively about how they commission care, and how and where they refer patients. The third

issue is payment by results, which in some sense helps to simplify the commissioning process because it takes some elements—price, for example—out of the equation. But the introduction of payment by results also brings risks and potential instability for stakeholders operating in the NHS. Bradford, whose foundation trust got into financial difficulties when it misjudged the effect of the changes on its income and workload through this system, is a case in point.

So, what tools and expertise do we need to put in place to help practice-based commissioning thrive in this new policy environment? We recognise that there are a range of opportunities for individuals and organisations with different skills sets and different incentives to contribute to strengthening different aspects of the commissioning task. But what would good commissioning look like? It's an easy question to ask, but difficult to answer. What I'll try to do is describe what I think good commissioning would look like under a number of headings.

The first of those headings is "levels". The Health Foundation completed some research recently that sets out how different commissioning tasks belong at different levels. Some services can be purchased at quite a local level, others are better done for larger populations. So some kind of aggregation seems sensible, and indeed when we look at what PCTs [primary care trusts] do at the moment, they often work together to purchase some of those more aggregated type of services. Other commissioning tasks clearly require quite a high-level view, such as how the market is managed and how services are configured. Practice-based commissioners would find those pretty hard to do on their own.

My second heading would be "information". It's likely that good commissioning needs to be based on good information. So, if commissioners are going to be effective in how they redesign services or how they manage patients, they're going to need good information, and therefore good evidence. My third enabling factor involves having the skills and tools to be a good commissioner. As I've said, commissioning is a very skilled task, and in many cases those skills don't really exist or are significantly underdeveloped in the NHS. In the foreword of our report, Nigel Edwards (policy director at the NHS Confederation) notes that the NHS doesn't employ any actuaries at all. Some of you might regard that as a good thing, but I think we have to recognise that actuaries do

have something to offer here, especially in needs assessment, and in linking that to long-term capacity planning. The question is: how do we bring skills into the NHS, and make them part of the skills sets that commissioners use?

The final theme that I would mention is "incentives". It's an obvious point, but if commissioners are going to be good, they need to have the incentives and the power to make them good. That might mean them having the right financial incentives, having a clear mandate, and having the ability to look over an appropriate long-term period.

In our report, we introduced the term "strategic commissioning". We use that as an all-embracing term for commissioning which recognises the themes that I just outlined. So it includes giving commissioners the information, power and incentives they need to do their job properly. It means that commissioners not only undertake the routine administrative tasks such as claims handling and patient management, but also have good incentives to undertake the longer-term tasks, such as risk man-

agement, needs assessment, actuarial planning and service reconfiguration. If we think about where the big potential future savings for the NHS are likely to lie, it's going to be in those areas. It's going to be about treating

patients in different ways, about managing disease more innovatively, and about intervening earlier.

Some of the skills needed to provide this breadth already exist within the NHS. Others could be developed in partnership with other collaborators and some might be brought in with the private sector. It's fairly easy to see that for some services, various commissioning tasks could be brought in on a contract basis – for example, if a PCT wanted an organisation to handle its claims and billing systems. The trickier issue is how you encourage a commissioner to focus on the longer-term things, to think or behave strategically?

I think PCTs find needs assessment and long-term planning difficult to do. This is partly due to a lack of skills, but it's also because it's a very long-term game and not a priority for the PCT. How do we make it a priority task for our commissioners and for the NHS? In our report we suggest that there might be something around how you structure the financial incentives and the financial flows, so that you encourage certain stakeholders within the system to focus not just on a one- or three-year budget, but on how to manage risk over a longer period. Could we envisage a system where a strategic commissioner is ►

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## We can't devolve everything. Some aspects of commissioning will naturally sit at a higher level

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▶ contracted to undertake tasks around needs assessment and risk management for a group of practices where the financial rewards that that commissioner gets depends on how well they manage the risk of patients over a five- or ten-year period?

This notion of strategic commissioning is not intended to work against the current policy direction of trying to devolve responsibility to a local level. It's about recognising that we can't devolve everything, and some aspects of commissioning will naturally sit at a higher level in the system while still being an integral part of supporting practice-based commissioning.

**Pieter Degeling** What I'm going to do is relate the findings of this report to some policy initiatives that have come out in the past month or so under Sir Nigel Crisp's name, and then relate them to some research that we've been doing with three strategic health authorities.

In my view, the effectiveness of commissioning policy will ultimately be judged in terms of how it delivers on other policy objectives, particularly those where it will facilitate an increase in patient choice. Will it facilitate a shift in service provision from acute to primary care? Will it engender a greater focus on value for money considerations, for example, in terms of incentives to improve hospital efficiency? Will it encourage contestability? Furthermore, will it encourage increased flexibility of service provision regarding the location of service, treatment centres, walk-in treatment centres, stand-alone high speciality care units, one-stop shops for primary and personal/social services? And will it also deal with the issues in relation to public-private mix. For example, how is it going to cope with the government's directive for 16 per cent of service provision to be delivered through private service provision? How will it focus on long-term conditions? How will it affect clinician engagement? And to what extent will it deal with devolution?

When you think about the policy goals that I've talked about in terms of value for money, shifts in service provision, increased flexibility in service provision, and chronic disease management, inevitably all of these issues involve questions about redistribution: redistribution of resources, patient flows, money, staff, power, authority and status within the system. Ultimately, the success or otherwise of a commissioning strategy will be the extent to which it, in any way, helps people to deal with the politics

of that redistribution. So, in addition to the things that are mentioned in this report in respect of getting the appropriate levels, getting the right sort of information in the right place, creating the right sorts of visibilities so that questions are posed, and having the right sorts of skills, what I would also ask is, to what extent are these commissioning institutions going to be able to cope with the politics of redistribution, for example the politics of redistributing services out of acute care into primary care?

What's involved has become very clear to us, in the work we've been doing with three strategic health authorities involving about 15 health economies. We've been doing an analysis of the data and saying: what does that data tell us about where services can be shifted from acute to primary care? What does it say about the prevalence of chronic disease and the impact of that upon the healthcare system and what that might mean in terms of shifting services from acute to primary care? And what might that mean in terms of workforce, capital investment, etc? The data that's coming out shows that in a typical district general hospital, about 53 per cent of all care episodes and 83 per cent of all bed days are consumed by patients who

were admitted through A&E. Out of 547 healthcare resource groups [groupings of clinically similar treatments using common levels of healthcare resources which allow for costings across services], 30 account

## You've got to have some sort of organisation. I'm not sure one needs a strategic commissioner

for 46 per cent of all these emergency episodes. Of those top 30, 18 reference clinical conditions with a high risk of repeat admission; 54 HRGs account for all inpatient elective episodes, 30 account for 75 per cent of all day case episodes. For emergency admissions, in a two-year period, 200 HRGs had 40 episodes across all trusts. And equally, 330 had fewer than 40 episodes over the same time period.

Those are enormous issues in terms of clinical governance, and quality. Why are these hospitals doing these things? In terms of judging the effectiveness of any commissioning model, we need to consider variability of practice and the rate of emergency admissions in this data, which varies markedly between PCT and GP practice. The rate of re-admission for high-volume chronic conditions also shows marked variations. What is commissioning going to do about that and the politics that that entails? It's a massive redistribution exercise.

That then raises questions about levels and information, but ultimately it seems to raise a question about who "owns" those issues in a commissioning exercise. Part of

the answer might be that we have to have a strategic function which has the skills, information, power and authority to do this. But my question still remains: how are you going to manage the politics that will ensue?

**Julian Le Grand** I've seen this report before and was impressed by it. I think it's a very useful way of organising our thoughts. There are chunks of it, as Edward knows, that I'm less sure about. Perhaps we can open that to discussion.

Commissioning is terribly important, particularly since we're putting in place a whole range of factors that will drive up demand unless we get them under control: Things such as payment by results involve setting in place a fee-for-service system, which as every economist knows, leads to supplier induced demand. We're setting up lots of powerful providers, powerful foundation trusts and an increasingly powerful independent sector that will also be looking for business. We are going to need some strong instruments to control demand. Indeed, "demand management" is a term I prefer to commissioning.

The instrument that the government has chosen to use is practice-based commissioning. I think there are legitimate questions to raise, and the paper raises them, about how effective that's going to be. There is experience from the GP fundholding experiment and a lot of good research coming out now about that. The useful thing about GP fundholding, from the researcher's point of view, was that it wasn't universal: so it was possible to undertake semi-controlled experiments by looking at what happened in areas where there was fundholding and areas where there wasn't. There is some sophisticated work being done at York and elsewhere which suggests that fundholding was effective at controlling referrals, bringing referrals down, and also controlling drug costs. There is some evidence to suggest that practice-based commissioning, being in some senses similar to fundholding, is likely to be an effective



tool for demand management.

That poses the question which Edward has raised: are there some bits of commissioning that practice-based commissioning cannot be relied upon to do? I think I'm a little more sceptical than he is that effective alternatives do exist. The problem I have with the phrase "strategic commissioning" is that I think what it reminds me of is central planning. We've had a lot of experience with central planning in the health service.

We know that, if we lived in a perfect world with perfect information and perfect incentive structures, we could plan things perfectly. But we know that we don't live in such a world and that planning, more often than not, leads to disaster.

So, the question is: can "strategic commissioning" cope with all the problems that confront a planner and do it effectively? If we look at some of the things that the report says practice-based commissioning can't do, I think it's useful to see exactly why it can't do it, and what other body might do it instead.

Let's start with practice-based commissioning. Why can't it monitor and review the quantity and quality of services delivered? In fact, the experiences of fundholding, and perhaps even more so, those of the total purchasing pilots – groups of fundholders together – were that they were rather effective at monitoring quantity and indeed quality. Of course, it might require information resources that are not open to the average GP practice, or indeed the average collection of GP practices, but something like the Healthcare Commission or Dr Foster, a healthcare information publisher, can provide a whole set of very useful information. You've certainly got to have some sort of organisation, centrally located or in the private sector, that provides information, but I'm not sure that one needs a strategic commissioner to review the quantity and quality of services delivered.

I reach for my gun when I hear the words "capacity ►

►management”. Again, that’s old scale-planning. We work out what we need, as though we know what we will need in five or ten years’ time. We work out the capacity, do the calculations. It never works and, furthermore, it’s not clear to me that it’s needed in this world.

We do have an elaborate set of regulators in the health service, but none actually does the one regulation job that I think is really rather important, which is market management. Specifically by that, I think of things such as monitoring anti-competitive practices, checking out mergers, whether they actually serve the public interest, etc. But I think there are organisations already in place – it might be Monitor [the NHS foundation trusts regulator], it might be the Healthcare Commission – that could act as the market manager, and I don’t think we need a separate strategic commissioner to do that.

I’m also not sure why the report separates assessment of need as well as demand. In a world where healthcare is provided free at the point of use, it’s not quite clear what the distinction between need and demand is, but I assume that what’s meant is something like unmet need, the need that does not turn up in the GP practice to be dealt with. Again, I think there are organisations like Dr Foster

that are providing information and I think information does need to be provided on that. GP practices are quite well placed to use that information, if they get it, because they’re local. Of course, you’d have to set the incentives in place to make sure they do. Under PCTs, GPs do not currently have incentives to go out and find new sources of need, but one can imagine incentive structures that could be used to do that.

Finally, let’s look at large-scale investment and reconfiguration of services – the kind of thing that Pieter was talking about. Who would own this problem? In conventional markets, nobody owns it or insofar as anybody does, it’s the providers themselves. Planning goes on in conventional markets, only it’s not undertaken by some kind of centralised purchaser or centralised commissioner, but by the provider units themselves. Sainsbury’s or Airbus make a big investment decision and they don’t have some kind of centralised planner or commissioner that tries to think how they should actually do it. There have got to be real questions as to why we can’t do that in healthcare. Healthcare policy follows the medical profession in always thinking that it is exceptional. There may be an exceptional case here, which says we cannot look to the

big providers, the big foundation trusts, or the private or independent sector to make the investment decisions and take the risks involved, but I certainly want to hear the argument as to quite why we can’t do that.

**Pieter Degeling** Private-sector risk and how you’re managing the risk is registered on your share listing on the stock exchange. But who, for example, ultimately carries the risk that goes with how successful the general management team of Birmingham acute trust has been in terms of its assessment of risk? Ultimately it’s the politicians, because when Birmingham acute trust goes bust it’s they who are called into action. You are not going to let that hospital go bust as a result of a significant shift in service provision. It’s not as if public-sector managers are different or that they are trading on the sort of “sacredness” that’s attached to medicine. It’s ultimately the editors of the *Mirror* and the *Telegraph* that will hold the politicians responsible, in the event that risk managers in provider

organisations get it wrong. That’s the politics that I’m talking about.

## We have been able to choose our GP since 1948. Has that produced a universally good service?

**Julian Le Grand** As a description of what has happened in Britain historically, that’s absolutely correct,

and it’s a real issue for government, this question of who bears the risk. Other countries with more pluralistic systems of provision do have hospitals that go bust. I think Japan had 200 hospitals going bust not so long ago. Precisely because of the division between the commissioner and the provider, it didn’t actually land up on the government’s door.

An interesting example, and quite a hopeful one for the future, was what happened in Bradford with respect to the role of Monitor. Neither the Secretary of State for Health nor the Prime Minister had to stand up in the House of Commons and defend what was going on, or indeed be held responsible, and that’s one of the first times in history when a bedpan has fallen off the bed and the sound has not resounded through the Commons.

The development of organisations such as Monitor and perhaps the Healthcare Commission is exactly the way that we should be going to try and engage in this distancing effect, but I do agree with Pieter, that it is an absolutely crucial issue and one that the government has to address.

**Rod Griffiths** Much of this I think we went through in 1990 to 1994. It’s interesting that somebody has finally

concluded that some aspects of fundholding were good.

Kidderminster comes up whenever you address those configuration issues. I was the regional director for public health for the West Midlands when Kidderminster was being reconfigured. We did exactly what you talked about, mostly lead by the health authority but with contributions from the regional office. We checked all the numbers, and we looked at the small-volume things that were done in Kidderminster that ought not to have happened. The figures showed that they weren't doing it terribly well. There were lots of things they could do well: 80 to 90 per cent of what they had been doing they should have gone on doing. But there was 10 per cent they shouldn't have been doing, including a silly little A&E department that was actually quite dangerous.

We reconfigured them and it led to the creation of a new political party [Independent Kidderminster Hospital and Health Concern], the loss of a junior minister and we were told never, ever, to do that again. That decision has hung over two parliaments and Dr Richard Taylor is still there in parliament still saying the same kinds of things, and Kidderminster is probably a little safer than it used to be.

So, we did the right thing, but in the end we couldn't manage the political consequences. Someone should go back and analyse that with some distance, not people like me who were half-involved, but an outsider who can do it without any preconceptions.

Regarding the statement that the NHS doesn't employ any actuaries, we do employ quite a lot of public health people who do epidemiology and statistics and so forth. My sister-in-law is an actuary and, comparing her curriculum and ours, there is a lot of what she does that our people are trained to do. But we have screwed up the public health system in this country, and every time we reorganise, we scatter them about and make them apply for their jobs again, and people take early retirement. And every time we look like we've got any kind of capacity, we kill it off, without thinking twice.

This current paper doesn't even mention public health. It's going to melt down the public health system and make everybody apply for their jobs again. So, you won't get public health people having enthusiasm for putting their skills into commissioning if they're given safe havens to



run to such as the Health Protection Agency, or whatever. You need to build the right kind of workforce if you're going to get that kind of analysis.

Reducing the number of providers and licensing may offer a solution. Through the process of designation, we do stop people dabbling – we insist that only three or four places – or even one – will do heart transplants and we make them join it up across the country so that people have access. You can do the same with relatively uncommon conditions. You should maximise what's done with GPs: they're good at volume and quality but not very good on effectiveness. And you may still want to look at effectiveness in a local sense because travel times and things like that matter as well as just whether or not the right procedures are being prescribed.

I think the real lost opportunity – and it's not just in relation to commissioning, but other things – is that we're not looking at local authorities as well. If this government doesn't know by now what it should do with local authorities, then it ought to be shot. Where you've got a unitary authority and a PCT that matches, you get much more strategic thinking, energy and partnership, and that enables you to think about innovative solutions for more care outside of hospitals, transport patterns, and getting people exercising, for example, to stop diabetes down stream. We ought to be reorganising local government ►



consultant they go to, it's about the nature of the care and everything else that's available. What I'm not clear about is how you can build that degree of service user involvement into the commissioning process, whether it's at GP level, or at PCT or national level. The dangers seem to be that what you're actually doing is placing people's various judgements as a proxy for what users want. That may be the GP, on the basis that GPs, in the traditional role as gatekeeper to the NHS, know best what their patients need, though I think that's debatable. Or it may be that the commissioners further up the chain are making that judgement, but again I think some thought needs to be given as to what the basis of that is. Or are we simply saying that the mere act, whether it's actuarial or public health management or anything else of that nature, is going to deliver more effective and more user-led services? I don't think that's proven by any means: it's just a leap of faith.

► and the health service together. We've done that with crime and disorder partnerships and many other things and it's very successful where you get on top of it. It puts a duty on people and it's that duty that drives things forward. If you want decent commissioning, then you need to create the right sort of partnerships.

**Lord Harris of Haringey** I think every document about the health service in the past 50 years has always started with some sort of rubric about putting the patients at the centre. I haven't read Sir Nigel Crisp's latest document, but I'm sure that somewhere in there will be a sentence to that effect. But actually, most of the debate we've had has been about the values of centralised planning versus local commissioning, and neither are necessarily consistent with the other group of rhetoric about putting patients at the centre. There has got to be some very serious thought about how you reconcile that and make it meaningful.

My own view is that it is, by and large, beneficial if users of services have had a considerable say in specifying what service it is they get, and are actually able to exercise real choices. That isn't necessarily about which hospital or

**Matt Tee** I wanted to pick up on Pieter's point about hospitals not going bust. I think we have had hospitals go bust: Mid Yorkshire hospital being bailed out to the tune of £50m last year is a pretty good example of a hospital going bust. What we haven't been is very transparent about it. I think it would be quite interesting to ask the people around Mid Yorkshire what they thought about their hospital being bailed out for £50m because it wasn't able to meet its budgets.

I want to go on to Julian's model, with which I have some sympathy. It seems to me that historically we've always been in a situation where there has been an imbalance between providers and commissioners, whether they be GP fundholding commissioners or PCTs or health authorities. It has always been the provider "tail" that's wagged the dog. That was true in the internal market when I worked at Guy's and St Thomas'. We wagged our tail quite a lot. Now we're still in a position where foundation trusts are looking to grab what they can of the community services that are being prised away from PCTs, and all of that is coming in advance of these primary care commissioners being ready to take on those sort of providers and

to leverage up the sort of improvements in healthcare that I think we all want to see.

Around the country, I don't see lots of GPs desperately saying, give me the budget and I'll do the commissioning. I think there are some who are quite intrigued by it but they're nowhere near as far down the track. My worry is that by the time the commissioning is actually strong enough to do something about that, we'll have restructured it out into something different.

**Richard Lewis** I also accept quite a bit of the rebuttal that Julian gave to the notion of strategic commissioning. However, I don't go quite as far as him. Practice-based commissioning is the only game in town at the moment. I'm sceptical of the sort of incrementalist approach that Julian put forward – that the aggregation of lots of decisions by fundholders will necessarily add up to something at a strategic level.

There is literature that shows or purports to show that healthcare cannot be traded simply as an economic good. One of the reasons why it might be different is that we impose societal values on what we expect and we don't see it as something that's simply traded in a marketplace. We might want healthcare to deliver a range of services for patients who might not have a voice, and we need some sort of bulwark to ensure that it's not simply the vocal or the profitable services in a marketplace that drive the system. You could manage that through some sort of regulation, and I accept there is a lot more work to be done looking at how we regulate health services.

But there is another issue that's come into the fore under practice-based commissioning: key commissioning decisions in this mode will be those of eligibility criteria. When someone is sitting in a GP's surgery, the demand management function of a GP will actually be exercised through deciding whether somebody is eligible for a service or not. Historically (and I think quite rightly), this has been seen as an essentially political decision that requires some sort of forum at a local or national level, but I suspect more effectively at a local level, to determine whether eligibility criteria are appropriately applied or not.

Leaving eligibility simply in the domain of demand management is dangerous territory, and the government has sort of recognised, in part, this requirement to balance market mechanisms with broader societal political mechanisms through the creation of foundation trust accountabilities. But it does seem to me that that's the bit of the reforms that's most underwritten.

**Julian Le Grand** Choice of provider is perfectly compat-

ible with practice-based commissioning or whatever: the GP decides what treatment is needed and then offers a range of choices of provider to the patient. I agree with you about choice of provider. If you want to go down the route of what patients want, it's choice of treatment rather more than choice of provider, but I think choice of provider serves an incentive function. The problem with the choice of treatment, is that, if you offer informed choice of treatment, patients would always choose the most expensive form. It's very difficult to marry it with a system of public spending and cost containment. Evidence from the US suggests that, particularly as far as basic surgery is concerned, if you do offer patients the choice, very often they go for the least-expensive option. That's not true with drugs. If you offer patients drugs, they want more of them and the more expensive ones. There is a problem reconciling the gatekeeper role with the choice of treatment and cost containment.

In certain areas, we did get some things into the manifesto that I was quite pleased about: a certain amount of choice of treatment. In mental health, we got some commitments to a choice of talking therapies, such as cognitive behavioural therapy, and most of the evidence shows that it is just as cost-effective as drug therapies and much more popular with patients. In maternity care, where choices have sadly decreased in recent years, a choice of home birth or hospital birth. And in palliative care, more choices around the availability of palliative care in the home. All those things we tried to get in and hopefully there will be some commitment to them.

I agree with Matt's point about timing. If we were starting from scratch I would have introduced practice-based commissioning first. In fact, I would have abolished GP fundholding and argued strongly against it in the early days of the Labour government. Then I would have introduced payment by results and then foundation trusts and the independent sector. We've actually done it in precisely the reverse order and I agree there is a danger that it may be too late, which is why the drive towards getting commissioning right is so important now.

On the social values point that Richard was raising, I would have thought that the whole drive behind a quasi-market, or whatever, is that equity is taken care of in the financing system. The evidence from other countries is that patient choice is rather more effective in helping the poor than patient voice. Systems that don't allow choice are often much less equitable than systems that do because choice gives power to patients at the poorer end.

On linking health and local government, I've always been sympathetic to the Swedish model, where you've ►

▶ got county councils who control health. But the key there, and it relates to the Kidderminster example too, is that the county councils tax as well as provide services, so if a local community wishes to keep a local service going, they don't do it at somebody else's expense. Here, people just see the loss of a service. They don't have to bear the costs of keeping an uneconomic service going. If they did, their decision might be somewhat different.

**Pieter Degeling** Who would do what you did in Kidderminster in the structure that's being proposed by Sir Nigel Crisp?

**Rod Griffiths** We did something similar in Rugby, but we used a safety criteria and almost nothing else. We persuaded the Rugby and Coventry trusts to merge because the Rugby one would have become dangerous and have ended up in an inquiry if it had been allowed to go on indefinitely. We did that despite opposition from local MPs.

I'm all for the fundholding type model, because I think it's effective. But I do think you need someone who looks down on it over a bigger area.

**Peter Degeling** On the question of hospitals going bust, the important point is that they are always bailed out. If Sainsbury's goes bust, it goes bust. But if the hospital is always bailed out, the question is whether this is a market or a phoney market. It's got nothing to do with moral values; it's a case of whether market forces will be allowed to operate. And then it is a question of the consequences, in market terms, when people make undisciplined decisions.

It seems to me that the PCTs and strategic health authorities are both in a situation of regulatory capture, and the issue is: how do you deal with that. One of the things might be to say: rather than having foundation hospitals let's have foundation commissioning organisations – where there is a fund that is owned by a particular locality, and it says: there is the money, now you deal with the politics of how that money is allocated. But at the moment it's always shifted back to somebody else.

On the issue of patient choice, it's interesting that when I look at the paper by Sir Nigel Crisp, and I look at what the GP commissioning role is, it's actually quite minimal. They are responsible for operating within an indicative budget, and that's ultimately what it is. Their so-called commissioning actually comes via how they refer patients

and their involvement in designing services. So, in the case of chronic disease management, what they're likely to be involved with is working with patients such that a patient co-producer element is a very significant component of the service which then results. If this then leads to the emergence of something called Chronic Disease Management Inc – as a result of, say, five or six GP practices coming together and saying: this is how we're going to organise our services – who is going to finance that? Who is going to be carrying the risk, as they shift services from acute into primary care? The GP practices, the acute trusts, the PCT? None of that is mentioned in any of the documents. And what does it mean when patients have a hand in designing the services and they don't become the active co-producers that we're hoping they'll become, because they choose to continue to smoke or whatever?

**Edward Bramley-Harker** The first issue is to address Julian's observation about a sort of centralist agenda. That certainly isn't what we were trying to get across in the report. This isn't some attempt to try and introduce one or two very large strategic commissioners who centrally plan and micro-manage everything that goes on in the local health economy. I guess I find it more helpful to see a strategic commissioner simply as a collection of tools and those tools could be provided by all sorts of

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## If Sainsbury's goes bust, it goes bust. But if a hospital is always bailed out, this is a phoney market

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different people. We recognise that while the bit that happens in the GP surgery, the decision to refer, is fairly straightforward, you need a lot of information to make that decision, and make it consistent across different practices. How do you get the information to make that happen? The fact that we see things like the Dr Foster tools cropping up periodically in certain points within PCTs is indeed very encouraging, but it's not happening on a wide scale at the moment. How do we encourage the development of those sorts of tools, to make them become an integral part of the armoury that general practices use to identify and manage that need through the system?

I was interested in a couple of comments that Rod made. As part of the background to this research we went out and did some interviews with PCTs, and we had a long discussion with them about how they make use of public health information. They all said that they had directors of public health and they do this and they do that. What was missing was how that really gets integrated to become a core part of the work that the PCT does. It was almost as if they

were saying: “yes, that’s very interesting but we’ve got far more pressing things that we, the PCT, need to manage, that we get assessed on, that are very visible to patients and to politicians, so that kind of takes priority”. The very important public health agenda is left out.

I would wholeheartedly endorse the comment about integration of PCTs with local authorities. That came across very strongly during our interviews – that if you’re going to manage the patient and chronic conditions in the community effectively, you need to make that link between health and social care.

**Thelma Agnew** Do the panel actually think there is any real need for the latest wave of change, ushered in by Sir Nigel Crisp’s paper, at this time? A lot of the people I’ve spoken to in the service have said they think it’s poorly thought-out and rushed, and the last thing staff on the ground really need at the moment is yet more casual change.

Also, what is the likely impact going to be on staff? Staff who’ve actually heard of the Crisp paper are wondering who is going to be employing them, and whether it is going to be a real shift or some kind of bogus rebranding.

**Jim Thompson** If you give patients choice they’re likely to exercise it, but with that there has to be some form of strategic planning. Cognitive behavioural therapy, for example, is mostly used in mild to moderate depression. It is an enhanced service. GPs are unlikely to be rewarded for diagnosing this condition, which is just as well because there are very few practitioners out there in the marketplace. So there is a risk in giving patients the choice to choose CBT when it’s actually not widely available.

**David Mallet** These comments are based on long and bitter experience as a commissioner, and not necessarily the views of my current organisation. Partnerships between local authorities and health authorities can be a problem. For example, no local authority is going to close its local A&E. In fact, they won’t close their local community hospital, even when there are quality issues involved, let alone when there are no funding issues involved.

I understand the arguments about how successful GP fundholders were, but they were overfunded. They were



deliberately given too much money because that was the policy direction at the time. We would have run out of money for the eighth or ninth wave of GP fundholding at that rate. However, they were financially incentivised in ways that appealed to them because they could tackle secondary care, and if they did that effectively they got a nice extension to their premises out the back. If that’s what you need to make a secondary to primary shift work effectively, fine. But in the present proposals, I can’t see what the good incentives to primary-based commissioning are. It’s all well and good us managers talking about it, but we come and go every three or four years, whereas GPs have to work with the consultants in a locality for 25 years.

**Nicola Golding** I think there is consensus among the panel that we somehow need to boost the power of the commissioning function, whether it’s a PCT or something else, and whether it’s because it needs to have the power to push through the politics of reconfiguration or to manage demand effectively. The big question is, how? Through regulation? Through some sort of incentive system? A combination of the two? How do we give the necessary power to commissioners – not necessarily PCTs – to make sure the tail no longer wags the dog?

**Howard Catton** I think it’s hugely important to make sure we’ve got some of the workforce issues on the agenda. ►



**Nick Goodwin** It's going to be the chronic disease management, the treatment of people with co-morbidities and the growing elderly populations, which will be the most expensive things that need tackling in the near future. If the aim, through practice-based commissioning, is in some way to reinvest in primary community care and particularly in things such as chronic disease management, and to take appropriate services out of the acute sector and place them more appropriately in community care, I'm just wondering whether the system we're introducing is going to be able to do that. If you're going to be able to tackle chronic diseases, you need to develop more integrated forms of delivery. And if primary care services are commissioning the care, they will undoubtedly want to try to work within budgets. Is not the patient then in the middle of a battleground between the commissioners and providers, providers that all working to a different model?

► There is no doubt that the Crisp paper has caused huge anxiety from grassroots through to a senior level. Often, staff will let the latest reorganisation go over their heads, but not this one. One reason is that having been told by politicians that staff are the most valuable asset, the new letter implies that some are going to be transferred out. That may have implications in the future in terms of recruitment and retention.

A lot of the discussion has concentrated on the important role that GP colleagues play. But, in terms of tackling long-term disabilities, it's nursing and therapy staff who are leading the way and absolutely need to be engaged.

On whether the public are concerned about who the provider is, I'm reminded, in a previous life, of going through a situation of trying to transfer council housing stock away from the public sector to the private and independent sector. In a vote, the tenants rejected a move to the private sector because they liked to know that it was Councillor Smith up the road who they could hold accountable if their door wasn't painted or if their central heating wasn't fixed. They didn't believe that being transferred out wouldn't mean an increase in their rents.

**Richard Thompson** When I listen to healthcare policy analysts, I feel as though they move the health service around like pieces on a chess board, forgetting what effect those changes will have. For instance, you suggest that commissioners might, say, take urology out of a hospital and move it to what they think is a better site. What happens to the hospital you take urology out of? You need acute urology. If you've got an A&E, you can't just strip it out, because you'll then have a very poor service.

Then you talk about patient choice. My experience is that most patients actually want to choose their local hospital, and if you're living in Carlisle or Exeter, you only have one local hospital, so it's a very limited choice.

Someone said that evidence has shown that you can reduce the number of referrals to hospital, implying that that's a good thing. I would suggest it's a bad thing. My experience as a clinician in a hospital is that not enough patients are referred, or they're referred very late. We should think very carefully whether this is improved quality, which is what we all want in the health service.

**Jackie Brown** A lot of the debate today has been around changes in the commissioning function, and as a director

of finance in a PCT, I'm quite concerned about how things will change for our organisation. We've talked about the skills gaps in the primary care trusts and how they will be addressed, but as commissioning moves towards practice-based commissioning and we transfer some of those responsibilities to GPs and groups of practices, we have a concern around the skills gaps in those practices and how they're going to be addressed.

**Tim Baker** To effect changes on the supply side, whether in healthcare or in other markets, you often require quite significant investment, and for that, some form of aggregation of demand is required. An example is whiplash cases, of which there are currently about 250,000 in the UK. Most of those people are treated within the private sector, and it's a fairly DIY form of access, often through family, friends, your GP, A&E, maybe even the Yellow Pages, or you may be case-managed by a lawyer with a view to getting compensation. At Norwich Union, because we've got something like 20 per cent of the motor market, we pick up 50,000 of those cases every year, and therefore an investment in how those patients are treated becomes worthwhile. So we've set up a pilot treatment centre in Maidenhead, working off protocols that we've developed with Dr Foster, with a view to getting a better outcome for the patient and better managing those costs in the system. The early indications are that it's worthwhile, but it would not have happened had we not had 20 per cent of the market in the first place. So, I just wanted to say that strategic commissioners may well be a route for that kind of aggregation of demand.

**Eddie Saville** I think you've got to look at the Crisp letter in a wider context because, as well as the commissioning elements, there was a whole series of cuts in services: 15 per cent in jobs and a £250m cut generally in services. Staff who will be affected certainly feel very concerned.

We've already seen a PCT in Surrey where it is proposed that 700 staff transfer to a company called Therapies Limited. The only benefit that I can see for the staff is that they may become shareholders. There is no indication of who is going to manage the structure, and there will be instances where they may seek to make cuts. But where services are cut for a limited company, they'll sink or swim on the basis of how they do out in the marketplace. We really need to look at the issue from the staff's point of

view, and also in relation to their general terms and conditions. When you take out lots and lots of workers from the NHS, and put them into the private sector, you've got a cost to the Treasury, particularly in relation to pensions, which is a big issue in the public sector. I think over time we'll see that there will be a significant detriment to those people transferred out.

**Pieter Degeling** I find it very interesting that since Julian Le Grand left the room, the need for strategic planning has come back in. In a sense, the issues that have been raised – possibilities of market failure, workforce issues, under-recognised conditions, public accountability, the ability of the service user to be able to use a political route to get responsiveness in the system – do seem to me to point to the need for some strategy, and there are questions about how that might be managed. In the case of GP fundholding, maybe it was the people who were actually involved, rather than the system itself, that actually made a difference. Who is going to attend to the quality issues and the

competence issues that are raised as a result of going down a total market route. What's the market going to do about competence vis-à-vis GP fundholders?

And, in terms of chronic disease management, who is

going to deal with the skills issues? I ask because it's entirely different if you say that your service is going to be based around the proposition that the patient is not a patient, but a co-producer in their health. That's a very different way of positioning yourself as a service provider.

**Edward Bramley-Harker** There is clearly some dissatisfaction in the room about how the Department of Health has recently gone about trying to move the commissioning debate forward, so the question I am left with is: would somebody that has the strategic commissioning responsibility, who is not at the level of the Department of Health but is somewhere between the Department of Health and practice-based commissioners, be more in touch with what's happening on the ground? Would they have the right incentives to approach some of the themes that are outlined in Sir Nigel Crisp's letter? Would they approach those tasks in a view that is more in tune with the needs and the wishes of local populations?

**Wilf Stevenson** Thank you very much indeed for a very interesting morning.

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## The proposition is now that the patient is not a patient, but a co-producer in their health

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