The challenge of commissioning for populations

INTRODUCTION

The health reforms in England have elicited considerable public and professional angst and concern. There has also been a flurry of activity among GP commissioners and health managers trying to set up the clinical commissioning groups as well as simultaneously figure out how to carry out the task of commissioning. In the process, several key issues have surfaced that need to be addressed. First, what is the vision of commissioners and for whom do we commission; do we act primarily in the interests of our patients, our communities, our practices, our local health services, or for ourselves? Secondly, how do we reconcile competing and differing voices in the commissioning forum; what are the values and considerations that underpin our decision-making? The need to articulate this is crucial as it informs the strategic direction of commissioning activities.

ENGAGING MULTIPLE STAKEHOLDERS

It was evident from the government's listening exercise on the proposed health system reforms that a wide range and number of different stakeholders want to be engaged in the commissioning of health services.¹ Greater involvement by hospital clinicians and nurses, public and patient representatives, as well as potentially local politicians, will now be a part of the reforms. Undoubtedly shared leadership and collaboration in commissioning is important as well as the need for meaningful stakeholder engagement and 'buy in' to any service changes. While multi-agency engagement is desired, what is less clear is how it will work in practice.² Whose voice takes precedence?

The journey of any one patient through our health system is complex. So for commissioning to work, the decision-making process needs both to be informed by the separate stakeholders of the system and also to operate corporately with a shared vision and direction. Collaboration across the system is needed to produce a system that serves individual patient needs. However, more often than not commissioning discussions, both past, present, and in the future, are inflected by the separate agendas of the participants. Despite signals that NHS commissioning will be expected to embrace 'whole areas' rather than 'collections of practice

populations', stakeholders may adopt 'tribal' allegiances, championing their own individual, professional, practice, or service interests. These interests can be diametrically opposite and, unless some compromise and commonality is achieved, friction and standoff will inevitably arise. Managed poorly, this could degenerate into a 'trade union-esque' dispute between stakeholders and the decision-making risks becoming paralysed by internecine infighting. Without stakeholder 'buy in' into the process, at best we will get half-hearted involvement and at worst the potential 'sabotage' of any attempts to implement service change. Therefore, how such conflicts of interest and intent are reconciled is a crucial issue.

THE POPULATION APPROACH TO COMMISSIONING

We need a paradigm shift in how the stakeholders approach commissioning. Commissioners need to understand that their remit extends beyond practice or service boundaries. Indeed, they are not commissioning solely for individuals, practices, groups of practices, or even services, but for whole populations. This population health approach to commissioning is not radical or new but it forms the bedrock on which the NHS was founded, of a health service accessible to all. With widening health inequalities and poor health outcomes for many of the marginalised and deprived groups in society, now more than ever the public health perspective is essential. Unfortunately, there is a real risk that the voice of public health is lost in the cacophony of competing demands on commissioners, as was evident in the King's Fund commissioning simulation in Lincolnshire in early 2011.³

We should unpick what 'public health' means, as there is a lack of understanding and awareness as to what it is. Public health has been inaccurately thought of as a nebulous field that merely involves drains, sewers, air pollution, and immunisations. This view, unfortunately, barely touches on the much larger remit and functions of public health that include both the health protection and health promotion aspects, but also 'healthcare public health'. The latter is a significant part of the workload of public health specialists that has gone on

quietly in the background for years which includes the coordination, development, and improvement of health services, their quality assurance, and patient safety aspects, as well as clinical governance, and extensive technical briefing material for decision-makers that often cannot be authored by non-clinical managers. The work of public health occurs at the 'population level' and in particular on vulnerable or disadvantaged groups of the population where health inequalities are manifestly poor. Some public health specialists have been engaged in commissioning for many years now and consequently have, over time, developed considerable skills and knowledge in commissioning that are invaluable to new clinical commissioning groups. Indeed, the NHS Future Forum report recognised the need for expert public health input at all levels of commissioning.¹

But what is the public health approach and how is it relevant to GP commissioners? For some, it is seen in terms of a bag of skills, knowledge, and techniques to help commissioners 'do the job'. It is a set of values and an approach to clinical decision-making that prioritises the population over the individual. In relational terms it is about leadership across the whole health system that seeks to develop both the organisations involved and the people so that they can best serve the needs of the population. In ethical terms, it adopts a utilitarian view as opposed to the individual 'rights-based', autonomy-biased approach that clinicians are more familiar with.⁴ Put simply, it seeks the greatest benefit for the greatest number. Translated into action, it includes the targeting of resources at upstream causes of ill health (often where the most cost-effective interventions are to be found), identifying and addressing health gaps and inequalities, forecasting health impacts, and aiding decision-making in various issues such as clinical prioritisation and rationing that must necessarily be done.

The public health approach is not an exact science but more an art, balancing competing voices in decision-making such as the evidence of efficacy and cost-effectiveness of interventions, patient demand, clinician or specialty interests, financial constraints, collaborators' and other stakeholders' agendas, quality standards, targets, and so forth. That said

“... decisions founded on the interests of the individual patient alone can run counter to the best interests of the wider community ...”

the public health science skills are not a mystic art form but can be learned and acquired by many clinicians. Indeed most health professionals to some degree already are public health practitioners and will have differing levels of involvement. Key to this will be their ability to apply a ‘population health’ approach to their day-to-day decision-making. For example, GPs in their day-to-day work act as gatekeepers to more costly secondary care services, thereby ensuring that only those patients who truly need them will use them. Others carry out audits and reviews of their own practice and service to ensure the quality and safety of their work. It is an approach to clinical issues that looks not just at the ‘individual patient’ but adopts, alongside the view of the individual, a more holistic ‘population-level’ view.

RECONCILING COMPETING VOICES

As intimated earlier, the population health approach can be used to reconcile competing voices in the commissioning forum. How this approach can aid decision-making is briefly exemplified below.

Evidence

One common ‘voice’ bandied about by many is that of ‘evidence’. Evidence, be it clinical or research evidence, has often been accepted at face value by most clinicians as an essential ingredient in the mix. However, most academics will acknowledge that much of research reflects varying ‘strengths of certainty’ of opinion and theory. What is ‘research evidence’ for a particular intervention is not necessarily a guarantee that the science is right. One only needs to look back on the track record for thalidomide, hormone replacement therapy, and tonsillectomies to see how miracle technological cures can achieve pariah status. In addition, it is increasingly apparent that evidence of effectiveness of an intervention is not enough to justify its application at the population level.⁵ Conversely, the word ‘evidence’ in local authorities is often used to refer to evidence of activity not effectiveness.

Financial constraints

In the current financial climate with real

term contractions in healthcare expenditure relative to healthcare use, the concerns of ‘balancing the books’ assumes greater primacy. Rather than the commissioning of services, commissioners will increasingly be tasked with decommissioning or reconfiguring services. While financial considerations are key to the longer term viability and sustainability of services, cost-saving measures again need to be devised and informed by a public health approach. Low value services and clinical procedures where disinvestment is required have to be reliably and robustly identified. A public health approach applies critical appraisal of the evidence base for their clinical efficacy. Tougher rationing of services must be safely implemented such that vulnerable groups in the population are not marginalised or denied access, and that we do not risk aggravating health inequalities. This is especially pertinent in many areas where large inequalities exist and the inverse care law operates. Commissioners need to be wary that the strategic vision for population healthcare planning is not lost in the fog of trying to find cost savings alone.

Patient demand

Similarly, the constant political, media, and patient clamour for greater patient involvement and patient choice is another consideration. There is a myth that some believe patients do not want choice. In this regard, the politicians and the media have a better feel for the zeitgeist of the day than health professionals. While it may be an unspoken issue between the doctor and the patient, the public’s desire for greater control and input into their personal health care should not be underestimated. Indeed, if seen as a business model, healthcare providers who ‘neglect’ the wants of their customers, the patients, are on shaky ground. The current healthcare reforms could lead to greater patient empowerment with patient organisations such as HealthWatch gaining powers including statutory ones that would enable them to intervene more in healthcare services. However, what individual patients ‘demand’ are not the same as what they may ‘need’ or are able to benefit from. Commissioning that leans too heavily towards the patient’s

viewpoint could lead to the commissioning of services, that while demanded, may provide little in the way of health benefit to patients. Furthermore, decisions founded on the interests of the individual patient alone can run counter to the best interests of the wider community as there will be opportunity costs associated. A public health approach in action here would be the health needs assessment process used to accurately identify and describe population (rather than individual) health needs. Subsequent service development and delivery can then be soundly based on the foundations of the needs assessment. In the current financial climate, there can be no rational reason for commissioning services that have no health benefit for patients.

Service providers

The Department of Health has indicated that there will be greater input from hospital clinicians including nurses in commissioning.⁶ As key stakeholders in the organisation of health services it is only fitting that they are involved. Much of the detail of how this will work in practice remains to be seen, including the issue of how conflicts of interest are resolved. Service reconfiguration or disinvestment will, without doubt, generate disquiet among the service providers and users of those services. Unsurprisingly, health providers would be anxious that reforms instituted by commissioners do not compromise the viability of their own services. There is a real danger of commissioners commissioning services in a piecemeal fashion at the expense and risk to existing providers, for example, establishing some services in the community that were previously provided by secondary care such as ENT, dermatology, or diabetes services. In metaphorical terms, it becomes a case of ‘rob from Peter to pay Paul’.

The local health system is far more complex than that with considerable interconnectivity; changes in one part of it can and do affect another. For example, the introduction of B-type natriuretic peptide testing to rule out heart failure could lead to a reduction in the number of echocardiograms carried out to a level that would influence the viability of the existing echocardiography service. Similarly, if genito-urinary medicine (GUM) services were brought out into primary care, this could affect the financial viability of HIV/AIDS services that routine GUM work cross-subsidises. The call for integrated healthcare reforms is therefore well

"Public health is part of the conscience of the NHS in its aim of fair and equitable access to care for all."

founded but much more challenging to implement.⁷ Strong public health principles help to see and address the health system holistically, ever mindful of wider secondary indirect effects that changes can create. Only with this awareness can adverse effects be mitigated against.

Non-healthcare stakeholders

Central to the public health approach is the concept that 'prevention is better than cure'. Public health takes a total view of ill health and asks the all important questions 'what are the underlying causes of this individual's ill health' and 'what can we do at a population level to prevent people becoming unwell'? Many of the solutions to these problems lie outside the formal healthcare system in wider determinants of health such as housing, education, and the environment. There are complex interactions between these factors and evidence of effectiveness can be hard to evaluate, yet they offer powerful levers to decrease patient demand on the healthcare system. The achievement of improvements in population-level health outcomes cannot be achieved by health care alone, and requires a joined-up approach with efforts from other non-healthcare partners such as the third sector and local authorities. Commissioning that ignores these stakeholders will be less effective and could miss out on potentially beneficial synergies. The application of a systematic public health approach to social care commissioning will therefore be an additional urgent priority.

CONCLUSION

To bring about effective change clinician commissioners will need to engage myriad of stakeholders each with their own unique and individual agendas. The commissioners themselves may harbour their own interests and agendas and a critical self-awareness of this is needed. In the cauldron of competing interests, what a strong population health approach offers is a unifying common ground that all stakeholders in the commissioning process can agree to and adopt. This approach will protect and aid commissioners immensely in retaining their objectivity and rationality in strategic decision-making. Public health is

part of the conscience of the NHS in its aim of fair and equitable access to care for all. If we truly wish to commission for better health for our patients, we must use this perspective. Balancing 'localism' with a 'national' health service will be challenging enough — public health principles in action might just enable us to achieve that balance.

Andrew Lee,

Senior Clinical University Teacher, School of Health and Related Research, The University of Sheffield, Sheffield.

Fiona Head,

Assistant Director of Public Health, NHS Bedfordshire, Bedford.

Chris Packham,

Associate Medical Director & Clinical Director, Nottinghamshire Healthcare NHS Trust, Nottingham.

Mike Robinson,

Joint Director of Public Health, London Borough of Hounslow and NHS Hounslow, Hounslow.

Provenance

Freely submitted; externally peer reviewed.

©British Journal of General Practice

This is the full-length article (published online 30 Apr 2012) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2012; DOI: 10.3399/bjgp12X641618**

ADDRESS FOR CORRESPONDENCE

Andrew Lee

SCHARR, Section of Public Health, Regent Court, 30 Regent Street, Sheffield, S1 4DA.

E-mail: andrew.lee@shef.ac.uk

REFERENCES

1. NHS Future Forum. *NHS Future Forum recommendations to government*. London: Department of Health, 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443 [accessed 15 Mar 2012].
2. Delamothe T, Davies E, Godlee F. Bury the bill [editorial]. *BMJ* 2011; **342**: d4050.
3. Imison C, Curry N, McShane M. *Commissioning for the future: learning from a simulation of the health system in 2013/14*. London: The King's Fund, 2011. http://www.kingsfund.org.uk/publications/future_commissioning.html [accessed 15 Mar 2012].
4. Callahan D, Jennings B. Ethics and public health: forging a strong relationship. *Am J Pub Health* 2002; **92**(2): 169–176.
5. Ubel PA, DeKay ML, Baron J, Asch DA. Cost-effectiveness analysis in a setting of budget constraints — is it equitable? *N Engl J Med* 1996; **334**(18): 1174–1177.
6. Department of Health. *Government response to the NHS Future Forum report*. London: Department of Health, 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf [accessed 15 Mar 2012].
7. Ham C, Imison C, Goodwin N, et al. *Where next for the NHS reforms? The case for integrated care*. London: The King's Fund, 2011. http://www.kingsfund.org.uk/publications/articles/nhs_pause_paper.html [accessed 15 Mar 2012].