

Commissioning and the impact of the purchaser-provider split on the NHS in England

The BMA is committed to an NHS funded from general taxation providing care free at the point of delivery and advancing the social goal of providing healthcare fairly and transparently. The BMA wishes to reverse the current government's policy, and that of the main opposition parties, which actively promotes a market approach in the NHS, with its emphasis on competition and private sector involvement at the expense of co-operation and a public service ethos.

What is it?

The purchaser-provider split was created in 1990 by the then Conservative government through the introduction of a new funding system that saw an end to the government paying all hospitals/providers directly. Instead they allocated funding to NHS agents or managers who then selectively purchased care from hospitals. This move established the internal market in the NHS. Despite the commitment of the incoming Labour government in 1997 to abolish the internal market, it prevails more strongly than ever today, taking the form of PCT commissioners who, within an allocated budget, purchase care from providers, such as hospitals, using the relatively new national tariff, the system of Payment by Results (PbR).

GPs are involved in PCT commissioning through Practice-Based Commissioning (PBC); all GP practices have had the right to receive an indicative commissioning budget from their PCT since April 2005. The indicative budget reflects historic spend by the GP practice and the minimum scope of services included in the budget covers all hospital-based care, services within the scope of PbR, prescribing, community services and mental health costs. Whilst PCTs hold the budget and remain responsible for contracting with all providers, GP practices are expected to manage their budget within the annual cycle and either not exceed it or, ideally, spend under it.

There is little opportunity or incentive within this system for commissioners and providers to work together in the design and delivery of healthcare and the relationship is dominated by two opposing aims; cost containment for commissioners and income generation for providers. To be effective, the model really relies on there being an equal balance of power between the commissioner and the provider, something which rarely, if ever, exists.

In addition, there is provision for the private sector to be involved in NHS commissioning through the Framework for Procuring External Support for Commissioners (FESC). The FESC comprises fourteen private sector companies – selected by the Department of Health through a national procurement exercise – from which PCTs can procure any necessary support services in order to fulfil their commissioning function.

What is the rationale?

The aim of the internal market was to introduce tension into the system by creating purchasers who would then incentivise providers to become more efficient in order to secure contracts/business. Building on this, the present model explicitly incorporates new elements – namely, patient choice and enhanced competition between providers – as further levers intended to improve the quality of NHS services.

PBC is an attempt to better understand and meet the needs of patients by involving front-line, primary care clinicians in the commissioning process. The encouragement of private sector involvement in NHS commissioning through the FESC is designed to improve PCTs' commissioning capabilities.

What is the reality?

Evidence shows that competition and market incentives do not lead to better or more positive outcomes in healthcare. The purchaser-provider split is expensive, divisive and creates artificial divisions between different parts of the health service. The opposing policies of PbR – which encourages hospitals to treat more – and PBC – which encourages GPs to use secondary care less – establish inherently adversarial relations and the potential to strain relationships between primary care doctors and their secondary care colleagues. The current system compels

organisations to formulate and pursue their own strategy in isolation and there is an absence of a shared strategic vision for how services will develop and work together as part of a system of care.

A system of commissioning that is based on division and that actively discourages collaboration can never be truly effective, nor can it develop co-ordinated services that deliver the best care for patients. Commissioning should enable cross-sector collaboration and co-operation and ensure an appropriate balance between cost-effectiveness, quality and long-term sustainability of the health economy.

The establishment of the FESC is permissive of the privatisation of commissioning; its usage will be an extra demand on PCTs' already limited resources and there is no evidence to suggest that it will provide value for money. It has the potential to de-skill the NHS if PCTs treat the FESC as an alternative to developing in-house expertise. It may also prove to hinder the development of clinician-led commissioning, such as PBC, by introducing a third party into the commissioning process. Although some arrangements are in place to address potential conflicts of interest – for example where FESC suppliers may be contracted to commission services when they already provide clinical services in the PCT area – these remain untested and may prove to be inadequate.

Commissioning seeks to balance the clinical needs of patients with the finite resources that society is prepared to make available via general taxation. Patient care and the overarching ethos and ethics of a publicly provided health service should therefore be at the heart of this process. Commissioning is a key function of the NHS and its future does not lie within the private sector.

Conclusion

In the long run, the promotion of markets in the NHS and the lack of incentives both for providers, and providers and commissioners to work together, are creating a more fragmented service, which is likely to have an adverse effect on the quality of care for patients – particularly those with long-term conditions. Seamless care pathways and better co-ordination between the different sectors within healthcare are unlikely to be achieved when providers are in competition, rather than collaborating, with one another. The BMA strongly supports an alternative approach, one encouraging co-operation and collaboration between providers.

We also support an approach which encourages greater involvement of patients in the decisions about where and how their treatment will be provided – both on a collective basis and an individual basis. Other than using the market-forces lever, there is nothing in the present policies to incentivise this.

Close cross-sector collaboration and dialogue between secondary and primary care clinicians, including public and community health doctors, is necessary in order for clinician-led commissioning to achieve its full potential. Furthermore, private sector involvement in NHS commissioning does not provide the solution to these problems, nor that of weaknesses in PCT commissioning.

Additional information

The BMA has published a set of 'Principles for effective and successful commissioning'

www.bma.org.uk/employmentandcontracts/independent_contractors/commissioning_service_provision/bmaeffectcomm.jsp

A more mature form of commissioning is proposed in a BMA discussion paper 'A rational way forward for the NHS in England' and further developed the paper 'Towards a model of healthcare delivery'

http://www.bma.org.uk/news/lobbying_campaigning/caring_nhs/rationalwayforward.jsp

The BMA has also produced guidance on 'Involvement of Consultants in the Commissioning Process'

www.bma.org.uk/healthcare_policy/nhs_system_reform/commissioning0409.jsp

The BMA urges the Government to restore the NHS to a service based on:

- **public provision, not private ownership**
- **co-operation, not competition**
- **integration, not fragmentation**
- **public service, not private profits**