Health Care Commissioning in the International Context: Lessons from Experience and Evidence

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This paper provides a high level overview of the available evidence on health care commissioning in Europe, New Zealand and the United States as a contribution to a review commissioned by the NHS West Midlands. The paper focuses particularly on the United States as this is the country where there is extensive experience of commissioning and a wide literature on which to draw.

Foreword

If you are reading this document, it is likely to be because you have an interest in how we can improve health care commissioning in the NHS and an appetite to use international comparisons to help us to do so. Our rationale for asking Chris Ham to produce this high level paper was based on a conviction that management decision making should be as much as is practicable evidence based (acknowledging the evidence is drawn largely from empirical observation) and that it is imperative to learn from the experience of others. We need always of course to take into account when making international comparisons the different historical, social, economic and political context which shapes the provision of health care. Nonetheless, there are some very powerful observations in this paper relating to the fundamental challenges of commissioning for health care; the need to recognise the probable limitations of commissioning as the sole tool to deliver a world class health care system; and that the best performing systems are characterised by integration of commissioning and provision with alignment of incentives for clinicians. I will endeavour to keep these messages in my mind as we move forward in the West Midlands on the implementation of World Class Commissioning.

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Introduction

Health care commissioning has received increasing attention in a number of countries as part of a world wide process of health care reform. In this process, systems that have traditionally integrated the funding and provision of health care (e.g. the UK, New Zealand and Sweden) have experimented with the separation of commissioning from provision and the use of internal markets. In parallel, systems that have traditionally separated the roles of insurers and providers (e.g. Germany, the Netherlands and the US) have sought to strengthen the role of insurers vis à vis providers. This includes moves to transform insurers from passive payers to active commissioners of care, and in some cases to offer consumers greater choice of insurer.

Mays and Hand (2000) have summarised the main reasons behind these reforms as:

- to improve technical efficiency by allowing purchasers to select the best value provider accessible to their populations, including private and voluntary sector providers, thereby giving purchasers some control over providers
- to allow those charged with determining the future pattern of health services in relation to the needs of the population to concentrate on this task unhindered by their previous responsibilities for managing health care institutions and, at the same time, to allow the providers to manage their own affairs with the minimum of unnecessary interferences
- to act as a counterweight to decades of professional dominance of service specification and to challenge traditional patterns of resource allocation and sectional interests (active purchasing rather than passive funding or bureaucratic planning)
- to improve allocative efficiency by permitting purchasers to negotiate a new balance of services with providers
- to encourage providers to respond more accurately and effectively to the needs of individual patients in order to retain contracts from purchasers
- to facilitate clear lines of public accountability for the performance of the purchaser and provider roles in the health system
- to clarify providers’ costs and the amount spent in each service area by comparing the services and costs of each provider
- to make priority decisions more explicit

In summarising developments in health care commissioning, this paper focuses on the main findings from the literature. The references included at the end enable readers to explore more deeply the overview provided here.

Europe

The most comprehensive study of the experience of health care commissioning was published in 2005 by the European Observatory on Health Systems and Policies (Figueras, Robinson, and Jakubowski, 2005). The study encompassed experience in central and eastern Europe as well as western Europe.

It found that European health care systems display considerable diversity in terms of the organisations that carry out purchasing. Countries differ in terms of the types of organisations that act as purchasers (for example, central government, regional government, municipalities, health insurance funds), the numbers of organisations that carry out this function (that is, market concentration) and the ways in which they interact with each other, in particular whether there is competition between purchasers. They also vary in terms of their funding sources (for example, social insurance versus tax based) and jurisdictions (for example, geographical, occupational, religious affiliations). This diversity derives from the complex interplay of social, economic, cultural and historical factors.

A strong message to emerge from this study was how little competition seems to exist between purchaser organisations in Europe. Despite the rhetoric of market-based reform that has swept European health policy debates in recent years, the purchaser function is rarely carried out in a competitive environment. Other key findings included:

- the appropriate level of purchasing will depend on conditions such as the type of services to purchase, the incidence and prevalence of different conditions, the number of places where the necessary services can be provided efficiently, and the appropriate size of the risk pool to handle risk
- active contracting is a fairly new activity in many countries, having only really developed during the 1990s, and its development is uneven; most contracts are unsophisticated
- for contracting to work, providers must have management and financial flexibility to respond to the contract’s demands and incentives; the evidence shows that greater provider autonomy, such as in corporatized hospitals, leads to an increased response to contracting
- health needs assessment is not routinely carried out in many systems, and when it is it may not be incorporated into purchasing decisions; there is more activity in assessing and seeking the public’s views

Figueras and colleagues emphasised that a central lesson derived from their analysis was that if policy makers are to achieve the desired results they will need to take a broad systems approach to purchasing and act upon all the various components of this function. When purchasing is narrowly focused on individual elements such as contracts, payment systems or provider competition, it will not reach its full potential. They also emphasised that in assessing the impact of purchasing, there are challenges in attributing any effects to purchasing (as opposed to other functions), and there are gaps in evidence that hinder the drawing of lessons from experience in different European countries.

In summary, they noted:

‘Authors in this volume agree that, despite prevalent rhetoric, strategic purchasing is not in place in many countries and, as a result, the impact has been limited. However, they also agree in highlighting its significant potential to improve systems performance’ (p. 75)
Beginning in 1993, New Zealand introduced a separation of purchaser and provider roles into its health system, and this remained in place (albeit in changing forms) until 1999. Based on the limited evidence available from evaluations of the health reforms, the following observations have been made about this experience:

- purchaser-provider contracting was initially hampered by the lack of information on the pattern of services previously delivered, their quality and costs, and purchasers found it difficult to compare prices between providers
- the ring fencing of budgets, continued political involvement in priority setting and requirements imposed on providers, reduced the flexibility the reforms were intended to increase
- there was very little competition between public hospitals which were often monopoly providers in their areas; little use was made of private hospitals
- relations between purchasers and providers were sometimes difficult and confrontational, reflecting the difficulty of managing relations between monopoly providers and monopoly purchasers
- additional transaction costs were incurred and it was not clear if these were justified in terms of efficiency gains
- too much attention appeared to have been paid to the legal form of contracts and not enough to the development of relationships between purchasers and providers

More specifically, they listed the challenges facing New Zealand purchasers between 1993 and 1999 as:

- lack of a single integrated health care budget
- lack of time to develop skills, relationships and experience
- lack of choice and competition between providers
- lack of clear incentives for hospitals and other providers to become more efficient
- the involvement of Ministers as owners of public health hospitals constrained the ability of purchasers to bring about changes (including closing down providers)

On the positive side, this study noted that purchasing had encouraged purchasers and providers to focus on costs and volumes of the services they provided, and to clarify the types and level of services provided. Providers also reported that written contracts encouraged them to focus on how they might improve quality of care.

The authors of a report summarising these observations and reflecting on New Zealand experience commented:

"Overall, the introduction of contracting generally improved the focus of providers on costs and volumes; led to greater clarity through the detailed specification of services; encouraged providers to focus on methods to improve quality; and enabled new styles of service provision from providers that had not traditionally received public funds for health services. A particular challenge now is how to ensure the gains associated with contracting are retained while continuing to reduce the associated transaction costs" (p. 30).

More recently, a study of the New Zealand experience reached broadly similar conclusions, highlighting both the gains and the challenges that have resulted from the development of purchasing and contracting. On the negative side, lack of good information on costs, volumes and quality made it difficult to compare providers' performance and negotiate contracts. This, together with the adversarial approach taken in New Zealand, encouraged an adversarial environment. Negotiations were often acrimonious and transaction costs were high. These challenges were compounded by shortage of skills among purchasers and providers, especially legal expertise and contract negotiation skills. A further consideration was that competition law concerns were at odds with other objectives, making it difficult to develop longer-term contracts or co-operative relationships. It was reported that the development of these relationships was hindered by repeated structural reorganisations and changes in personnel (Ashton, Cumming and McLean, 2004).

Echoing other analyses, they commented:

"Overall, the political, technical and financial ability to implement strategic purchasing is the single most important factor in determining its success or otherwise. Most, if not all, strategies reviewed here are very complex and require a high level of technical and managerial skills together with wide ranging information systems that are lacking in many countries" (p. 77).
It is worth emphasising that these observations relate to the purchasing of mainstream health and disability support services. New Zealand also has experience of agencies responsible for purchasing services for people involved in accidents and for purchasing pharmaceuticals, and there is some evidence that these agencies have been more effective in discharging their responsibilities (see Davis, 2004, on PHARMAC).

### US experience

The traditional model of health care financing and delivery in the US for much of the twentieth century centred on indemnity insurance under which patients chose their providers and providers billed insurers on a fee for service basis.

In this model, providers were in a dominant position and patients exercised a large degree of choice. Indemnity insurance came under pressure as a consequence of rapidly rising health care costs, driven by medical advances and a system in which there were few controls over doctors’ decisions. In response to rising costs, the approach referred to as managed care emerged as the funders of health care sought to control health care inflation and introduce restrictions on doctors’ decisions and patients’ choice.

### Managed care

The development of managed care in the US in the 1980s and the 1990s was based on the funders of health care (employers, insurers and government programmes) taking on a more active role as purchasers or commissioners. Reflecting the complexity and diversity of health care in the US, a wide range of approaches were adopted, making it difficult to summarise the experience that was gained. Nevertheless, drawing on sources that have attempted to review this experience, and its relevance for the NHS, the following points can be made (for example, Light, 1998; Weiner, Lewis and Gillam, 2001; Kirkman-Liff, 1996):

- managed care was characterised by restrictions on patients’ choice of provider and of providers’ freedom to practice autonomously
- providers increasingly came together in groups and these groups negotiated contracts with purchasers for the provision of care
- reimbursement of providers shifted from fee for service to prospective capitation and prospective per case payments, together with other incentives designed to drive up performance
- providers’ freedom to practice autonomously was constrained by prior authorisation, practice guidelines, gatekeeping and provider profiling
- purchasers developed measures for comparing the performance of providers, in some cases publishing the results of these measures to empower patients
- purchasers contracted selectively with networks of providers, and used incentives to encourage patients to use providers offering best value care, and to discourage patients from using providers outside these networks
- purchasers increasingly distanced themselves from providers and in some cases collaborated with other purchasers in buyers’ groups and purchaser coalitions
- purchasers focused on contracting for integrated care rather than for primary and secondary care separately, often through multispecialty medical groups that held the budget (and risk) for all care

A recurring theme in the reflections of US observers on the NHS is the need for commissioning organisations to be large and strong, and to have sufficient resources to hire staff with the requisite skills. As Light has commented:

> ‘The best American commissioning groups have concluded that health care is far more complicated to purchase than anything else – mainframe computers, aircraft, telecommunications systems – you name it. Their salary and bonus packages are designed to attract the best and the brightest. They require excellent data system analysts and programmers, clinical epidemiologists, clinical managers, organisational experts, financial specialists and legal advisers’ (Light, 1998, p. 67).

The evidence indicates that managed care moderated the rate of increase in health care costs in the US, at least temporarily.

The quality of care delivered to patients was comparable with that of fee for service providers and they provided a higher level of preventative care to their patients. On the other hand, patient satisfaction with managed care was lower than with fee for service providers (Robinson and Steiner, 1998; Chuang, Luft and Dudley, 2004).

Despite this evidence, the managed care backlash that started in the late 1990s has resulted in a reinvention of the health insurance industry as part of the so called ‘consumer directed health care’ movement. The backlash arose out of concerns about the power exercised by the ‘big ugly buyers’ (Morrison, 2000) of health care and the restrictions they imposed on both patients and providers.

Robinson has summarised this development in the following way:

> ‘During the managed care era, from approximately 1980 to approximately 2000, the health insurance industry focused its strategies on understanding and influencing physicians, with only secondary attention to understanding and influencing patients. The guiding principle was that the key decisions in health care are made by physicians rather than consumers, that physicians differ widely in the cost and the quality of the services they provide, and that insurers have the organisational capabilities and social legitimacy to intervene. The health plans discovered that patients often did not appreciate managed care initiatives, which they interpreted as efforts to save money rather than improve access and quality. The industry subsequently has sought to reposition itself as an agent of the employer rather than the employer and to focus its activities on informing and supporting consumer health care choices’ (Robinson, 2004, p. 1881).

Robinson goes on to argue that in the consumer directed era, health insurers are offering much less comprehensive benefits designs, refocusing on broader but still constrained provider networks, and scaling back on controls over provider autonomy, such as prior authorisation and gatekeeping. He adds:
Nevertheless, Robinson’s analysis underscores the need for commissioners to pay attention to the demand side as well as the supply side. Put another way, commissioners need to understand the populations they are serving and anticipate the demands of these populations and how they can be met, while simultaneously incorporating the most positive lessons from the managed care era in relation to working with providers to control costs and improve performance.

Recent developments in policy for people with chronic and long term conditions in the NHS resonate strongly with this observation. It might be added that a further feature of health care reform in the US is the interest in pay for performance under which providers are rewarded for the quality of care they deliver. This again echoes UK experience, specifically in relation to the new GMS contract and the incentives contained within the quality and outcomes framework.

Robinson concludes his analysis by observing that changes in the US health insurance industry may have some impact on health care inflation but in themselves are unlikely to be sufficient. For this reason, he predicts that the emphasis in the managed care era in controlling costs by targeting providers is likely to re-emerge:

The contemporary approach focuses on stratifying the enrollee population by health status and potential for successful intervention, developing distinct programmes for particular conditions and levels of severity, focusing interventions on patients and processes where financial savings are to be obtained, and offering broader programmes to those payers willing to pay more and get more (p. 1889).

Value-based purchasing

Reflecting the complexity and diversity of health care in the US, the role of purchasers has continued to evolve alongside the reinvention of the health insurance industry described by Robinson. A recent study has reviewed trends in ‘value-based purchasing’ which has been defined in the following way:

The methods of managed care enjoyed initial success before encountering increasing opposition and declining effectiveness, and it is to be expected that the benefit, network, medical management, and pricing strategies currently being developed by the health insurance industry will experience subsequently the iron law of diminishing returns. During the long term, the insurance industry will need to combine its contemporary focus on consumers with a commensurate focus on physicians, administrative simplicity, and the social pooling of risk if it is successfully to balance limited resources and unlimited expectations in health care (p. 1886).

Examples of value-based purchasing

The Massachusetts’ Group Health Insurance Commission provides and administers health insurance and other benefits to the commonwealth’s employees and retirees, their dependents and survivors. The Commission’s Clinical Performance Improvement Initiative was launched to improve provider performance and quality of care. Health plans contracting with the Commission assign hospitals, physician groups, or individual physicians to different tiers based on quality and efficiency. These tiers are tied to varying cost-sharing requirements to encourage members to select higher quality and more efficient providers.

Minnesota’s Smart Buy Alliance comprises a group of public and private health care purchasers. Member groups in the Alliance developed purchasing principles and strategies such as pay for performance, public reporting, and designating centres of excellence to promote and reward higher value. These strategies are shared with other members for potential implementation.

Washington State’s Puget Sound Health Alliance brings together payers, purchasers, providers and consumers of health care. Its goal is to promote reforms in quality, evidence based medicine and purchasing that will also address rising health care costs. The group’s current focus is on developing and disseminating public performance reports on health care providers across five counties. It is also developing evidence based clinical guidelines for conditions such as diabetes, back pain, heart disease and pharmaceutical prescribing.

Wisconsin’s Department of Employee Trust Funds administers health and other benefits for state and local government employees and their families. It is pursuing value through public reporting of health plan performance; using tiered premiums as incentives to members to purchase more efficient plans; giving financial rewards to health plans displaying favourable cost and quality; developing an innovative pharmacy benefits management model emphasising transparency; and becoming involved in public-private collaboratives with a statewide health data depository.

Research into early examples of value-based purchasing concluded that they had had a limited impact. A recent analysis focusing on examples in four states described the range of strategies being pursued under three headings.
First, purchasers joined together to standardize performance measures and data requirements, generally based on national measures and best practices such as the HEDIS measures. Second, they gave priority to public reporting of performance data in order to increase transparency in the health care market. Third, value-based purchasers were using incentives to change the behaviours of consumers, employers, and providers in ways that promote better quality care and value. Examples included tiered premiums or co-payments to encourage consumers to choose higher value performers, and pay for performance programmes to reward health plans or physician practices for quality improvement.

In describing these three strategies, the study noted that it was too early to measure in a quantifiable way their impact. At an anecdotal level, there was evidence of positive impact, such as health plans and providers using information on comparative performance to improve the quality of care they offered. At the same time, a number of challenges were noted, including getting consumers to use such information.

In summary, the authors noted:

‘...a considerable amount of time must be available for VBP initiatives to gain significant participation and reach the critical mass needed to make an impact on their local market. The case study sites highlighted in this report have a good head start, but replication in other regions that have different histories and cultures may be more challenging. The value-driven health care movement will be further slowed by attempts to address the technical and other formidable challenges described in this report’ (Silow-Caroll and Alteras, 2007)

Coming from the country that has arguably put most effort into the development of health care commissioning, this is a timely and salutary reminder of the challenges that face the NHS in developing world class commissioning.

**Conclusion**

The high level overview provided in this paper has highlighted the difficulties involved in health care commissioning. Experience and available evidence from Europe, New Zealand and the US indicates that in no system is commissioning done consistently well. To be sure, there are examples of innovation and ‘good practice’ in all systems, but equally there are examples of the limits to effective commissioning and the barriers that have inhibited commissioners from negotiating on equal terms with providers.

Why is health care commissioning so difficult? The answer can be found in the complex nature of health care and the need for commissioners to have a high level of technical and managerial skills (as emphasised by Figueras et al and Light in their analyses). Because health services tend to be complex, are difficult to define in clear contractual terms, exhibit marked information asymmetries between buyer and seller, involve the exercise of professional discretion, require lengthy training to deliver, frequently rest on long term relationships between patients and professionals and, for some services, are subject to major problems of local monopoly, there are major obstacles to the efficient operation of systems in which the roles of commissioners and providers are separated (Mays and Hand, 2000). In the language of transaction costs economics, health care involves ‘intractable transactions’ (Williamson, 1996), and as such may be more suited to integrated arrangements than contracting arrangements.

Empirical support for this conclusion comes from the experience of integrated delivery systems such as Kaiser Permanente, Group Health Co-operative, Health Partners and the Veterans Health Administration. In the US, these systems perform well in comparison with other systems, part of the reason being that they combine commissioning and provision within the same organisation. In so doing, these systems align the incentives facing the insurer or commissioner with those facing providers, often but not always through relationships of mutual exclusivity. Of particular importance is the engagement of physicians in achieving high levels of performance and bringing about quality improvement.

In the language of transaction cost economics, integrated systems ‘make’ rather than ‘buy’ care, recognising the complex and intractable nature of health care provision, as noted by Williamson and others in this branch of economics. To return to the starting point of this paper, the performance of integrated systems raises a major question about the direction of health care reform in the last two decades. Put simply, the challenge in making systems based on a separation of purchaser and provider roles work effectively, reflected in the experience and evidence summarised here, may mean that integration offers a more promising way forward.

The difficulty in acting on this insight in the NHS in England is that policy makers have made a major commitment to a separation of commissioner and provider roles and the development of world class commissioning. In view of this, the conclusion to be drawn from international experience is that commissioners need to be much stronger than has been the case to date if they are to come close to achieving world class performance any time soon. Specifically, this means attracting the best and the brightest, to cite Light, and it means investing resources in hiring experts with relevant skills on a scale much bigger than hitherto contemplated.

As Weiner and colleagues have noted, managed care organisations in the US have levels of administrative support 30 times higher per capita than primary care organisations in England (based on 1999 data). Similarly, Mays and Hand, in their analysis of New Zealand experience, note that ‘purchasers need to be large enough to recruit high calibre staff with the expertise to take on specialist providers’ (2000, p. 14). These observations are reinforced by evidence from earlier UK experience of commissioning indicating that total purchasing pilots with higher levels of management cost achieved the best outcomes (Mays, et al, 2001)

While there is little in the literature on international experience that addresses the issue of skills and competences directly, the high level overview provided in this paper indicates a number of areas in which commissioners will require expertise. To return to Robinson’s analysis of the health insurance industry in the US, commissioners need to be able to relate effectively to the demand side and the supply side. On the demand side, the skills required by commissioners include:
understanding the population’s needs through health needs assessment and seeking the public’s and patients’ views

profiling the population according to risk and developing programmes of prevention and disease management in response to risk

working with primary care teams to assess their utilisation of resources and use of specialist services

developing plans setting out the aims of commissioning and how these are going to be achieved

On the supply side, commissioners require skills in:

- developing effective relationships with providers, including negotiating, specifying and monitoring contracts to encompass quality and outcomes
- acquiring and analysing information about the performance of providers to make decisions about the use of resources
- shaping payments and incentives to reward providers for desired levels of performance, while also managing financial risk
- facilitating clinical engagement in contract discussions, and working with clinicians to redesign care pathways, including through the development of multispecialty approaches

A clear message from this review relates to the philosophy and behaviours needed to support effective commissioning. There are warning signs from other systems of reforms that result in adversarial and legalistic approaches and do not give sufficient attention to relational contracting. There are implications here for the skills and competences needed by top level leaders in commissioning and provider organisations, as well as those that have system wide responsibilities. Leaders need to tread a careful line between using selective contracting and contestability to drive innovation and quality improvement and nurturing long term relationships in which commissioners and providers work together (recognising the reality of monopsony and monopoly or oligopoly contexts in health care) to deliver health system goals.

The other point to reiterate is that commissioning is only one element in the programme of health reforms and its impact will be affected by how other elements are taken forward. For example, the evidence reviewed here suggests that much will hinge on providers having autonomy over their own affairs and the ability to respond rapidly to changing market conditions. Similarly, the impact of commissioners will be influenced by the payment systems that are in place, the strengths of the incentives contained within these payment systems, the arrangements for market management and regulation (e.g. in relation to the disclosure of information by providers and the opportunities to compare provider performance on a consistent basis), and the degree to which politicians are willing to ‘let go’ and allow commissioners to exercise their leverage, even if the consequences are unpopular with the public.

To make these points is to argue that even if world class commissioning is developed, it may fall short of its potential in the absence of other changes in system design.

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World Class Commissioning

Health Care Commissioning in the International Context: Lessons from Experience and Evidence has been developed as part of a wider review of commissioning competency carried out by HSMC on behalf of NHS West Midlands. The first paper from this review: Toward World Class Commissioning Competency (Woodin and Wade 2007) was published in December last year.

While welcoming the Department of Health’s current emphasis on developing commissioners and commissioning organizations, this paper argues that actually defining and validating commissioning competency is likely to be incredibly challenging. There are a number of reasons for this, including the fact that existing evidence tells us relatively little about the specific mechanisms through which commissioning competency does, or does not, lead to improved health system outcomes.

The report also stresses that a meaningful definition of competency must take into account organisational, contextual and behavioural factors, and not focus entirely on the knowledge, skills and capabilities of individuals. The paper identifies fourteen domains of competency for world class commissioning; that is areas of activity regarded as important foci for performance excellence in this field.

It suggests that many of the skills required for world class commissioning are already present within the NHS, although they could be more effectively mobilised. Others are well developed and clearly articulated in other sectors, but need to be more rapidly incorporated into the healthcare commissioning workforce.

A third category of competencies (in particular those associated with up-stream interventions on the demand-side of the healthcare system) is still in the process of being defined as commissioning itself evolves.

The full report can be found on the HSMC website at: http://www.hsmc.bham.ac.uk/news/TowardsCommissioningCompetency.pdf

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