COMMISSIONING FOR VALUE

Adjunct Associate Professor Paresh Dawda,
Australian Primary Health Care Research Institute, ANU

Angelene True,
Director Service and Systems Development, Capital Health Network

Commissioning for Value

Part A (13.45-14.25) (35 mins)
- Context
- What is Commissioning
- Case Study

BREAK (5 mins)

Part B (14.30 to 15.10) (40 mins)
- Feedback
- Commissioning for value – Part 2

Context

Political ideology
- devolution and local accountability
- addressing local needs through local solutions - improvement, innovation, integration
- promoting a market response

Commonwealth reviews
- Review of Mental Health Programmes and Services, Nov 2014
- MBS/PBS, Apr 2015 – new payment models
- Better Outcomes for People with Chronic and Complex Health Conditions through PHC, Aug 2015
- PHI Review, Sept 2015 – value of PHI for consumers and its long term sustainability
- ACSQHC
  - Version 2 - National Safety and Quality Health Services Standards, Aug 2015
  - Practice level indicators of safety and quality for PHC, Sept 2015

Ideal health system

- Centred on the patient's health and well-being
- That is safe, provides the right care, in the right setting, at the right time, and supports prevention and early intervention
- Where consumers are empowered to manage their health and health risks, and to make health care decisions
- That is fair and supports disadvantaged and vulnerable people and communities;
- that operates effectively, delivers value for money, and eliminates waste
- With flexibility for innovation, adaptable to meet local circumstances, and encourages continuous improvements in services;
- Anticipates and responds to the needs of an ageing population
- That measures success and aligns incentives with people's health and wellbeing, and
- Supported by clear roles and responsibilities so the public can hold governments to account

Reform of the Federation: White Paper – Roles and Responsibilities in Health, Dec 2014

Reform of the Federation

Pressures in the health system

- Increasing demand, increasing expenditure
  - Demographic reasons
  - Non-demographic reasons
- Equity challenges
- Regulatory Complexities
- Health workforce
- Fragmentation

Six Principles

- **accountability**
  - for performance in delivering outcomes, but without imposing unnecessary reporting burdens and overly prescriptive controls;
- **subsidiarity**
  - whereby responsibility lies with the lowest level of government possible, allowing flexible approaches to improving outcomes;
- **national interest considerations**,
  - so that where it is appropriate, a national approach is adopted in preference to diversity across jurisdictions;
- **equity, efficiency and effectiveness** of service delivery
  - including a specific focus on service delivery in the regions;
- **durability**
  - (that is, the allocation of roles and responsibilities should be appropriate for the longer-term); and
- **fiscal sustainability**
  - at both Commonwealth and State and Territory levels.

Reform options

Option 3

- The Commonwealth and the States and Territories jointly responsible for funding individualised care packages for patients with, or at risk of developing, chronic or complex conditions

Option 4

- The Commonwealth and the States and Territories share responsibility for all health care through Regional Purchasing Agencies

Option 5

- The Commonwealth establishes a health purchasing agency

Reform of the Federation: Issues Paper – Roles and Responsibilities in Health, Jun 2015

So what is commissioning?

- A hateful word prone to ambiguity!

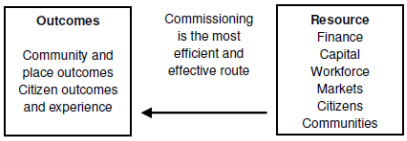
Commissioning environment

- Little 'commissioning' experience
- Structural changes:
  - Introduction of PHNs
    - DoH and PHN commissioning capability
    - Evaluation of PHN Programme, EY and UNSW
- Growing interest in the commissioning approach in the public sector:
  - Education and Research communities:
    - *Commissioning public services evidence review: Lessons for Australian public services*, Helen Dickinson, March 2015, Melbourne University
    - Commissioning Public Services (MPA, MPPM), University of Melbourne
    - Commissioning Public Services: Redesigning service delivery for better outcomes, Criterion Conferences
  - Government:
    - "*Governments should look to adopt a commissioning approach*", Australian National Audit Office, 2013
    - Commissioning Masterclass, Health Leaders' Forum, 28 August 2015, EY
    - Better Services Performance and Accountability Framework and Better Services Outcomes Framework, ACT Government (in development) – strategic investment

What are we trying to achieve?

Consumers can plan their care and support with people who work together to understand them and their carers, support them to self-manage and bring together integrated, coordinated services to achieve health and wellbeing outcomes important to them.

So what is commissioning?



(adapted from *Outcomes & Efficiency Leadership Handbook, PIPC 2012)*

Commissioning is…

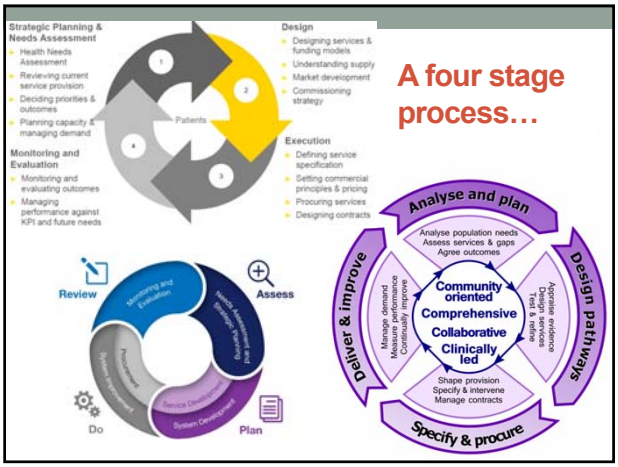
- Commissioning may incorporate procurement and purchasing but is significantly different:
  - Actions – including needs assessment, priority setting, procurement through contracts, monitoring of service delivery, and review and evaluation
  - Combination of these functions is a 'commissioning' process defined as a '*cycle of assessing the needs of people in an area, designing and then securing appropriate service*.' (Murray, 2009)
  - A cycle of assessing needs of people in an area, designing then securing appropriate service' (Murray, 2009)

Strategic planning and investment in the improvement of local health services and systems to better address the health and wellbeing needs of the local population, deliver high quality and integrated primary health care, enhance workforce capability, and achieve better value and efficiency for the health system

(A Blueprint for Capital Health Network, 2015)

- Securing the highest quality healthcare services to meet the identified needs of a population within available resources.

A three stage process…

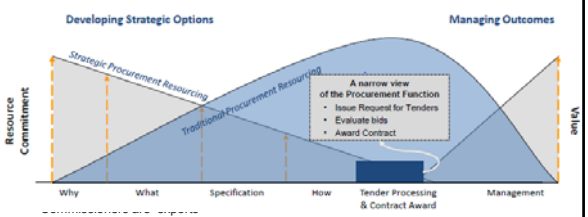


A four stage process…

AMLA Commissioning Framework

Mythbusters …

- Commissioning is not simply…
  - Purchasing or procurement



Source: CIPS Australia 2nd Annual PSPF Govt Conference 2006 - Paul Hopkins (Deputy Director-General Procurement) NSW Department of Commerce

"Australia's health arrangements are complex. It is a web of government and non-government funders and service providers acting across the different but inter-related sectors."
Reform of the Federation and *Reform of Australia's Tax System – Health Issues*

Task 1a. Measures

"Value…should define the framework for performance improvement in health care. Rigorous, disciplined measurement and improvement of value is the best way to drive system progress. Yet value in health care remains largely unmeasured and misunderstood".
Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481

Task:
- Consider the case study and define the performance measures you consider relevant to the provision of homeless services
- What challenges does this present?

Notes:
- Please appoint a scribe who would be willing to hand the notes over at the end of the workshop (Leave on the table, mark with name and contact number of the scribe)

Feedback:
- Please appoint a rapporteur who may be asked to provide feedback on the above:
  - complement what has been said before rather than duplicate points that have already been made
  - keep feedback clear and succinct.

Task 1b. Model

"Value should always be defined around the customer and in a well-functioning health care system the creation of value for patients should determine the rewards for all actors in the system. Since value depends on results not inputs, value in health care is measured by outcomes achieved, not volume of service delivered …nor process of care used".
Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481

Task
- Design a new service model:
  - Who is it aimed at?
  - What does it look like? Where and when will it be provided?
  - Where does it sit in the service system ?
  - What principles will guide it's operation?
  - How does it deliver value? And to whom?

Notes:
- Please appoint a scribe who would be willing to hand the proposed service model over at the end of the workshop (Leave on the table, mark with name and contact number of the scribe)

Feedback
- Feedback your proposed new service model
- Be prepared to be challenged:
  - Does it address the performance framework as developed in Task 1a.?

Task 1c. Costs

"Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false 'savings' and potentially limiting effective care".
Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481

Task:
- Consider the case study and cost the current service model. In doing so,
  - Consider the cost to the various 'actors' and quantify the cost(s) where possible
  - Consider how you could calculate the costs of the missing components

Notes:
- Please appoint a scribe who would be willing to hand the notes over at the end of the workshop (Leave on the table, mark with name and contact number of the scribe)

Feedback:
- Please appoint a rapporteur who may be asked to provide feedback on the above:
  - complement what has been said before rather than duplicate points that have already been made
  - keep feedback clear and succinct.

Feedback 1a. Measures

- Task 1a.
  - Test where measures fit in performance hierarchy
    - Tier 1 Health Status achieved or retained
      - Survival
      - Degree of health or recovery
    - Tier 2 Process of recovery
      - Time to recover and time to return to normal activity
      - Disutility of care or treatment process (eg: diagnostic errors, ineffective care, treatment related discomfort, complications, adverse effects)
    - Tier 3 Sustainability of health
      - Sustainability of health or recovery and nature of recurrences
      - Long term consequences of therapy eg. care induced illness
  - Map onto framework (make visible)

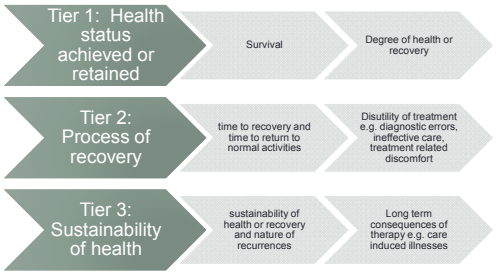
Value in Primary Care

…practices that use the implementation of patient-centered medical homes as an opportunity to divide patients into subgroups, build truly integrated teams to serve them, measure subgroup-specific outcomes and costs, and focus on process improvement may dramatically improve value in primary care.
Porter, M.E., Pabo, E.A. & Lee, T.H. (2013) Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs. Health Affairs, 32, 516-525.

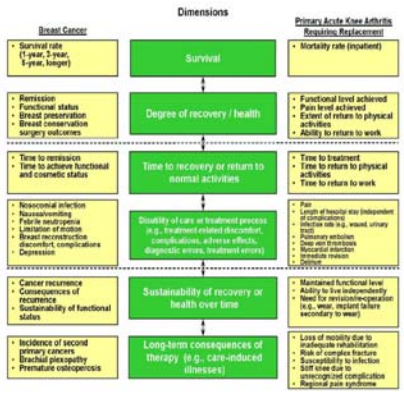
- Rather than plan services around conditions, identify groups of patients that have similar needs and challenges
  - not based on segmenting the population by discrete diseases such as diabetes, hypertension, and depression.
- Create a needs based delivery system

Outcomes

A focus on outcomes



Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481.



Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481.

Feedback 1c. Costs

Task

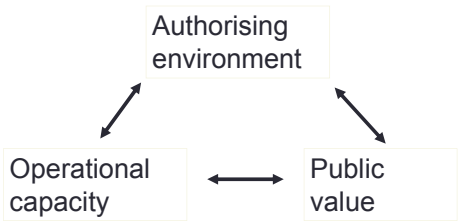
- Task 1c.
  - Provide feedback on your cost modelling exercise
    - What costs did you consider and what were these?
    - Were you able to quantify any costs? If so what are these?
      - Consumer, Provider, Funder, Commissioner etc?
      - Direct/indirect costs
      - Unintended consequences and costs
    - How does the model add value? You'd need to test

Costs

What is Value?

- Definitions
  - Value: 'optimal use of resources to achieve the intended outcomes'
  - Public Value: strategic triangle - 'public value aims', 'authorising environment' and 'operational capacity' (Moore, 1997)
  - Value in health care: 'health outcomes achieve per $dollar spend' (Porter M)
- Value to who?
  - Consumer/carer,
  - Professional/practitioner (make life easier for…)
  - the Sector
  - the System
  - Role of the commissioner to add value at all levels

The Strategic Triangle



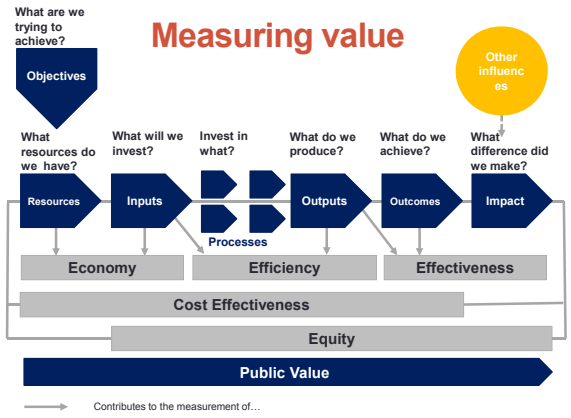
Mark Moore (1995)

Value in Health Care

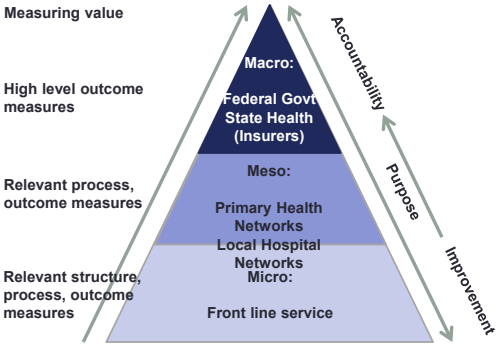
- "Improving performance and accountability dependents on having a shared goal that unites the interests and activities of all stakeholders…**Achieving high value must become the overarching goal of health care delivery, with value defined as** health outcomes achieved per $dollar spend. This goal is what matters for patients and is what unites the interests of all actors in the system. If value improves ; patients, payers, providers and suppliers can all benefit while the economic sustainability of the health care system increases".
- "Value…should define the framework for performance improvement in health care. Rigorous, disciplined measurement and improvement of value is the best way to drive system progress. Yet value in health care remains largely unmeasured and misunderstood".
- "Value should always be defined around the customer and in a well-functioning health care system the creation of value for patients should determine the rewards for all actors in the system. Since value depends on results not inputs, value in health care is measured by outcomes achieved, not volume of service delivered …nor process of care used".
- "Process measures and improvement are important tactics but no substitute for measuring outcomes and costs".
- "Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false 'savings' and potentially limiting effective care".

Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481

Measuring value

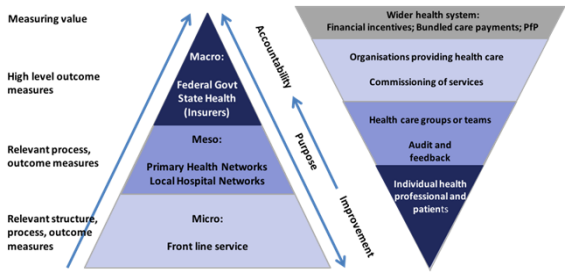


Hierarchy of measures



Commissioning – perspectives from the ground, Australian Journal of Primary Health, Dawda P, Wells L, True A (2015, awaiting

Levels of QI and Measures



Feedback 1b. Service model

- Task 1b.
  - Provide feedback on your proposed service model
  - Does it address the outcomes set out in the framework?
    - If so how?
  - Did you have everyone you needed around the table?
    - Who else could have been there?

Reflection 1

- Defining measures
- Measuring costs
- Defining the service model

Reflection 2

"Improving performance and accountability dependents on having a shared goal that unites the interests and activities of all stakeholders…Achieving high value must become the overarching goal of health care delivery, with value defined as health outcomes achieved per $dollar spend. This goal is what matters for patients and is what unites the interests of all actors in the system. If value improves; patients, payers, providers and suppliers can all benefit while the economic sustainability of the health care system increases".
Porter, M.E. (2010) What is value in health care? New England Journal of Medicine, 363, 2477-2481

- When conducting Task 1, did you have all the necessary 'actors' around the table? If not,
  - who was missing?
  - what would they have added?
- What are the current enablers and barriers to commissioning for value?
- What are the top 3 things you would change to drive the value agenda?

Value - Misconceptions

- It's only about the Service offer (ie: activity)
  - C4V adopts a consumer centric approach
  - C4V adopts a long term and sustainable focus with an emphasis on outcomes rather than inputs/process
  - C4V adopts a whole system and whole health economy perspective
  - The health commissioners role is to '*maximise the benefit of the whole heath system for consumers, funders, service providers and health professionals alike*'
- It's all about cutting costs: ie: VfM
  - C4V focuses 4 levels of value (4Ss)
  - C4V requires a complete understanding of the use and maintenance of key RESOURCES to achieve the quadruple aims
  - However, financial resources are and should be considered a limited resource
    - wise spenders not big spenders
    - doing things differently not more
    - sustainable organisations
    - reducing variation and waste and realising efficiency savings to reinvest in system improvement
- It can only be achieved through hard nosed 'procurement'
  - C4V is a transformational process focused on quality and safety, improvement and sustainability
  - C4V is relationship based - shared vision, common purpose and goals
  - C4V may not encompass procurement but may include policy change, pathways development, strengthening system enablers, capability development and so on
  - C4V is premised on ability to influence others as much as purchasing power

Why a Commissioning for Value approach?

- The international evidence for commissioning is not conclusive, but suggests it has potential for addressing health system issues with some insights into successful enablers and barriers (Dawda et al, 2015)
- It is necessary if the health system is to be consumer focused and incorporate the views of consumers (Shircore and Shaw, 2013)
  - NHS Outcomes Framework falls short of consumer expectations and understanding ie: What's important to them?? What do consumers value?
- Every decision is a commissioning for value decision
- It is possible to achieve commissioning for value
  - English PCTs demonstrated this could be done (Martin, 2010)

Benefits of commissioning for value

- Better engagement with consumers and citizens and increased satisfaction
- Identification of new ways of delivering outcomes
- Elimination of duplication of services and efforts between agencies
- Stronger and varied partnerships
- Improved and more coherent services
- Avoidance of cost shunting between organisations
- Joint assessment and understanding of needs
- Shared assets and premises
- Shared workforces and integrated teams
- Economies of scale and/or increased 'purchasing power'
- Brings an understanding, empowerment and credibility to public services

(Commissioning for better public service, LGA (UK), 2011)

Learnings

- Output and process measures are important – but no substitute for outcome measures
- Outcome measures are often difficult to define – but important
  - The goals that tie the 'actors' together
- Commissioning for value requires:
  - A focus on value to the consumer, provision of quality service provision and outcomes
  - Meaningful focus on EEEE and associated performance framework
  - A longer term view and investment
  - Carefully and sustained monitoring: managing variance; understanding variance
  - System stewardship – changes in the market, system, environment may well impact (+/-)
  - A mature approach to financing, funding and costing
  - A focus on ROI/SROI – the measurement of public value
  - A engaging and developmental approach
  - Investment in capacity building – PHNs and others including governments

Habits of successful commissioning organisations

- Relationships - effective collaboration/partnerships
- Outcomes focused performance framework
- Monitoring and measurement
- Authority and accountability
- Clinical leadership and broader clinical engagement
- Symbiotic relationship - Managerially literate clinicians and Clinically literate managers

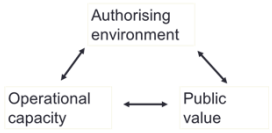
(Dawda et al,2015)

Success Factors

- Investment in leadership, management and infrastructure (Casalino, 2011,UK)
- Authorising environment:
  - Clear mandate
  - Legitimacy and support
  - Recognition that we won't always get it right - failure will occur
  - Advocacy
  - Shared risk
- A focus on:
  - consumer focused quality improvement
  - service system integration
  - changing relationships, changing behaviours through effective change management
- Ability to:
  - optimise improvement, innovation, integration
  - leverage
  - mobilise at scale and pace
  - demonstrate value
- Standards driven approach
  - Commissioning standards
  - Service standards

Commissioning for Value

- Person centred and outcomes focused
  - Person-centred and focused on outcomes
  - Promotes health and well-being for all
- Inclusive
  - Promotes positive engagement with all 'actors'
  - Solutions co-produced with all 'actors'
  - Promotes equality and diversity
- Well led
  - Well led: leadership, values and behaviours
  - Demonstrates a whole system approach
  - Uses evidence about what works
  - Requires managerially literate clinicians and clinically literate managers
- Promotes a diverse and sustainable market
  - Ensures diversity, sustainability and quality of the market -
  - Provides value for money and makes best use of system resources
  - Develops the commissioner and provider workforce
- Delivers public value
  - Health outcomes achieved per $dollar spend



Mark Moore, 1995

Adapted from:

- Commissioning – perspectives from the ground, Australian Journal of Primary Health, Dawda P, Wells L, True A (2015, awaiting publication)
- Commissioning for Better Outcomes: A Route Map, University of Birmingham (UK), Health Service Management Centre and Institute of Local Government Studies, OCI 2015

Adjunct Associate Professor Paresh Dawda,
Australian Primary Health Care Research Institute, ANU
E: dr.paresh.dawda@gmail.com

Angelene True,
Director Service and Systems Development, Capital Health Network
E: a.true@chnact.org.au

Conclusions

- Alignment of boundaries is simply not sufficient: requires engaging and mutually beneficial partnerships:
  - Shared purposes/goals (eg: ACT HS Outcomes framework)
  - Requires collaboration with consumers –citizens as 'definers' of public value and 'co=designers and ebeneficaries' of public services
  - Collaboration required across sectors, founded on respect and trust, leadership, time and resources
  - Commissioning needs time to mature
- Effective commissioning and C4V needs focus on relational aspects: shared purpose/goals, Collaborative, Transformative – we're all in this together whether 'funder', commissioner' or 'service provider'
- Meaningful measurement requires a degree of equilibrium …health spending in one year will no t achiev desierd outcmes in same year e: value

Key messages:

- For policy makers and Government:
  - Imperative that PHNs are permitted to mature and develop into effective commissioning organisation enabled by both levels of Government, who need to support and empower them. WHAT SUPPORTS DO PHNS NEED??? From State/Federal Government. WHAT DO WE NEED TO EMPOWER PHNs???
  - Potential to make federalism work at the polin at wich Cwth and S/T responsibility in PHC intersect (eg: pooling of funds, alliance/collaborative commissioning approaches)
  - Create environment for change and authorising environment
  - Capability development (not simply us and them – joint responsibility – vicarious liability)
  - Macro level impacts: levers (eg: funding mechanisms) and systems response
  - Commonwealth agencies: ACQSHC; NHPA etc...
- For commissioning organisations (PHNs/LHDs/Govts and others etc)
  - Commissioning for value is more than simply procurement: Maximising the benefit of the local health system for your local population: addressing local needs and shaping the local system (influence and impact)
  - System stewards and facilitators: change agents
  - Innovation and agility (Not more but different)
  - Long term journey – never finished - Consistent and persistence
  - PDSA: Measure, and monitor
  - Need to develop local infrastructure to measure nad understand both outcomes and vlaue across the system in a blanced way: health outcomes, cost and consumer experience (triple aims)
  - Need to poerate within an 'authorising environment' – support of govt, partners, stakeholders, users and interest groups and citizens
  - Requires:
    - a clear mandate: from government and policy makers (not sure if PHNs have that yet)
    - Two way relationships – collaboration, trust, respect (at all levels micro,meso, macro)
- For CAC and CC
  - Ensure decisions, investments an innovations are consumer centred, cost effective, locally relevant and aligned to local care experiences and expectations.
- For Providers
- For Clinicians (leadership)
- For Consumers

Process, Enablers, Levers (Needed??)

- Process:
  - Continuous
  - Iterative
  - Long-term
- Enablers:
  - Relationships
  - Engagement
  - Co-design – shared responsibility
- Levers:
  - Consumer focus
  - Financing
  - Funding

Governance/Roles/responsibilities

- Effective governance:
  - To whom?
  - For what?
- Roles and responsibilities
  - Policy makers (Federal/State)
  - PHN Board, CAC, CCs, LHDs
- Fund managers
- Commissioners: holding the ring…(vicarious liability)
- Consumers
- Suppliers (potential/actual)