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PRUComm Research Seminar on Healthcare Commissioning

NHS Commissioning Practice and Health System Governance

Rod Sheaff

University of Plymouth,

012, 9 Portland Villas
Drake Circus,
Plymouth
Devon PL4 8AA,
UK

'phone +44-(0)1752-586652
e-mail <R.Sheaff@plymouth.ac.uk>

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Themes

- Commissioning as governance
- Power and Commissioning: England and Germany
- Implications

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A policy dilemma

How to reconcile ...

- 'Hollowed out' state – and health system
  - Diversification of providers
  - Cost containment and shifting
- Political salience of NHS – bed-pan doctrine still applies

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The Bedpan Doctrine

'If a bedpan is dropped on a hospital floor in Tredegar, its noise should resound in the Palace of Westminster'

Commissioning as governance 'solves' the dilemma

- Responsibilisation of local managers
- 'Depoliticisation'
- Proxy control and accountability of providers

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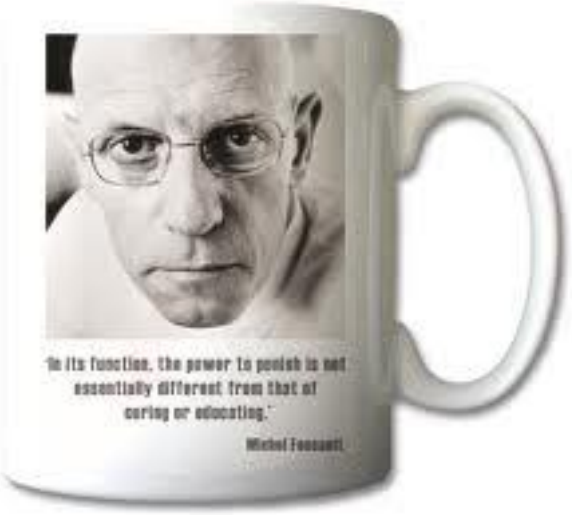
Commissioners' governance over providers



- Several media of control in parallel
- Each one a 'technology of power' (Foucault)
- Each combination has distinct properties (a 'dispostif')
- Each combination has distinct particular effects on providers

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Commissioners' media of control (power) over providers

- Managerial performance
- Negotiated order
- Discursive control
- Resource dependency – incentives
- Provider competition
- Juridical and regulatory control

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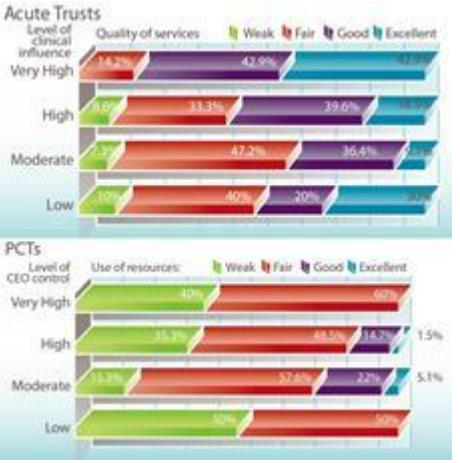
Managerial performance



- Proposing contracts to potential providers
- Where permitted, select providers.
- Contract negotiation
- Audit and monitor provider performance.
- Maintain transparency of provider activities and costs
- Private sector managerial inputs (US firms, consultancies)
- Involve doctors – see below
- Imitate corporate procurement techniques?

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Negotiated order

- Explicit or tacit division of labour - who participates?
- Agenda setting, framing, closure
- Explicit or tacit rights of non-interference

– pay-back for participation

- When negotiations recur
- Psychological tactics
- 'Relationality ' - path-dependent *and* structural basis
  - High trust > discursive control, transparency
  - Low trust > non-discursive control

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Discursive control

- Etic
  - Evidence-based medicine
  - Epidemiology
  - Service and/or financial modelling
- Emic
  - Professional discipline
  - Political authority
  - Ideologies (religion, economics, new public management)

Depends on each side having some common discourse(s)

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Resource dependency

- Creates possibility of incentives
- Depends on:
  - How resource-dependent the provider is
  - What discretion commissioner has
    - What services to finance
    - Unit of payment
    - Payment variations (bonus / penalty)
    - Conditional payments
- Spectrum: commissioner-led to passive reimbursement

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Provider competition / contestability

- Accentuates provider's resource dependency
- Depends on *credible* threat of alternate provision
- Monopsony – oligopsony – competition – oligopoly - monopoly
- Commissioners strengthen their position by:
  - Inviting new providers
  - Help establish new providers
  - 'Make' for themselves instead of 'buy'

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Juridical control

- Contract terms – completeness, presentiation
- Appeal to
  - Regulatory and / licensing bodies
  - Political authority
  - Informal arbitrators
  - Courts (administrative, civil, constitutional)

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Implications of the mode of commissioning

- Mode of commissioning = particular combination of the above media of power
- … all mediated through provider management.
- Nevertheless, differences in modes of commissioning *help* explain health system:
  - Patterns of provider development (medical technologies, absences of services, corporatisation, concentration of capital).
  - Capacity for cost control
  - Management of commissioning – medical involvement
  - Development, use of EBM

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Research Questions

- Cross-country comparisons one way to expose and analyse modes of commissioning.
- Research Questions:
  - How do modes of commissioning differ between the German and English health systems?
  - With what implications for market-based 'reforms', in particular future development of commissioning?

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Methods

- Systematic comparison of two national case studies – England (managed competition), Germany (social health insurance).
- Data from national, commissioner and provider level in Germany and England, 2011-12
  - Interviews
  - Grey material
  - National events
  - Published data
  - Ad-hoc enquiries to experts
- Analytic framework is media-of-power schema above
- Problem of counterfactuals – what would A have otherwise done?

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Management: modelling *versus* planning (1)

England (PCTs - and CCGs?)

- Plan services for geographical population
- Some collaborative commissioning
- Cash limits
- Provider opacity and/or glut of unanalysed information
- Epidemiologist + GP inputs
- Voluminous guidance on EBM - used at local level
- Transaction costs not (publicly?) known

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Management: modelling *versus* planning (2)

Germany

- Land bed-plan constrains commissioners & providers
- Multiple social health insurers – collaborative
- Case-mix spread-sheets per hospital – negotiate, re-model, re-allocate *within* overall total
- SHI can recruit more subscribers
- Audit and confirmation of payments to hospital, ambulatory doctors
- Sophisticated almost real-time modelling by commissioners, e.g.
  - volumes of hip replacement revisions per provider
  - disease management programme costs and outcomes for diabetes

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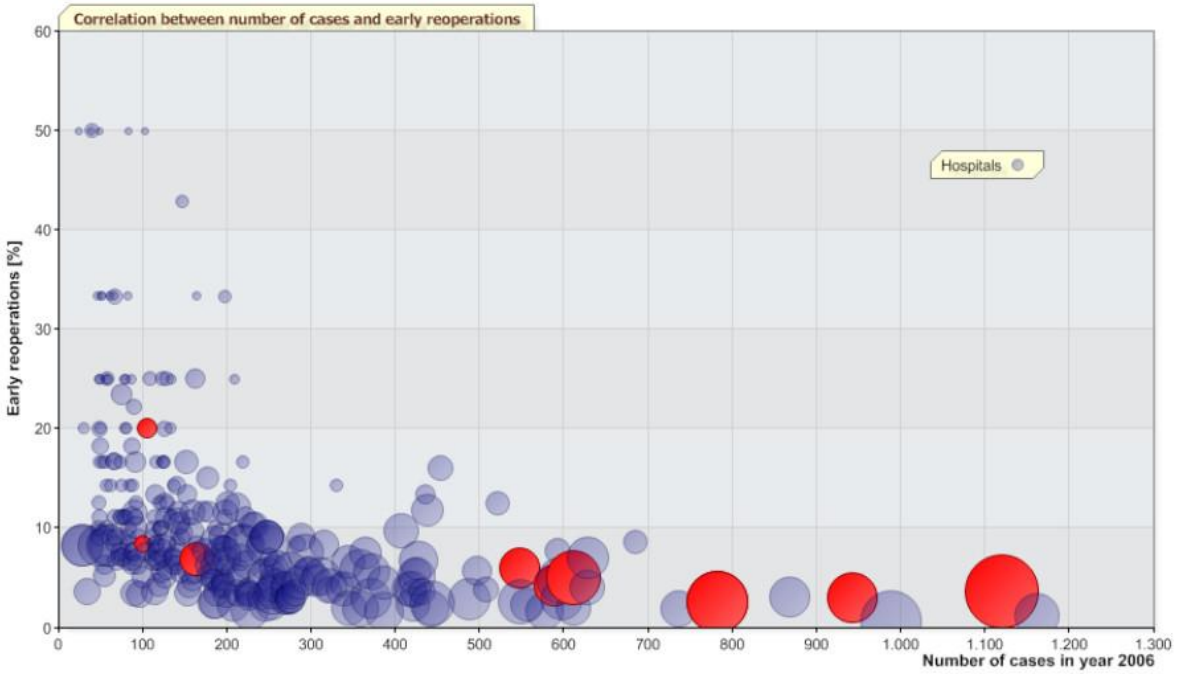
Example

WINEG

3. Data analysis: examples

Early reoperations



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Negotiated order: Principal-agent *versus* consensus

England

- Except for GMS, provider negotiations are local
- Principal-agent model
- Wide, flexible remit
- Some 'micro-commissioning'

Germany

- HS framework at national, provincial levels.
- Rhein / Ordoliberal model – consensus + veto
- BG-A decides which care technologies are in tariff
- Episode-based

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Discursive control: Solidarity *versus* authority

Etic

- Germany
  - detailed empirical case-mix modelling

(D-DRG points, allocations, financial implications)

  - EBM at national level (IQWiG)

- England
  - EBM guidelines and data at all levels

Emic

- Germany
  - Professional discipline
  - Juridical rights and obligations (based on 'solidarity')

- England
  - Central political authority
  - New public management (neo-liberal variants)
  - Professional discipline

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Incentives

- Both systems
  - DRGs for hospitals
  - Points systems for GPs (QOF, Einheitliche Bewertungsmaßstab)
  - Per-diem for certain kinds of long-term care
- England
  - Additional incentives for hospital quality (CQIN)
  - PCT (and CCG?) discretion and supplements at the margins
- Germany
  - Nearly all passive reimbursement
  - Except disease management and 'managed care' programmes

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Competition

- England - NHS commissioners can choose providers
  - PCT (and CCG?) controls over/under doctored areas
  - APMS contracts
  - Exceptions – treatment centres
  - Disease management programmes
  - Patient (or GP?) choice of provider
- Germany - commissioners cannot choose providers
  - Patient choice of provider
  - All licensed episodes per provider must be paid

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Juridical control

- Germany
  - Very complete regulations, entitlements, tariffs
  - Incomplete control of clinical practice, quality
  - Medizinische Dienst and Schiedstelle arbitration + courts.
- England
  - Fairly complete GMS contract
  - Other contracts – national framework + 'white spaces'
  - NHS contracts – Secretary of State arbitrates
  - Courts – only for non NHS providers

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Implications - Modes of commissioning

- Surrogate planning ← 'competitive bidding' quasi-market architecture
- Case-mix commissioning ← 'social insurance' quasi-market architecture
- Client-based commissioning – includes 'primary doctor purchasing' quasi-market architecture
- Others exist

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Modes of commissioning, media of power

	Case-mix commissioning	Surrogate planning
Managerial Performance	Case-mix modelling + audit + subscriber marketing.	Service planning for geographical population.
Negotiated order	Consensus, multi-stakeholder model + Episode-based.	Principal-agent + micro-commissioning
Discursive control	Consensus, multi-stakeholder model + Episode-based.	Principal-agent + micro-commissioning
Financial incentives	Fixed tariffs.	Pay for performance (defined prospectively) + ad hoc + fixed tariffs.
Provider competition	None: referral 'framing' at most.	Competition or bilateral monopoly.
Juridical.	Comprehensive regulation + administrative law	Unwritten constitution + common law.

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To what effect?

	Case-mix commissioning	Surrogate planning
Evidence based practice	Constrained by tariff	Widespread (but uneven between care-groups)
Care integration	Provider 'silos' + experimental projects	Commissioner 'silos' + micro-networks + experimental projects
Patient choice	Universal	Vicarious + constrained by shortage of provision
Care quality, safety	High, occasional scandals	High clinical, lower for 'hotel' services, occasional scandals
Cost control	Low – only within 'corridors'	High – cash limits
Policy-responsiveness	Low: negotiative + Last-resort political interventions	High: Centralised, politicised

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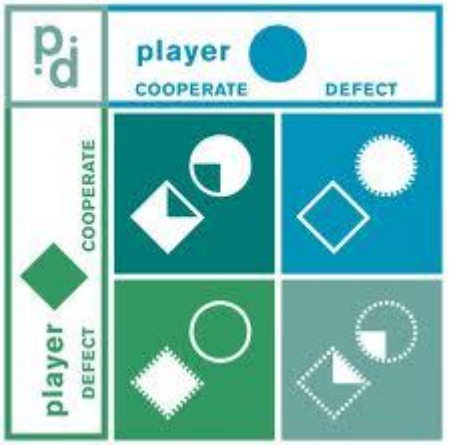
A few more dilemmas



- Case-mix based commissioning – German *commissioners* cannot exploit provider competition …
- … *because* there is patient choice of provider
- Cost control requires less provision, competition requires redundancy
- Different sub-modes of commissioning seem to be required for different care groups

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Questions? Comments?

Sheaff R, Chambers N, Charles N, Exworthy M, Mahon A, Llewellyn S, Byng R & Mannion R (forthcoming) How managed a market? Modes of commissioning in England and Germany, BMC Health Services Research.