European Commission

Report of the

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH (EXPH)

on

Best practices and potential pitfalls in public health sector commissioning from private providers

Health and Food Safety

EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH

(EXPH)

Best practices and potential pitfalls in public health sector commissioning from private providers

The EXPH adopted this opinion at the 14th plenary meeting of 3 May 2016

About the Expert Panel on effective ways of investing in Health (EXPH)

Sound and timely scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. To this end, the Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health (Commission Decision 2012/C 198/06).

The core element of the Expert Panel's mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The advice does not bind the Commission.

The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

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http://ec.europa.eu/health/expert_panel/experts/working_groups/index_en.htm

ABSTRACT

Different policy instruments can be used to improve the performance of health care systems. One of those instruments is commissioning health care services from private providers, which appears to be increasingly used in the European context. Commissioning is defined is this report as a proactive and strategic process for the planning, purchasing and contracting of health services.

In this report, we highlight some important principles as well as practical considerations related to commissioning. We illustrate these with examples of commissioning in European countries, both successes and failures, with a focus on the experiences from Sweden and the UK.

Commissioning from (private) health care providers is a policy option that needs to be carefully compared to alternative policy options and evaluated in terms of costs and benefits, both short and long term. Whether benefits outweigh the costs depends on many contextual factors, including market structure, measurability of quality, good payment structures, etc. It is crucial to optimally align private providers with the goals of the health care system.

Success in commissioning from private providers requires professionalism and experience on the side of buyers and providers. This stresses the need for careful and evaluated introduction of commissioning, whenever deemed beneficial in attaining health care goals.

The knowledge base regarding commissioning from (private) providers in European health care systems is limited and stregthening this is encouraged.

Keywords: EXPH, Expert Panel on effective ways of investing in Health, scientific opinion, commissioning, private providers, best practices

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EXECUTIVE SUMMARY

European countries typically pursue health systems goals that include high quality, efficiency, equity, affordability and accessibility of health care. Balancing and optimizing these goals is a difficult and delicate policy exercise. Different policy instruments can be used to improve the performance of health care systems and, therefore, (the equitable distribution of) health. One of those instruments is commissioning health care services from private providers. Given the developments in many European health care systems in which a split of providers and purchasers is realised, commissioning, including that of private providers, appears to become more common. Commissioning is defined in this report as a proactive and strategic process for the planning, purchasing and contracting of health services.

In this report, we highlight some important principles as well as practical considerations related to commissioning. Many apply whether commissioning from public or private health care providers. We illustrate these with examples of commissioning in European countries, both successes and failures, with a focus on the experiences from Sweden and the UK.

We highlight that commissioning from (private) health care providers is a policy option that needs to be carefully compared to alternative policy options and evaluated in terms of costs and benefits, both short and long term. Whether benefits outweigh the costs depends on many contextual factors. In many cases, the policy question may not be whether or not to commission private providers, but how to do so and how to find an optimal mix of providers.

There are no general rules for the optimal use of commissioning in different sectors, circumstances or countries. These decisions and evaluations need to be tailor made. Both the planning and contracting phase require expertise and professionalism, on the side of the providers as well as on the side of the public buyer. Often, the success or failure of commissioning can be determined by details in the different phases of the commissioning process. It is crucial to well define what is to be commissioned and to decide how to monitor the costs and effects from commissioning. Hence, the Panel stresses the need for strong commissioning bodies and well-designed commissioning processes whenever countries choose to use commissioning from (private) providers as a policy instrument. This is a prerequisite and requires clear structural investments in order to make the commissioning process a (lasting) success.

Engaging private providers in the provision of publicly financed health care, especially for profit providers, requires additional information (on, e.g., ownership and financial stability) and potentially additional regulation. Commissioning from private providers does not transfer the responsibility for an adequately functioning health care system and attaining societal health care goals to private providers. The relevant authorities remain responsible for this.

Starting commissioning is easier when a well-defined and well-functioning market exists, but commissioning can also help in creating one. Moreover, building up experience with commissioning and interactions between purchasers and providers can improve the commissioning process over time. This requires a careful, limited start in commissioning in order to be able to build the required experience without too much risk.

There is no single dominant procurement strategy, but this needs to account for the exact context in which the commissioning takes place. Important aspects are the definition and measurability of the (quality of the) commissioned services, market structure, investments required by the providers, ability to monitor inputs, outputs and outcomes, transaction costs of the procurement to both sides as well as the distribution of risks, both for the sort and long term. Duration of contracts is an important issue as well. This highlights the need for careful design of the commissioning process, contracts and follow-up on a case by case basis, as well as professional and knowledgeable commissioning bodies.

Risk sharing is not an objective of private commissioning, but commonly is a part of it. This should be done in such a way that the commissioned side has the right incentives and is optimally aligned with the goals of the buyer. Again here, this needs to be determined in the context of a specific commissioning procedure and evaluated. An important part of developing adequate commissioning strategies is the development of adequate payment systems, which gives incentives for quality, cost-effectiveness and control of costs. This holds both for commissioning from private as well as from public providers.

Defining, measuring and monitoring quality often can be difficult. This may lead to a situation in which commissioning bodies focus on better observable aspects such as prices and numbers of patients treated. This risks lowering quality of care, patient health and the performance of the health care system. Hence, much attention needs to be given to defining and monitoring quality to ensure that providers act in line with the values of the payer and patients.

When considering commissioning from private providers, specifying the expectations regarding commissioning is important. A checklist was developed which may aid countries in that context. In commissioning and evaluating commissioning, the focus should not only be on the short run, but also on the long run.

Professionalism in the commissioning process is highly important, but needs time and practice to acquire. This emphasises the importance to start commissioning on a small scale and in those sectors where this is deemed less difficult and only later, if at all, on a larger scale and in sectors where it is considered more difficult. The legal context and the reversibility of actions are important.

At present, the knowledge base regarding optimal commissioning, optimal mixes of private and public providers as well as success and failure factors is relatively limited. The report highlights some successes and failures in commissioning. It is important to learn from these examples and the knowledge in these countries.

The EU could facilitate more knowledge in this area and the spread of this knowledge to EU Members States currently considering expanding or introducing commissioning from private providers in their health care sector. Increasing knowledge and sharing experiences may also help to manage expectations regarding the effects of commissioning of health care services on quality, costs, availability etc., and make the decision to introduce commissioning more evidence based. Also comparable data on the extent of private commissioning across European countries is lacking.

The legal aspects of commissioning also require attention. Not only within Member States in relation to European legislation, but also in relation to legal issues on sharing information, creating a level playing field between private and public providers, and in relation to cross-border care when private providers from other countries are commissioned.

This Opinion hopes to contribute to improved policy making regarding whether and how to commission health care from private providers within the European Union.

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BACKGROUND

European countries typically pursue health systems goals that include high quality, efficiency, equity, affordability and accessibility of health care. Balancing and optimizing these goals is a difficult and delicate policy exercise. Different policy instruments can be used to improve the performance of health care systems and, therefore, (the equitable distribution of) health. However, the choice of particular instruments should be the result of an explicit evaluation of the positive and negative consequences associated with each instrument, in comparison to others, and the conditions favouring the selection of the range of possible instruments.

European health care systems are organised within different political and economic structures and have developed in different ways. Consequently, health care policies need to be sensitive to context; what is a good policy in one country need not be good in another. Notwithstanding the important differences in, for instance, background, epidemiology, organisation and level of spending between European countries, at a general level one may observe some convergence of health care systems. There has been a general tendency, in many areas of European public health care systems, to separate payment and delivery of health care, creating a so-called purchaser- provider split. The rationale for this split was set out in the 1980s and 1990s by those who saw it as a means to improve the access, innovative strength, patient choice and efficiency of health care systems, while retaining their basis in solidarity, by increasing the role of patient choice and (regulated) competition between health care providers (e.g. Enthoven, 1988; Van de Ven and Schut, 2009; EXPH, 2015a).

This implies a split between purchasers of care (on behalf of the insured population) and providers of care, who need to deliver the required care to that population. In order to steer a health care system that is organised this way, third party payers have (more or less explicit) contracts with providers of care in order to ensure adequate and efficient health care delivery to the relevant population. These providers receive payments for their services, and the structure and level of the payments create incentives and restrictions that influence the quantity and quality of services delivered.

One way of contracting providers is through commissioning of provision of health care services. This commissioning by the purchaser (third-party payer) can take place with public providers or private providers. The latter providers can either be for profit or non-profit organisations. Commissioning either type of private providers to deliver publicly desirable and financed goals appears to be an increasing phenomenon, not only in health

care but also in other sectors where the government was previously more directly involved in the production of services (e.g. Eurofound, 2015). The delivery of publicly financed goods and services by private providers is not new, but the expansion of the phenomenon may be related to a redefining of the role of the state (World Bank, 1997) and changing political context.

Using contracting and commissioning rather than directly controlling and directing health care providers (as in a classical integrated health care system) has advantages and disadvantages. The use of contracts typically reduces the flexibility that bureaucracies have when they exert direct ownership and control.[1] On the other hand, properly designed contracting may increase efficiency, innovative strength and quality of provision, when it provides a better set of incentives to providers than in integrated health care systems. In general, it is important for health care policy makers to carefully consider which health care services and coordinating tasks should be performed and provided by 'the public sector' and which could be 'outsourced' and commissioned from private providers.

Not only do different types of health care systems exist in Europe, they also have their own histories and experiences with (commissioning from) private providers. Two main types of health care systems can be distinguished to illustrate this point: insurance-based health care systems and tax-based 'integrated' systems. The latter (e.g. UK, Denmark, Sweden, Spain) typically relied more heavily on public provision of services whereas the former (e.g. Germany, France and The Netherlands), traditionally have been using a mix of public and private providers to deliver health care services. For instance, in The Netherlands, with an insurance-based health care system, the provision of hospital care has been almost exclusively through private hospitals. The split between the roles of health care purchaser and health care provider in health care systems with a traditionally greater public provision, has provided an opportunity for an increased the role of private providers. At the same time, in insurance-based systems, payment systems and contracting schemes are developing (from simple payment per visit or bed-day based systems to performance based payment) in an attempt to further control and steer private providers. This could be interpreted as a convergence of health care systems, with a central feature of health care purchasing and commissioning by third-party payers on behalf of the health care system and the insured population, in which both public and private providers may play a role. Considering the goals of health care systems, the central issue does not seem to be whether health care providers are public or private, but

[1] Although, in some ways, flexibility of policy makers may also be reduced by only having public providers, since in that case it may be difficult to increase performance or terminate providers.

whether they optimally contribute (both in short and long run) to these health care goals. The extent to which each type of provider does this, and what mix of providers might be considered optimal in a specific setting, remains a matter for empirical assessment.

It must be stressed here that all health care systems obtain goods and services from private providers. This is not only true for non-clinical services provided as a means for the health care system to operate (e.g. ICT, consultancy or cleaning) or medical products (pharmaceuticals, medical devices or laboratory tests), but also for many actual health care services. In most countries, for instance, dental care will be largely provided by private providers of care (private dentist practices) and the same holds for GP care and pharmacies.[2] Such provision, and the commissioning thereof, is not without problems (in terms of quality, quantity, access or costs), but these problems are not typically linked to the fact that these providers are private entities. The main difficulty, in all of these areas, is to align these providers as closely as possible with the aims of the health care system (rather than private goals). In this report, we will focus on the commissioning of core health care services, including hospital care, where controversy and political attention appears to be the largest. Moreover, while we focus on commissioning from private providers, many of the questions regarding, for instance, optimal contracts and payment systems are equally important for commissioning from public providers.

Commissioning from private health care providers to deliver services is viewed here as a policy instrument. It is not a goal in itself or something to avoid at all costs. Publicly financed health systems can use this instrument in pursuing their goals and it can be beneficial in that context. However, commissioning from private providers is not without problems, risks or controversy. How tax payments are spent is a key aspect in public policy, and even suspicions of waste and inappropriate spending may undermine the support for polices that are supported in principle by the general public. Ultimately, the desirability of using this instrument depends on its contribution to the overall goals of a health care system relative to other policy options, such as public provision. The (long term) costs and benefits of the different options need to be explicitly weighted against each other. Moreover, the success of commissioning from private providers also depends on how well the instrument is used and the skills, expertise, and resources of those who use it.

Processes for selection of providers and contracts with (private) providers require careful design and management in order to provide incentives that are aligned with the health system goals, both in the long and the short run. The optimal design and incentive

structure is typically context dependent and needs to be tailor made, much like introducing competition between providers of health care (EXPH, 2015a).

This report highlights some of the main theoretical and practical considerations that apply when commissioning private providers in the EU context. Moreover, it provides recommendations regarding the practical use of this instrument in such a way that it contributes to the overall aims of European health care systems.

[2] It needs noting that the costs of some forms of care, like dental care, are less often covered through public insurance, which may have consequences for their provision and their relevance for this report.

TERMS OF REFERENCE

The Mandate provided to the Expert Panel was as follows.

Background

Many public health systems commission health care from private sector providers. The processes for selecting these providers, the strategy for developing and management of the market and the design of contracts require careful design in order to provide the correct incentives to providers, and to establish appropriate tariffs to ensure that the public get good value for money without undermining the sustainability of provision. The report seeks to establish the range of methods used to achieve these aims and determine which elements of best practice could be applied more widely throughout the EU.

Rationale

Strengthening of the evidence-base for best practices, making recommendations to Member States undertaking health policy reforms that involve commissioning from private providers.

Purpose

To develop a typology of methods used to commission health care from private sector providers that can be applied in the development of policy. This should provide guidance to evaluate which policies can best tackle inefficiencies in health systems. In particular, it would ideally highlight how different features of contracting affect incentives and outcomes.

Suggested structure

Theoretical framework	This would ideally include: • rationale behind private commissioning • potential problems and market failures (this could include, cream-skimming, segmentation, duplication of infrastructures if there is public spare capacity, etc.) • differences when dealing with non-profit providers
Effective commissioning features good commissioning should include to tackle the potential issues predicted by economic theory	This would ideally include: • what procurement strategy should be used? • how should risk be assessed and shared? • how should prices and quantity of service be specified to ensure adequate coverage, access, and sustainability?

	• how should quality standards be set and measured to safeguard patients? • good examples of contracts that have been used to this end
Transition	This would ideally include: • what are potential issues in transitioning from fully public provision to mixed public/private provision? • are there good examples of making this transition?
EU Action	Would there be room for specific EU action here and what would it be exactly?

1. OPINION

1.1. Background

One of the unique features of the European social model is the existence of (elaborate) welfare systems, which should protect and promote the health and wellbeing of European citizens, in an inclusive fashion (Eurofound, 2015). In order to ensure their inclusiveness, solidarity and close adherence to the publicly stated goals of these systems, most EU welfare systems have a strong public foundation. This also holds for health care systems. This is apparent in the widespread adoption of (primarily) mandatory health insurance or taxation, typically based on notions of income and risk solidarity, and health care delivery based on need. Having clear public goals for the health care system as well as public financing does not necessarily imply that the provision of health care services[3] needs to be delivered by public bodies.

Most European countries are continuously struggling with optimising the performance of their health care system in pursuit of important goals like quality, equity, efficiency and affordability. This leads to continuous reforms to health care systems. At a general level, Cutler (2002) distinguished three waves in health care reforms. A first wave (roughly from the 1940's to 1980's) focused on expanding coverage and the package of benefits included. The success of the first wave lead to questions about the affordability and financial sustainability of health care systems and to the second wave of health care reforms (roughly 1980's to 2000), focusing on cost control by limiting the (public) spending on health care. While this may have been successful in lowering (public) expenditure, it also increased awareness that lower expenditure could result in an inefficient allocation of scarce resources and inequities in provision. The third wave of reforms is therefore focused more on the efficiency of the health care sector: enabling optimal performance within available resources, a goal that often requires reforms at several levels of the health care system. One may see differences in where specific health care systems lie in this 'evolution of health care system policies'.

A separation between health care financing and delivery, implying a so-called 'purchaser-provider split', is one of the frequent and important elements in third wave reforms aimed at improving the efficiency of the health care system. It has been argued that fully

[3] The same is true for health insurance. Financial protection, based on risk and income solidarity, and inclusive (mandatory) for all citizens, can be arranged through private health insurers, as long as they operate under clear (publicly set) regulations and conditions (Van de Ven and Schut, 2008).

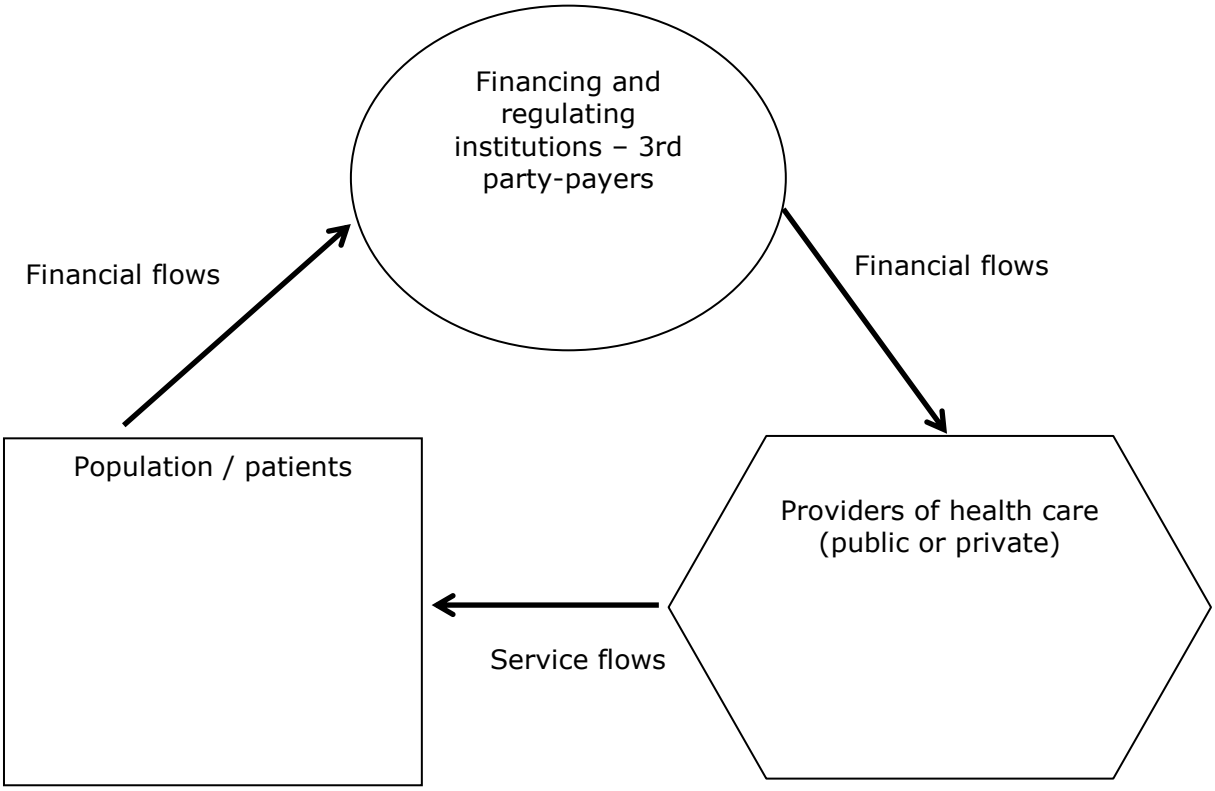
integrated health care systems, in terms of health care financing and delivery, may not provide the best incentives for efficiency in health care delivery (e.g. Docteur & Hoxley, 2003).

Moreover, governments may see the delivery of care as something that is not necessarily a public task – while ensuring solidarity, quality, access and efficiency is. In addition, health care professionals may have preferences for working for a private versus public provider for a number of reasons, which in turn may have consequences for the availability of manpower for different tasks, as well as for outcome and efficiency. As Preker et al. (2000) indicate, some view these developments as finding a new balance in the health care sector between public and private roles: *"A better match is desirable between the roles of the state and the private sector and their respective capabilities... In most countries this means rebalancing what is already a complex mix of public and private roles in the health sector."* We stress that, within this new context, governments remain responsible for the overall performance of the publicly financed health care system, whether this includes private activity or not.

The split of purchasers and providers of care also results in the need for purchasers to contract the providers of care in such a way as to align them optimally with the goals of the purchaser (and, ideally, the insureds and the health care system). One could claim that this process of commissioning and contracting public and private providers of health care is at the heart of fundamental health care reforms based on a purchaser/provider split. The purchasers should have the incentives to focus on the needs of patients and become a prudent buyer of care from public and private providers of care, of behalf of the people they represent. This involves the desire to contract the best quality care, in adequate quantities, at a reasonable price regardless of the driving forces behind the health care reform towards purchaser/provider split; mobilisation of resources for specific services, such as primary care or meeting objectives about efficiency and equity.

Figure 1 illustrates these arrangements.

Figure 1. The triangle of agents in health systems



Note: Many other flows exist in health systems, including as examples "reimbursement" payments from the third-party payers to the population/patients; "out-of-pocket" payments from population/patients to providers of health care.

Source: EXPH, Competition Report, 2015a

In figure 1, it is depicted that all citizens pay taxes or insurance premiums (financial flows) to the third party payers (insurers, governments). As a consequence, they are insured for medical expenses (fully or partially). If someone falls ill and requires care, providers of care will deliver this (service flows). Depending on the exact arrangements in the system, the patient may obtain this care free of charge (without co-payments) or by paying a part of the total costs (co-payments). The payer, based on the claim of the provider, subsequently reimburses the provider. These payments can be directly linked to services or have another basis. In many cases, an implicit or explicit contract between third party payers and providers of care exists to specify the conditions of health care delivery and corresponding payment.

In this report, we focus on the right hand side of figure 1. The relationship between the payers (which may be insurers, municipalities, trusts or governments) and providers of care are central here. As already shown in figure 1, providers of care can either be public or private entities. The same holds for third party payers. While the focus in this report is

on commissioning health care services from *private* health care providers, it must be noted that many of the theoretical and practical issues related to commissioning of health care services are independent of whether they are private or public, and even whether they are for profit or non-profit organisations. Moreover, contracting private providers next to public providers will often have consequences for the latter as well, for instance through loss of patients or benchmarking effects.

While we focus on the right hand side of Figure 1, it cannot be emphasised enough that the success of commissioning and contracting also depends on how the health care market is functioning more generally (i.e. the rest of Figure 1). For instance, if a third party payer does not have a strong enough incentive to be cost-conscious or quality-conscious, this may result in non-optimal commissioning. In other words, the design and functioning of the overall system provides part of the context for the commissioning process and should be considered in the decision to undertake commissioning of private health providers. Analogously, introducing commissioning from private providers can have an influence on the rest of the system.

1.1.1. Commissioning private providers

A first step in discussing commissioning is to define it accurately. NHS England (https://www.england.nhs.uk/commissioning/) defines commissioning as follows: "*At its simplest, commissioning is the process of planning, agreeing and monitoring services. However, securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.*"

Here, we will use the following definition of commissioning, following Shaw et al. 2013:

> Commissioning refers to a proactive and strategic process for the planning, purchasing and contracting of health services. (Shaw et al., 2013)

The importance of this definition is the focus on an active role of the purchaser, involving a planning phase in which health needs are assessed and the desired services (including target populations, standards etc.) are defined, as opposed to the simple payment for services received.

In this report we use the term "private providers" as to describe providers who are not owned by the government. Private providers can be private individuals or legal bodies, and can either be for profit or non-profit. They are private entities, not owned by the state, having own control over production factors and, if for profit, control the created surplus (profits).

In legal terms, in accordance with the definitions in the Directive 2014/24/EU on public procurement, one could define private providers as providers that are not public. The Directive uses the term "bodies governed by public law" to describe public providers. These public providers have all of the following characteristics:

(a) they are established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character;
(b) they have legal personality; and
(c) they are financed, for the most part, by the State, regional or local authorities, or by other bodies governed by public law; or are subject to management supervision by those authorities or bodies; or have an administrative, managerial or supervisory board, more than half of whose members are appointed by the State, regional or local authorities, or by other bodies governed by public law;

If any of these characteristics does not apply to a health care provider, it does not qualify legally as a 'body governed by public law', i.e. a public provider. From a legal viewpoint, the provider can be seen as a private provider.

In this report, the focus will be on the procurement and contracting. However, it is important to reiterate the point above that, if this is to achieve optimal results, - while the policy goals also include aspects like equity and affordability - commissioning must be based on sound health needs assessment and carefully designed, evidence-based, patient pathways. In practice, most health systems have limited availability of organisations and individuals with the necessary epidemiological and health services research skills to undertake these processes. This risks commissioning the wrong services, in general or in terms of quality or quantity of services.

Engaging private providers in the commissioning process and paying them from public budgets to deliver publicly desirable services appears to be increasingly common. Systematically gathered and comparable figures on an EU level are, however, lacking. On a national level, the figures are often not easily obtainable either. In the UK, for instance, some information is available from the Laing & Buisson Healthcare Market Review[4].

[4] http://www.laingbuisson.co.uk/MarketReports/LatestMarketReports/tabid/570/ProductID/634/Default.aspx

Eurofound (2015) indicates that commissioning from private providers is increasingly part of public welfare systems, including health care systems, for different reasons: "*In recent years, the selected Member States increased their outsourcing of public services. While in Sweden this was aimed at preserving access and quality simultaneously (by solving a capacity problem in employment services when the number of recipients increased), in the other three countries (EXPH: Spain, UK, Lithuania) outsourcing of public services led to increased co-payments on the part of service users, especially in long-term care.*"

Failure of the public system to meet health care needs and especially expectations of the population can increase the pressure to see whether, or not, private provision may improve performance. Ideological considerations (e.g. about the role of the state or the benefits of the market) may also play a role in this context (Reynolds and McKee, 2012).

Commissioned private providers deliver health care services to publicly insured patients, thus being paid (at least in part) from collectively financed health care funds.[5] Several reasons may exist to do so. For instance, one may feel that private providers would deliver better quality care or deliver care more efficiently than existing public providers, because they may have better incentives to be efficient and deliver better quality. Another reason can be that this would increase the possibilities for cost control or make it easier to deal with heterogeneous needs and preferences of patients, the available capacity for treating patients or the innovative strength of the health care sector. However, the evidence for such claims appears to be limited.

Nonetheless, if the benefits of commissioning private providers are real and outweigh potential threats and costs, commissioning these health care providers can be a policy instrument for health care systems in pursuing their health system goals. Commissioning needs to be tailored to the relevant country, sector, services and time, since the context and exact goals pursued by different countries with commissioning private providers can differ.

Contracts between the public system (through third party payers) and private providers require careful design. These contracts should provide correct incentives to providers, in order to align them in the short and long run with the public goals of the health care system. This includes elements like costs, quality, timeliness and continuity of care. A failure to do so may lead to a worse rather than a better performance of the health care

[5] It is interesting to note that in Sweden, co-payments from patients in some cases flow to the purchaser (principal), i.e. the regional authority, while in other are paid directly the provider (agent).

system. Moreover, when private providers are commissioned, they may compete with public providers In such circumstances, competition should be fair and, ultimately, beneficial to the health care system, taking account in particular of the scope for cream-skimming and risk transfer that could destabilise the overall system. In a previous report the Expert Panel has elaborated on the advantages and disadvantages of competition between health care providers (EXPH, 2015a). Many of the observations made there are relevant in this context as well.

Two final remarks relate to the way in which providers and commissioning of providers is perceived. First, the labels 'public' and 'private' may evoke different connotations, images and emotions. People may equate for instance 'private' with 'for-profit' even though this is not necessarily true. For example, most hospitals in the Netherlands are private, but not for profit. Similarly, equating 'public' with 'automatically aligned health sector goals' is not necessarily true either. The labels of public and private 'merely' relate to ownership.

Second, commissioning private entities seems to have different connotations in different contexts. For instance, the majority of NHS primary care in the UK is provided by ostensibly private individuals, partnerships and companies contracted to the NHS: GPs (primary care physicians), dentists, pharmacists, opticians. Although the situation is complicated because many of these individuals, such as GPs, have structural ties to the NHS, such as membership of its pension scheme, and are subject to many constraints on the economic activities they engage in, they are not 'public providers' in a strict sense. Still, in practice many view themselves as part of the NHS rather than fully private providers. Similarly, the UK has seen an increase in managerial staff employed through their own sole trading companies, and thus technically as commercial providers, working alongside salaried staff as this has conferred tax benefits for the individuals concerned, a practice that has been clamped down on in 2016.[6] Ownership of high street pharmacies and opticians, and whether local NHS GPs and dentists are private contractors to the NHS (as most are), as opposed to salaried employees of the NHS, has been relatively uncontroversial. Ownership of providers of secondary care, including acute hospitals, has been a much more controversial issue. Even then, in contexts where the possibilities for certain behaviour are regulated, ownership may not be as much of an issue. For instance, in The Netherlands, the fact that hospitals are private has not attracted much attention. However, allowing them to make a profit (and paying dividends) is a different matter, leading to heated political and societal debates (e.g. Plomp et al., 2015).

[6] See HM Treasury. Budget 2016. London: UK Government, 2016 & http://www.independent.co.uk/news/uk/politics/budget-2016-george-osborne-to-crack-down-on-off-the-books-tax-loophole-a6927846.html

This report will draw on the limited literature on commissioning health care, a selection of European experiences with commissioning health care services from private providers and the expert opinion of the members of the Expert Panel. It does not attempt to give a full overview of the literature or experiences, which is beyond the scope of this report, but attempts to address the questions in the mandate in a coherent fashion.

The report is organised as follows. The next section (1.2) will highlight some theoretical considerations in the context of commissioning from private health care providers. Then, section 1.3 will highlight some European experiences with commissioning health care from private providers. We will especially draw on experiences in Sweden and the United Kingdom. Section 1.4 will provide some recommendations for European policy and research and conclude.

1.2. Principles of commissioning

Commissioning health care services from private providers is seen in this report as a policy instrument. As a policy instrument, it should be designed in such a way as to optimally contribute to the objectives behind commissioning private providers and must be evaluated in terms of its costs and consequences and, based on that, whether it is beneficial or detrimental to the health care system.

The well-known Principal-Agent theory may be useful in thinking in general terms about commissioning health care services from (private) providers. Through commissioning of health care services, a purchaser (Principal) wishes to have the provider (Agent) act in the Principal's best interest, that is, maximally serving the goals of the Principal. Through the commissioning process, including planning, selecting eligible providers, contracting, monitoring and payment, the Principal will try to have the Agent act in the desired way. However, typically, the Principal cannot fully observe whether or not this is the case - a particular problem in health care (regardless of whether the Agents are public or private). This leads to asymmetric information, where the Agents may know more about their actions that influence the value of service or product that is being provided than the Principal. Moreover, in health care it is often impossible to fully specify desired behaviour and outcomes in a contract. Several important issues then arise, both in terms of the goal function of the Principal (and how that relates to the overall health care goals) as well as to how to steer the Agents in the desired direction, so that they act in the best interest of the Principal. Many of these issues are independent of the question of whether or not a *private rather than a public* provider is commissioned. In both cases, contractual agreements need to ensure alignment between the provider (agent) and the contracting body (principal). Some interests may already be aligned (e.g. caring for the wellbeing of patients) while others may conflict e.g. the contractor wants to pay less and the contracted party wants to earn more). Aspects such as the definability and observability of desired actions and outcomes importantly determine the success of commissioning.

In thinking about the functioning of commissioning in a particular context, as well as in designing the commissioning and contracting process, the well-known theory explaining performance in a particular (sub)market, i.e., the structure–conduct–performance (SCP) paradigm (Bain, 1959) may also be useful. This paradigm indicates that market performance results from the conduct of the economic actors on that market, which in turn is driven by the structure of that market. Understanding performance therefore

requires understanding the conduct of providers and purchasers of care as well as the underlying market structure. We will also refer to this theory. Moreover, we will illustrate some of the issues with European examples.

In this section, we will highlight some of the theoretical considerations we consider to be important in this context, loosely using the above-mentioned theory. Note that while we will mainly refer to the commissioning process as ultimately involving one purchaser and one selected provider, this commonly will not reflect reality in which numerous providers may be contracted by one purchaser and even compete within the contract. Moreover, providers sometimes need to obtain contracts from several purchasers. In such cases, the interaction between the different purchasers and providers is of crucial importance.

1.2.1. Make or buy?

A first fundamental question a Principal needs to answer is whether commissioning to private providers - or public providers operating at an arm's length - is the best option. On a general level, this may be viewed as related to the 'make or buy' decision. A Principal can either commission ('buy') or produce a product or service himself ('make'). Depending on the Principal, the commissioning can then be done from either public or private providers. In such a decision, transaction costs are highly important (e.g. Williamson, 1981), which depend on the nature of the product and the market.

Preker et al. (2000) notes how "*transaction cost economics emphasizes the limitations of contracts and the need for flexible means of coordinating activities. Principals and agents are both opportunistic. Agents seek to minimize aggregate production and transaction costs and to maximize their benefits. Unless closely monitored, agents may be unreliable, engaging in behaviour such as rent-seeking, cheating, breech of contract and incomplete disclosure. Principals may try to maximize their benefits to such an extent that the relationship could become unviable for the agent.*" In other words, commissioning and contracting are not perfect instruments. Sometimes, it may therefore be better just to produce the required service.

In this context, Preker et al. (2000) creates a 'make or buy grid' that may be useful in the decision whether to start a commissioning process, if the alternative is to have it produced by current public providers.[7] The grid distinguishes between high, medium and low contestability as well as high, medium and low measurability. Contestability refers to

the contestability of the market (e.g. ease of entry and exit) and therefore the degree of competition on or for the market. Measurability refers to the "*precision with which inputs, processes, outputs and outcomes of particular goods or services can be measured*". Highly contestable and highly measurable services may be left to the market, whereas services with low contestability and measurability may be better produced by the Principal. Under high contestability, easy entry and exit reduces the need for price controls of any sort. High prices attract entry and will be non-permanent. Under medium and low contestability, the option of commissioning will often bring price determination into the process.

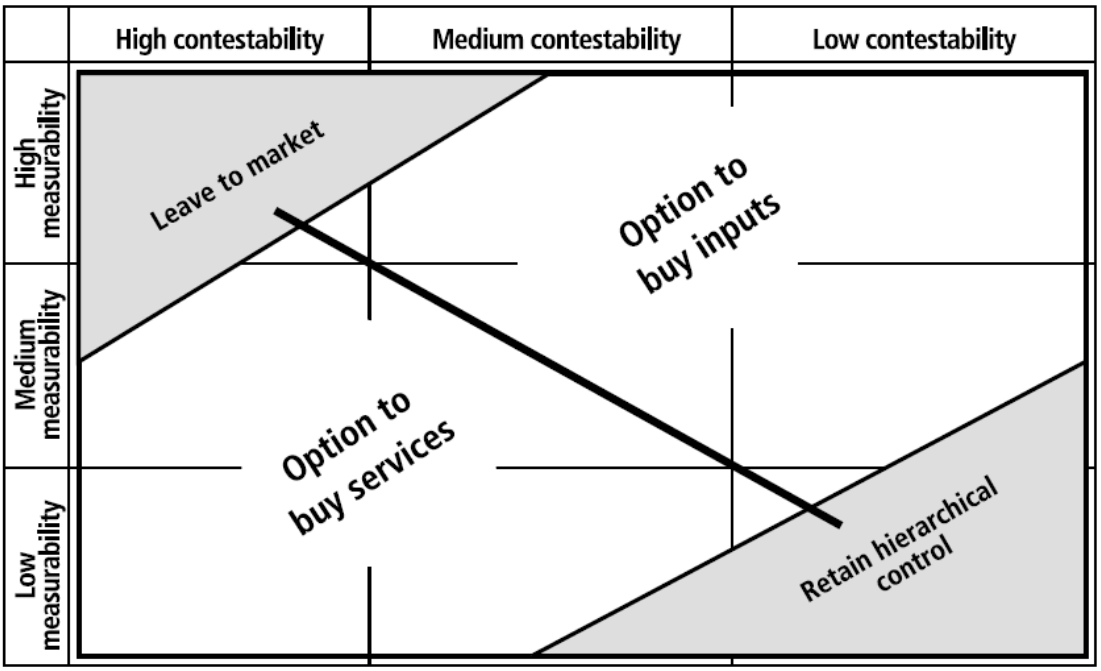


Figure 2: *'Make or buy grid'*
Source: Preker et al., 2000

In between these two extremes, the Principal has the option to purchase specific goods and services, a process in which costs and benefits of the make or buy decision need to be traded-off. Moreover, depending on the position in the grid, the commissioning process, including contracts and payments, may take different forms. With respect to the current report, one could think of certain types of elective surgery (e.g. cataracts) as being in the upper left corner, whereas specialised hospital care for rare diseases is in the lower right corner.

[7] Note that in this context it clearly matters whether the Principle is a private insurer (like in The Netherlands) or a Trust (as in the UK) for a decision to 'make' and what this entails. It could imply vertical integration

1.2.2. Principals' and agents' goals and responsibilities

Typically, health care systems are expected to pursue goals such as health improvement, quality of care, efficiency, fairness in the distribution of health, health care and health care financing and affordability. However, 'the health care system' is not one entity, it rather is a conglomerate of actors and organisations, all responsible for specific parts of the functioning of the total system. This has consequences for the definition of which party is Principal in a commissioning process and what the exact roles, responsibilities and environment of that party are. In fact, the bodies acting as Principal in a commissioning process may be seen as Agents from the perspective of the health care system, such as the Trusts in the UK, municipalities in Sweden or health insurers in The Netherlands.

Third party payers have their own goals and responsibilities. These goals may not be fully aligned with those of the health care system as a whole or even the people (insured) who they represent and on whose behalf they commission health care. For instance, health insurers responsible for their own budget, premiums and profits may have a stronger focus on cost-containment than national health care policy makers or even those insured may wish. This may especially occur in certain circumstances, for instance strong political pressure, strong price competition, etc. In such cases, the conduct of the commissioning Principal may need to be 'improved' by a higher authority (e.g. national government) to ensure a better pursuit of overall (health care) goals. This relates back to Figure 1 and the need to design the full health care system optimally. Eurofound (2015) states that "*When contracting authorities employ procurement procedures, the established selection criteria, especially in the case of long-term care, favour price over quality in Spain and the UK. In Sweden, quality outweighs price."* This underlines that if the final outcomes following commissioning are not perceived as optimal from the perspective of the patient or policy maker, this may therefore be related to the goals and behaviour of the Principal as well as those of the Agent. It is also important to note that verifiability of characteristics of the product or service is a relevant issue. If all relevant aspects of the product or service can be easily observed or included in the contract the problem would be easy to solve. The Principal just specifies what needs to be done and the Agent would comply with it. The existence of information problems that preclude such detailed and precise contracts brings complexities to the commissioning exercise.

When, on the other hand, it is easy to specify and verify the conditions and characteristics of the product or service, the main concern is to attract enough interested

between insurers and hospitals (both private) or not opening up a publicly run market to private providers.

providers to create mutual pressure to offer better conditions to the purchaser. Commissioning by tendering procedures aims at obtaining the benefits from competition among providers, and requires the ability to define and verify the product or service by the Principal. On the other hand, the quality of some health care services relies on decision and behaviour of the Agent that is difficult to observe and impossible to specify in a contract. Then, the use of extrinsic and intrinsic incentives to align interests of the Principal and of the Agent becomes key to attaining the objectives of the health system. Commissioning is then an exercise in planning and defining the adequate and possible incentives that best contribute to achieving such objectives.

If a purchaser opts for commissioning health care services from private providers, it is important to understand the reason *why* this commissioning takes place; which goals the payer is aiming for and whether commissioning private health providers is the best strategy to pursue these goals. If so, the commissioning process may need to be tailored to accommodate the specific goals (e.g. more capacity and improved timeliness of health care delivery) and health care sector context. One example may be that specific types of health care benefit from a long-term relationship between provider and patient. In those cases, attracting new providers may inherently disturb/destroy existing value in health care. The mere threat that other providers may be selected in the future may prevent current providers from making adequate investments for delivery of future contracts that they may lose, for example. Also, providers may be more prone to invest in aspects that they can have more value outside the relationship with the Principal even if those aspects are not the ones that deliver more value to the relationship.

Table 1 provides an overview of types of health care provision. It may be clear that commissioning generic pharmaceuticals, where the technical characteristics sought may be straightforward and verifiable in advance, requires a different approach than commissioning palliative care, where characteristics such as compassion are much more difficult to specify, observe, and measure. This immediately indicates that commissioning should be tailor-made, for specific health care sectors and contexts. Conditions like the definability, contractibility and measurability of the desired actions and outcomes are important in differentiating between different sectors.

Table 1. Types of health care provision

Type	Examples
Health goods	▪ Pharmaceuticals; equipment; supplies and devices used to promote or restore health or to provide diagnostic information.
Health services	▪ Health promotion activities, disease prevention, early detection, diagnostic procedures, curative treatment, rehabilitation and palliative care. ▪ Laboratory tests.
Non-clinical services	▪ Patient transport (ambulances), IT services, communications, catering, cleaning etc.

Source: Expert Panel, 2015a

In relation to Figure 2, some health care goods may be located towards the upper left corner, whereas certain health promotion activities for instance may be placed towards the lower right corner.

Moreover, for the commissioning process, it is also necessary to understand which specific problems should be solved / goals should be reached when commissioning from private providers. As indicated above, the increasing interest in contracting, new payment schemes and commissioning appears to be related by the desire to increase the efficiency of the health care system. This means that, even abstracting from the commissioning of *private* providers in particular, the attention paid to systematically selecting and incentivising providers is an important issue in health care. When it comes to commissioning private health care providers specifically (both for profit and non-profit), a number of general reasons may exist to commission these. Without being exhaustive and discussing elements like cultural, political or historical reasons, we discuss a number of these issues:

1) Lack of capacity within the public system

In cases of shortage of capacity (through shortage of personnel, shortage of knowledge, shortage of equipment or facilities), commissioning health care services from private providers may be a relatively quick (and sometimes cheap) way of increasing capacity. When public health care systems confront long waiting lists or an absence of specific types of expertise, private providers may fill those gaps. These private providers may be foreign suppliers of care in some cases (even foreign public facilities for that matter), which invokes issues surrounding cross-border care (EXPH, 2015b). Note that expanding capacity in such a way can also lead to excess capacity which may lead to difficulties for both public and private providers in the longer run. Moreover, hiring private capacity sometimes reduces public capacity (when private companies attract scarce personnel from the public sector), which could lead to a more expensive but not better system. Note that the greater the shortage of capacity in the public sector the greater the ability of private providers to obtain high prices in the commissioning process if there is not enough competition among private providers. Thus, some idle capacity in the public sector may serve as a bargaining device for getting better terms from private providers. Achieving the right balance between this situation and having excess capacity is not easy. Hence, before actually starting a contracting and bidding phase, the planning and evaluation phase should also address the feasibility and the benefits of expanding capacity.

2) Low productivity or high costs within the public system

In some settings public providers may be considered to have low productivity / efficiency or high costs. Under the right circumstances, commissioning, by introducing competition from private providers, may then lead to pressure on public providers to improve their performance. The commissioning of private providers then serves to make the market for public providers more contestable, ideally resulting in better performance of all actors.

It must be noted that such an instrument could work if the low productivity is real (not just a sentiment or strategic argument), the costs are unnecessarily high and performance can be improved by the public providers (as can also, for instance, be the consequence of regulations imposed by national policy makers or the market structure). Moreover, it needs to be ensured that the commissioning of private providers is done in such a way that a 'level playing field' is retained for private and public providers.

Moreover, when commissioning has, as its main goal, cost reductions, there may be a clear tension with quality goals. Only if costs are too high *given the quality standards* in the public sector and *only if* private providers can offer at least the same quality against lower costs, will this tension not exist. A too strong focus on costs can lead to problems with health provision and continuity of care (also due to bankruptcy of providers). Moreover, it needs to be assessed whether commissioning (private) health care providers will indeed lower costs. Sometimes, especially in the short term, transaction and transition costs may lead to higher rather than lower expenditures. More structurally, if the commissioning process is not well executed, introducing more providers through commissioning may lead to unnecessary activity, more expensive services, fragmentation of services and duplication of capacity, which may result in higher costs.

3) Low responsiveness and quality within the public system

The public providers may be considered to offer low quality, for instance through an insensitivity to specific patient needs and preferences. Incentives to be more sensitive to these aspects and to improve general quality may be lacking. This can be improved in many ways (e.g. by better monitoring and evaluation, by introducing payments related to performance or by having public providers compete), but also by commissioning private providers that offer a higher quality. Under the right circumstances, commissioning, thereby introducing competition from private providers, may create pressure on public providers to increase the quality of the care they provide. Again, commissioning of private providers then serves to make the market for public providers more contestable, ideally resulting in better performance of all actors. In this case, a policy to commission from private providers should be based on a clear analysis of the problem (i.e. to see whether commissioning from private providers is or even can be a solution) and the introduction of private providers needs to be done in a way that will really improve quality.

4) Increasing patient choice and innovation

Patient choice is an important policy goal in many health care systems. Patients should be able to choose those providers of care that they prefer and that best meet their particular wants and needs. Opening up a market to private providers may increase patient choice and diversity in health care delivery. A related issue is patient empowerment. Increasing patient choice and diversification of supply can lead to stronger patient empowerment. Patients ideally have the ability to

express their needs and preferences through being able to steer supply in the desired direction. This can also be done through patient organisations. Two different routes for patient empowerment can be distinguished in this context:

(i) patient empowerment through the functioning of the market, by increasing their choice of services. This takes place after the commissioning phase has determined which services can be offered.

(ii) through involvement of patients in the planning phase of the commissioning process, including the 'design' of the services that are commissioned. This empowerment provides patients with a direct influence on the definition of commissioned services and for instance the main outcomes on which to judge different providers. (Of course, issues of choices across different patient groups remain important as well, which requires balancing the interests of these different patient groups.)

Private providers may also be perceived to be more innovative. While one may argue whether this is a consequence of ownership or of incentives offered by the system, commissioning private providers may then stimulate heath care innovations, for instance through introducing new modes of health care delivery and interventions. It is important to note that aspects like payment systems and regulations also play an important role in innovation and the adoption of innovation in health care, which is true for both private and public providers.

Public providers may be less innovative due to the limited incentives they have for innovating. For instance, they may have difficulty in retaining any gain from innovations and may need to offer more standardised care (also to avoid complaints of discrimination). Contracting private providers may be a means to allow room for innovation by attracting heterogeneous providers who deliver health care in an innovative way.[8] This may lead to new modes of health care delivery, potentially better suited to meet the heterogeneous preferences of patients/citizens. If this aim is being pursued, the underlying contracts need to allow for this heterogeneity while ensuring quality (potentially by differential payment schemes). It must be noted here that innovation may result in lower costs but could also result higher costs (and health benefits) – in the latter case this may also require sensitivity in the payment system. The number of competing providers may also be important in this context. Innovative private providers may or may not succeed in successfully entering a market. When this is not the case, it

[8] Also because may be more feasible to see them fail in attempting a new mode of health care delivery or service.

may be relatively easy for politicians to let a private provider fail (i.e. go bankrupt or leave the market) in comparison to public providers.

These elements of the market, the service and the problem to be solved are all highly relevant in commissioning health care services from private health care providers. We emphasise that if a Principal decides to commission from private health providers using public funds, this does not imply that the Principal is no longer responsible for the outcomes and functioning of the health care sector. This responsibility remains intact, regardless of whether the provision of health care is commissioned from private providers. Moreover, whether it is justified to expect better performance from private providers per se (rather than for instance from introducing competition), should be examined in each case.

So far, we have used the term 'health care providers' to describe the Agents. It needs to be made clear that many different types of health care providers exist. Providers of influenza vaccines are different from providers of long-term home care, also because the underlying services are different. Such differences must be factored in to the decision of *whether* to commission specific services (from private providers) and *how* to do so. In the EXPH report on competition (EXPH report, 2015a), different health care sectors were highlighted where competition between suppliers might be more feasible than in others. These differences are relevant here as well (see pages 70-74 of EXPH, 2015a). As already highlighted above, commissioning is complex: long-term services require a different approach than commissioning the delivery of simple, homogenous products. When contracts are very long (20 or 30 years), commissioning can resemble Public-Private Partnerships. The EXPH report on that issue is also relevant in this context (EXPH, 2014d).

The Agent's goals may be more or less aligned with those of the Principal. If they are not intrinsically aligned, the contract and procurement needs to ensure this alignment, in the short and long run. This may involve aspects such as price, quality, scope of services and population served, as well as quantity. The difficulties in specifying and monitoring such contracts will be addressed below.

If a decision is reached to commission health care services from private providers, a number of important issues has to be dealt with, including:

- The market structure
- Legal aspects of commissioning
- Which providers to commission from
- How to commission
- Contracting aims and difficulties

These issues are addressed in the following sections.

1.2.3. Market structure

It is important to distinguish between commissioning new types of health care services and commissioning new providers in an existing market. The creation of a new market in general can be riskier, since quantities, qualities and costs are less predictable.[9] New markets often require specific investments, i.e., investments that a provider needs to make in order to enter the market and be able to provide the health care service in an adequate manner. This may lead to so-called 'hold-up problems' (e.g. Rogerson, 1992), in which both the contractor and contracted party are afraid of entering into a contract because they fear that the other party will have increased bargaining power. For instance, if a contracted private provider has made very high specific investments that cannot be recovered or sold outside this market, the contractor could pressure the provider to reduce prices. Similarly, if no other provider can deliver this specialised service, the contracted provider may pressure the contractor to accept higher prices or lower quality. Such situations highlight the need for careful design of contracts, including their length, arbitration and transfer of risks.

Commissioning is related to competition in the sense that a number of requirements for effective competition, including sufficient information (including on quality), sufficient suppliers, homogeneous goods and services are crucial in successful commissioning as well. The EXPH report on Competition between health care providers discussed this topic extensively (EXPH, 2015a).

If commissioning allows private providers to enter an existing market under predefined conditions e.g. payment systems, it is important to understand the existing market and

its features. For instance, if the existing market contains general, non-specialised providers of care and the payment structure is (implicitly) based on cross-subsidies between products or patients, new entrants may focus their activities on profitable services and/or patients. This 'cherry picking' or 'cream skimming' behaviour may subsequently result in high financial gains for the new providers and financial problems for existing providers who are left with non-profitable services and patients. This is an important issue that needs to be addressed explicitly. Moreover, if the tariff structure is inadequate, for instance resulting in losses from providing specific procedures at acceptable quality standards, commissioning private providers is not the answer to the real problem.

Entry and exit matter as well. If a market is relatively easy to enter and exit i.e. does not require very high investments from entrants, it is more contestable and this may lead to a different dynamic than when entry is very difficult. When commissioning in 'difficult to enter' markets, longer term contracts may be required. If exit is possible without great losses, there may be a danger of 'hit and run' providers who seek quick short-term profits and subsequently leave the market. In those cases, contracts may need to include enforceable clauses that make quick exits very unattractive, particularly in financial terms, for example, by posting of bonds to avoid the risk of exit via contrived insolvency. If barriers to entry exist, commissioning bodies may need to be careful to avoid too many existing providers exiting the market, since this may lead to new problems in subsequent periods of negotiations due to loss of knowledge/capital.

The number of providers in a market is important for several reasons. One is that having more providers in the market gives more bargaining power to the purchaser of care in negotiations and contracting. Dependency on one or a few providers, especially in a market in which entry is difficult, may lead to inefficiency (higher prices and/or lower quality) and an imbalance in bargaining. Here again, the dynamic situation also needs to be considered. If granting a first contract to one party, who will be the sole or one of the few providers of that service for a period, may create an imbalance in negotiations after the first period. The EXPH report on competition highlights several important aspects of market structure (EXPH, 2015a).

The structure of a market influences the conduct of actors on the market and therefore the performance of that market. A situation in which outcomes are unsatisfactory may sometimes benefit more from changing the structure of the market than from attempting to change behaviour. Specific market structures and rules may also attract specific

[9] This is not to say that commissioning in existing markets is without risk. Any commissioning requires careful consideration and investigation of the market. See also Textbox 7

providers to a market. For instance, a market in which profits are allowed to be distributed to private owners of providers may attract short term rent-seeking providers. Changing the responsibility for particular types of care from national governments or bodies to municipalities is another mechanism that can change the behaviour of all involved actors and therefore the functioning of the market.

1.2.4. Legal aspects of commissioning

In the current report, we have defined commissioning to cover the planning, purchasing and contracting of health services. Thus procurement of health services is one form of commissioning. Several legal aspects need to be dealt with when commissioning health services from private providers. It is important to understand the fact that the structure of the health care system interacts with the legal basis on which it operates. The difference between 'non-competitive' integrated health care systems (often funded with taxes) and those that have a more competitive 'market environment' (often insurance based), is also relevant. This difference in the structure of national health systems is also highlighted in the background section of this report.

The European Commission issued in December 2011 proposals to amend Directives that guide public procurement. The new Directives 2014/23/EU on the award of concession contracts and 2014/24/EU on public procurement were adopted by the European Parliament and the Council of the European Union on 26 February 2014.[10] The Member States have until April 2016 to transpose the new rules into national law - except with regard to e-procurement where the deadline is October 2018. The Directive 2014/24/EU defines *procurement* to be the acquisition by means of a public contract of works, supplies or services by one or more contracting authorities from economic operators chosen by those contracting authorities, whether or not the works, supplies or services are intended for a public purpose.

Concessions are partnership between the public sector and a (usually) private company. In a concession, a company is remunerated mostly through being permitted to run and exploit the work or service and is exposed to a potential loss on its investment. While public contracts were exhaustively regulated in the 2004 public procurement directives, those directives only partially covered works concessions and completely excluded

service concessions. These were only subject to the principles of equal treatment, non-discrimination and transparency in accordance with the TFEU. The lack of specific rules gave rise to practices that were not following the principles of the Internal Market such as the direct award of contracts without any transparency or competition.

Directive 2014/23/EU on the award of concession contracts was adopted to meet these challenges. It creates a new legal framework for public authorities and economic operators to ensure non-discrimination and fair access to markets and EU-wide competition for high value concessions. This gives the most efficient providers a fair chance of winning contracts by proposing the best offers.

Health services, as well as certain other services, that were previously listed as secondary (List B) services in the procurement Directives are now included fully under the rules of Directive 2014/24/EU. The Directive requires that any procurement of health services over €750,000 is advertised by way of a 'contract notice' setting out certain prescribed information, and that the award of the contract is advertised subsequently. Each country must legislate for the actual procedure to be followed between these two prescribed publications as it sees fit. This allows real flexibility to be introduced into the procurement process for health services, allowing processes to reflect local needs and context.

The new Directives will not affect the national organization of public services. Each Member State will continue to choose the way in which they organize their health services. Public authorities may either carry out their own public service remit using their resources or they may draw on an external body. However, the procurement rules may also limit the possibilities for co-operation between public bodies. The requirements of the article 22 of the Directive 2014/24/EU have to be fulfilled if a public contract between entities within the public sector should be left outside the scope of the procurement process. These requirements include the following criteria:

(a) the contracting authority exercises over the legal person concerned a control which is similar to that which it exercises over its own departments;

(b) more than 80% of the activities of the controlled legal person are carried out in the performance of tasks entrusted to it by the controlling contracting authority or by other legal persons controlled by that contracting authority; and

(c) there is no direct private capital participation in the controlled legal person with the exception of non-controlling and non-blocking forms of private capital

[10] Moreover, 2014/25/EU on procurement by entities operating in the water, energy, transport and postal services sectors was adopted.

participation required by national legislative provisions, in conformity with the Treaties, which do not exert a decisive influence on the controlled legal person.

Public funding to support the co-operation between bodies governed by public law and private providers may be seen as state aid that is distorting the competition in the field of health services (see EXPH, 2015a). This would cause problems for the funding of national health systems and for social policy in the Member States. The European Commission, in its Communication on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest[11] notes as follows: "*In the Union, the health care systems differ significantly between Member States. The degree to which different health care providers compete with each other in a market environment largely depends on these national specificities.*"

Member States can be classified into two groups. In some Member States, public hospitals are an integral part of a national health service run by the Government, and are almost entirely based on the principle of solidarity[12]. Such hospitals are directly funded from social security contributions and other State resources and provide their services free of charge to affiliated persons on the basis of universal coverage[13]. If the public hospitals are an integral part of a national health service, they are almost entirely based on the principle of solidarity.

The European Court of Justice has confirmed that, where such a structure exists, the relevant organizations do not act as undertakings[14]. Based on Article 107(1) of the TFEU, the State aid rules generally only apply where the recipient is an "undertaking". Whether or not the provider of a service of general interest is to be regarded as an undertaking is therefore fundamental for the application of the State aid rules.

Where the solidarity-based structure exists, even the activities that in themselves could be of an economic nature, but are carried out merely for the purpose of providing another non-economic service, are not of an economic nature. An organization that purchases goods — even in large quantities — for the purpose of offering a non-economic service does not act as an undertaking simply because it is a purchaser in a given market[15].

[11] http://ec.europa.eu/smart-regulation/impact/ia_carried_out/docs/ia_2011/c_2011_9404_en.pdf
[12] Based on the case-law of the European Courts, a prominent example is the Spanish National Health System (see Case T-319/99 FENIN [2003] ECR II-357).
[13] Depending on the overall characteristics of the system, charges which only cover a small fraction of the true cost of the service may not affect its classification as non-economic.
[14] Case T-319/99 FENIN [2003] ECR II-357, paragraph 39.

In the other group of Member States, hospitals and other health care providers offer their services for remuneration, be it directly from patients or from their insurers. In such systems, there is a certain degree of competition between hospitals concerning the provision of health care services. Where this is the case, the fact that a health service is provided by a public hospital is not sufficient for the activity to be classified as non-economic[16]. On the other hand, the Commission has outlined explicitly in its above mentioned Communication that "*An organization that purchases goods — even in large quantities — for the purpose of offering a non-economic service does not act as an undertaking simply because it is a purchaser in a given market*".

Health care services can thus be provided either as an economic or non-economic activity. This is the case e.g. in Finland (see Textbox 1), where health care is mainly financed through taxes and where health care is based on the principle of solidarity, but where private providers supplement public services. Public hospitals produce health care services but they can also acquire these services from other (public or private) producers. The private producers are undertakings and pursue economic activities. That, however, does not alter the character of the Finnish health care system. It currently operates according to the principle of solidarity, even when procuring services from private providers.

If health care services are provided as economic activity, the commissioning must take into consideration the state aid rules maintaining the transparency and non-discrimination in the Internal Market as well as the rules concerning public procurement.

[15] Case T-319/99 FENIN, paragraph 40.
[16] For example, Case C-244/94 FFSA, Case C-67/96 Albany, Joined Cases C-115/97, C-116/97 and C-117/97 Brentjens, and Case C-219/97 Drijvende Bokken.

Textbox 1: Finland

Finland: solidarity and commissioning

The Finnish health care system has for many decades, like the health care systems in the neighboring Scandinavian countries, been based on the solidarity principle. Everyone in Finland is entitled to adequate health care and social services. They are financed by taxation. At present, the municipalities are responsible for arranging and funding health care and they also collect part of the general taxes.

Primary health care is provided at municipal health centers. Special medical care refers to specialist health examinations and treatment that are carried out in hospital wards and clinics. Special medical care is performed in hospitals that are run by 19 hospital districts (that are joint municipal authorities). The hospital districts are owned by the municipalities in the area.

Employers are responsible for preventive health care for their employees and, where possible, also for nursing care. They may also arrange medical services.

Private health care services supplement municipal services. *Municipalities or joint municipal authorities may also procure services from private service providers, if they find them appropriate and useful or if the municipalities are not able to produce the services by themselves.*

The on-going reform of the social and health care service structure in Finland is aiming to ensure the quality, effectiveness and availability of services and to support the stability and sustainability of municipal economies. The reform aims to integrate primary health care and hospital services as well as health care and social services. They will be arranged by 18 regional authorities that will commission the health and social services from both private and public providers and non-profit organisations.

Hence, commissioning from private providers within a system traditionally based on solidarity, may affect the legal context of the health care sector and, subsequently, which regulations apply. It is important for national policy makers to be aware of this fact and the consequences this may have.

The legal status of contracts with commissioned providers is important as well. Textbox 2 highlights an example from the UK.

Textbox 2: Legal situation UK

The situation with regard to the legal status of contracts for the provision of health care in England has been evolving. Until 2012, NHS contracts were peculiar in that, unlike other contracts, they were not legally enforceable. Thus, Section 9(5) of the 2006 Act stated that an NHS contract must not be regarded for any purposes as giving rise to contractual rights or liabilities. As one commentator noted, "notwithstanding its name, an NHS contract is not a legal contract". ([1] http://www.weightmans.com/library/newsletters/2011/03/healthcare-march-2011/nhs-contracts/)

Instead, disputes were to be resolved by executive decision, by the minister. Rather surprisingly, this was never subjected to judicial review. Indeed, as one lawyer noted with regard to a penalty clause in the standard contract for hospital services noted, "It astonishes me that so far as I am aware since these provisions were introduced into the NHS Standard Contracts no provider, particularly no NHS foundation trust, penalised by the application of this provision, has challenged its legality." (http://www.hsj.co.uk/sectors/commissioning/commissioning-legal-adviser/penalty-clauses-and-the-rule-of-law-in-nhs-acute-services/5048561.fullarticle)

In 2012, the Health and Social Care Act was enacted as the legal basis of the NHS in England. The resulting architecture is extremely complex, now more so as innovative models such as that in Greater Manchester are being implemented that bear little resemblance to what most people felt was the initial vision of the Act. However, there are many ambiguities, such as the provisions on competition, which in theory set out the grounds on which a commissioner can avoid a competitive tender. As noted elsewhere, the legislation is internally contradictory in this respect. (http://www.bmj.com/content/346/bmj.f1733)

However, these ambiguities have led to fear of legal challenges among commissioners, even if actual legal challenges have been rare, although they have been mounted. (http://www.kentonline.co.uk/sittingbourne/news/legal-challenge-to-virgins-1284m-91885/) This is because the costs of responding to such a challenge, even if it never reaches the courts, can be enormous. (http://www.theguardian.com/commentisfree/2013/nov/15/competition-killing-nhs-bournemouth-poole)

1.2.5. Which providers to commission from

An important decision is which providers to commission from. On a general level, a Principal should preferably commission from providers that fulfil the requirements set out by the Principal and will / can be incentivised to behave in the way the Principal would like them to behave. The Principal has several options in pursuing this goal. Accreditation is one of them. This reduces the number of potential providers to those who fulfil specific

criteria e.g. in terms of expertise, employed professionals, quality standards, etc. In some instances, qualified (accredited) providers can deliver services against standard rules regarding payment etc. It needs noting that the use of the instrument of accreditation is not costless, as it can involve high (transaction) costs. Another option is commissioning. In this case, a specific contract is established between the payer and the provider of care. This allows a further specification of, amongst other things, what should be delivered, monitoring of costs and quality and the payment of the provider. Combinations of both instruments are also possible.

The commissioning body can decide which providers are eligible to participate in the commissioning process and receive contracts. In principle, this could be all possible providers, public and private ones (for profit and not for profit) and even those from abroad (Preker et al., 2000). However, it may well be that the commissioning body wishes to make the group of eligible providers smaller by for instance excluding foreign providers (i.e. these outside the EU) or even for-profit providers. This choice needs to be justified and legal, should suit the purpose of commissioning and needs to ensure a level playing field *within* the eligible group of providers.

Choices regarding admissible providers may also involve characteristics of the providers, including for instance specialisation, ability to deliver specific treatments, geographic area, having adequate quality control, disclosing particular types of information to the purchaser, etc. By making the requirements for potential providers strict the subsequent commissioning and contracting process may become easier. However, if the number of remaining providers is low, this may make negotiations more difficult and potentially leads to problems in power balance, likely to result in higher prices and/or low quality.

An important aspect is accreditation. Accreditation has several implications in the context of commissioning health care providers. If commissioning involves health care services for which the providers (at an individual and/or institutional level) require accreditation, this may help to ensure quality standards in the provision of health care and thus facilitate the commissioning process. Of course, this depends on the standards and quality of the accreditation process as well. On the other hand, strict accreditation may also make entry difficult as well as innovative modes of care delivery.

Textbox 3: Practical selection of providers in Sweden

When a County Council makes procurement according to the LOU (law on public procurement) or authorizes providers according to the LOV (law on freedom of choice) they have a possibility, and in some cases are obliged, to make demands on providers for them to qualify. If a provider does not meet the demands the provider is not accepted to participate in the procurement or to be authorized in a freedom of choice system.

Important criteria for being selected as a provider are the following:

- Financial stability and seriousness

  A provider will not be authorised if there is:
  - a low credit rating
  - no proof of financial stability
  - a problem showing a credible business plan at least for a two-year period
  - a current situation with tax and social security debts for the provider or those representing the provider
  - a history of tax debts or social security debts for the provider or those representing the provider
  - a history of involvement in bankruptcies for the provider or those representing the provider

- Quality

  A provider will not be approved if:
  - The Commissioner does not believe that the applicant can guarantee quality according to the demands, or if staffing will not meet with competence demands.
  - The Commissioner does not believe that the applicant has suitable localities and/or equipment.

- Follow-up

  A provider has to comply with a structured annual feed-back report. They are also required to report to relevant national quality registers, from which the Commissioner extracts comparative quality data.

Providers that no longer meet the criteria may voluntarily withdraw. The numbers of cases where providers are delisted from the accreditation are few. Four health care centres have lost their accreditation because of either systematic falsifications in invoicing or poor quality (mostly lack of permanent staff). The objective of the County Council is to evaluate all accreditations/contracts annually, but in reality they focus on certain areas like primary health care centres.

1.2.6. How to commission?

There are different ways of executing the phases of commissioning. This not only pertains to planning and evaluation, but also to purchasing and contracting. Optimal ways of finding and contracting providers need to be found. This involves a clear specification of the goals of the commissioning process and the services that providers will need to deliver. The latter may need to be very detailed in circumstances where a lack of specification could result in undesirable outcomes that cannot easily be changed as long as they are consistent with the terms of the contract.

The way in which eligible providers can compete for a contract is also important. This not only involves basic elements such as making known to all potential providers that a commissioning process is taking place, but also the mechanism by which they can solicit for a contract.

Several mechanisms exist. From simply contracting all willing providers on a standard contract, calls to provide new services (competition for the market – see also EXPH, 2015a), to tendering procedures, auctions or direct negotiations with selected providers. Such choices matter and should be made in the context of the care services commissioned, as well as the scale of the contract. Barros and Martinez-Giralt (2008), for instance, illustrate that the choice between contracting any willing provider (fulfilling some set of minimum criteria, including accepting a price previously announced by the Principal) and direct bargaining with potential providers will depend on the surplus that needs to be divided between the third-party payer and the provider. If that is high, contracting any willing provider is better for the third-party payer, whereas negotiation is better when the surplus is low. If competition is effective, the surplus in general will be low, if competition is not effective, surplus can be high. Market conditions and the specific services commissioned are therefore crucial in deciding on a specific contracting mechanism. While any willing provider has the price set by the contractor, and bilateral negotiation has both sides agreeing on a price, competitive bidding lets prices be determined by competition among providers. Below is an example from the Netherlands where competitive bidding was used in commissioning the supply of generic drugs.

Textbox 4: Competitive bidding for generic drugs in the Netherlands

On July 1, 2005 five large Dutch health insurers jointly started a competitive bidding process for three blockbuster generic drugs for ulcer disease, lowering cholesterol and preventing cardiovascular disease: omeprazole, simvastatin, and pravastatin. Their collective purchasing strategy was straightforward: for each of these generics, a supplier was preferred when it offered the lowest price at the reference date (July 1 and December 1 of each calendar year) or when its price was within a bandwidth of 5 percent above the lowest price offered by another supplier in that particular market. Due to the bandwidth, there was no restriction on the number of suppliers that could obtain a preferred provider status. Since these health insurers did not reimburse generics from non-preferred suppliers, their strategy entailed closed drug formularies for omeprazole, simvastatin, and pravastatin.

Initially, the price effects of the collective purchasing strategy fell short of expectations. Prices did not change and all but one of the generic suppliers of omeprazole, simvastatin, and pravastatin became preferred providers since their prices were less than 5% higher than the cheapest generic drug in the market. Only the original brand-name drugs were excluded from the preferred drug formulary.

By the end of 2007, however, things changed dramatically. One generic drug supplier, who newly entered the Dutch market, posted a price for simvastatin that was about 15% lower than what was until then the lowest price in the market.

Since all other prices were outside the bandwidth of 5%, as of January 2008 this supplier suddenly became the only preferred supplier for this generic drug. Subsequently all other suppliers of simvastatin reduced their prices even further. The fierce price competition led to a dramatic drop of more than 90% in the average price of simvastatin.

Replacing the joint competitive bidding process, in 2008 health insurers in the Netherlands started with preferred drug formularies for generic drugs on an individual basis. As a result of the increased price competition in the market for generics, prices for the ten biggest-selling drugs were structurally reduced by 76 percent to 93 percent (Boonen et al., 2010; Kanavos et al., 2011).

Source: EXPH, 2015a

The contracts typically should specify unit prices and volumes (potentially related: lower prices when volumes increase). They may also include specific arrangements related to monitoring input, throughput, output, outcome, quality and costs of the delivered services. This entails information disclosure by the contracted provider to the purchaser of care. This information can be crucial in (i) assessing whether the contracted services have indeed been delivered, (ii) whether the conditions in the contract were too lenient or stringent and (iii) whether renegotiation needs to take place. In general, the trade-offs between particular aspects (e.g. being more expensive but delivering better quality) are difficult.

The possibility of renegotiation is an especially important feature of long-term contracts (see also EXPH, 2014d). Note that dispute settlement and arbitration, which should also be agreed upon in the commissioning process, are different from renegotiation. As stated in the context of PPP's: "… *contracts need to be assessed on several criteria related to renegotiation: 1) who can initiate a renegotiation (usually both sides)? 2) how is the renegotiation organized? … 3) does the public side have the right to impose the change and is the value of it determined by some rule, or does the private side have the right to refuse it until a price is agreed? These rights determine the bargaining power of each side and may influence the costs of renegotiation to the public side. Often renegotiation triggers and rules are specified with relation to financial aspects … but a broader view is required*." Below we further highlight contracting aims and problems.

A very important, if often overlooked, issue is the difference in power on either side of the commissioning process. This also needs to be considered in the decision on how to commission. There can be vast differences in power between national, regional or local authorities and those from whom they commission certain services. Likewise, commissioning from a small local provider providing, for example, niche services for a particular client group, is clearly different from commissioning from a multi-national corporation providing health care globally. Unless the commissioning process is carefully designed, the former may be seriously disadvantaged because of the high cost of preparing tenders, the cash flow vulnerability arising from losing two or three tenders in a row, difficulties in raising performance bonds (i.e. a safety bond or guarantee issued by an insurance company or bank), etc. Large providers may be reluctant to provide packages tailored to local needs if the incentives to do so are lacking and the contract is not sufficiently detailed. Hence, the optimal scale of commissioning also needs to be determined.

Finally, choices as to the 'size' of contracts in the commissioning process (i.e., whether to grant one big contract or several small ones) have consequences. While smaller contracts may reduce the risk per contract, it may increase coordination costs and risk of reduced quality of care if one party can affect the quality of a full care chain.

1.2.7. Contracting aims and problems

Chalkley & Malcomson (1998) provide an important overview of contracting in health care. They write *"A key issue in contracting for health services is how to design contracts to induce providers to supply appropriate standards of service while keeping costs down."* They also acknowledge that contracts cannot specify all relevant aspects in such a way that the Agent will necessarily do everything in the best interest of the Principal: *"This issue cannot typically be resolved by specifying everything in a contract because, realistically, contracts are rarely able to specify in detail all the different elements that comprise a 'standard of service' in a way that is enforceable, nor is it easy to verify what measures a provider takes to keep costs down."* As they indicate, in this context, contracting relates to multitask agency (Holmstrom and Milgrom, 1991). This highlights the need for careful selection of providers, i.e. those who are or can be aligned with the general values and objectives of the principle.

Chalkley and Malcomson indicate several important aspects that need to be managed through contracting, including: (i) inducing appropriate quality levels at reasonable costs in the presence of information asymmetry, (ii) appropriate payment systems, (iii) monitoring performance, (iv) appropriate length of the contract and (v) importance of relational contracts given inevitable incompleteness of contracts. We will highlight these issues, as well as some additional ones below.

(i) Quality at reasonable costs

Contractually specifying appropriate quality levels is important, albeit often difficult (see point iii). When reliable indicators of quality and performance exist, these may be used to define appropriate quality levels (average and variation therein) expected from the health care provider. The costs of providing services, as distinct from the price paid for them, may be difficult to observe for the purchaser. This may be countered by contractually requiring openness regarding cost structures of providers. This need not necessarily result in lower costs. Providing incentives to keep costs low and quality high through the contract and payment system therefore remains important. Again, trade-offs between the two are typically difficult.

(ii) Payment system

In commissioning, the payment system can often be considered as being endogenous. That is, in principle it can be defined and tailor-made *within* the contract, in order to best

incentivise the providers of care to perform optimally. This is important, since it is well-known that different types of payment schemes have different effects on the behaviour of health care providers (Ellis and Miller, 2009; Langenbrunner et al., 2009) and that, as highlighted in the EXPH report on Primary care (EXPH, 2014b), no single payment system (e.g. capitation payment, fee for service, etc.) is capable of achieving all the potential goals.

Chalkley and Malcomson (1998) highlight the importance of mixing prospective payments which give a strong incentive to keep costs as low as possible with cost sharing (sharing the costs between the provider and payer under particular circumstances) arrangements, as these can lower average costs. Cost sharing allows risk sharing when costs, for instance for some patients, can be exceptionally high, but also to share potential savings. As Chalkley and Malcomson (1998) acknowledge, cost sharing "*… of course, reduces the incentive for the provider to keep costs down but, at the margin, it is worth relaxing that incentive a little in order to ensure, on average, less surplus to the provider.*" It can also reduce undesirable avoidance of more costly patients. Chalkley and Malcomson conclude that "*Only if the purchaser has full information about costs, or it is simply too expensive to monitor the actual costs incurred, is it optimal to make payment purely* prospective." Textbox 5 gives an example of payment models used in commissioning contracts in Sweden.

Textbox 5: Payment of commissioned providers in Sweden

There are four main types of payment models used in commissioning contracts in Sweden:

1. Budget allowances (fixed and prospective)
2. Capitation (Population-based, fixed and prospective)
3. Fees based on DRG: s or care episodes; bundled payments. (Activity based, prospective)
4. Fee for service (Activity based, retrospective)

The different types of payment models are often used in combination with result-oriented bonus schemes; based on quality or care indicators or health outcomes. In some cases poor performance, including non-compliance with reporting of data, is punished with withholding some of the payment. Including costs for potential later complication in the fee is a way to create incentives for prevention and optimal patient management, as well as incentives for innovation.

Effects of different models.
All reimbursement models have both positive and negative effects for different objectives. Fixed budget allowances give a good cost control for the payer, but gives low incentives for a high volume and productivity improvements. The opposite goes for activity based reimbursement, where there are incentives for increasing volumes and productivity, but where the financial risk is with the payer. For bundled payments like DRG, there are incentives for optimizing the costs per treatment episode.
Budget allowances and capitation fees carry the risk of sub-optimization, for example referral of complicated patients to other caregivers and/or to keep long waiting lists. This could be mitigated by freedom of choice for patients to select providers with a preferred way of practice. Fee for service pay for performance models can create an incentive to select less complicated cases.

Empirical evidence shows that manipulation of payment systems can be a problem if you do not have control systems in place. Systems for collecting and reporting the relevant payment data must be reliable and open to audit. It is recommendable to use more complex reimbursement systems, like value-based reimbursement, in treatment areas where volumes and costs are large. The potential benefits with more sophisticated management tools are greater in these cases. For simpler case-groups and also for the more complex and heterogeneous patient groups more traditional reimbursement systems are suitable.

Incentives for innovation can be created if a payment model is developed on value-based principles and payments are linked to outcomes.

Case study in outcome based payment
Bundled payment for spinal surgery to authorized providers (patients' freedom of choice) was introduced within the Stockholm County. The accredited providers receive a bundled payment linked to the patient's health outcome. The bundled payments also include a cost responsibility in case of potentially avoidable unwanted events, a so-called complication guarantee clause.

The payment structure consists of a prospective part that is supposed to cover expected treatment costs, including potential complications, combined with an individual case-mix adjustment. A retrospective payment is made one year later, based on data from the Quality Register SWESPINE, including the patient's self-assessment of outcome compared to their situation before treatment.

New models of payment, that link payment to performance (outcomes) – as also illustrated in the Textbox above, should be considered in the context of commissioning (see also EXPH, 2014b). These models link the payment of providers to the performance that they demonstrate. Thus, there may be a direct incentive to focus on final outcomes rather than availability, inputs, throughputs or output.

However, despite the growing interest in pay-for-performance (P4P) schemes, the evidence that they are effective in improving performance is lacking (Eijkenaar et al., 2013). Eijkenaar (2013) reaches an important conclusion with respect to P4P program design and implementation that may also be useful in the context of commissioning health care services (summarised in Table 2).

Table 2: P4P design and implementation

What to incentivize

- Performance is ideally defined broadly, provided that the set of measures remains comprehensible
- Concerns that P4P may encourage "risk selection" and "teaching to the test" should not be dismissed
- Outcome and resource use measures should only be used with adequate risk adjustment and sufficient sample size
- In addition to risk adjustment, other strategies to mitigate incentives for risk selection may still be necessary
- Measure sets should at least incorporate "high-impact" measures. The less technical / more indeterminate aspects of care such as patient satisfaction and continuity of care are ideally also included or at least regularly monitored
- P4P incentives should be aligned with professional norms and values; it is therefore vital that providers are actively involved in program design and in developing, selecting, and maintaining the performance measures
- Monitoring, feedback, and information technology are important in preventing undesired provider behavior

Whom to incentivize

- Group-level incentives will typically be preferred over individual-level incentives mainly because performance profiles are more likely to be statistically reliable as a result of larger numbers of patients
- Individual-level or small-group incentives as well as using measures with small available samples sizes will become increasingly feasible as methods for constructing composite performance scores continue to evolve
- One should be cautious with applying schemes incorporating both individual- and group-level incentives
- Participation is ideally voluntary provided that broad participation among eligible providers can be realized

How to incentivize

- Whether rewards or penalties should be used is context-dependent. Offering providers a choice among schemes also including penalties may be a viable option
- Although increasing the size of the incentive increases its strength (up to a certain point), relatively low-powered incentives are preferred, provided that providers' opportunity costs of improving performance are covered
- Provider-specific absolute performance targets and/or a uniform series of absolute targets, possibly combined with piece-rates for each appropriately managed patient, are preferred over single targets and relative targets
- The time lag between care delivery and payment should be minimized
- P4P should be a permanent component of provider compensation, and is ideally decoupled from base payments
- Performance measures should be reevaluated periodically and regularly be replaced or updated (as necessary)

Source: Eijkenaar, 2013

These conclusions point to several important issues, also relevant for the context of commissioning. For instance, in the context of evaluating the performance of different commissioned providers in terms of costs and quality, knowing (and correcting for) the case-mix of patients can be very important. To illustrate, if specific providers attract more severe patients, this may affect both costs and outcomes. Moreover, to make sound judgements, one typically requires sufficient numbers of patients receiving

particular services. Providers should be involved in the design of performance measures and the performance measures should be evaluated periodically (and improved where necessary).

(iii) Difficulty in monitoring quality

A classical difficulty in health care is the difficulty of measuring quality (EXPH, 2014a). If quality is not readily observable, this may lead to undesirable conduct of providers and hence suboptimal performance. For instance, if prices are fixed in a contract, (unobservable) quality of care may be lowered in order to reduce costs and therefore increase profitability (Gaynor et al., 2012). This risk needs to be addressed in the context of commissioning health care services in any context, but potentially even more so when contracting (profit seeking) private providers.

Difficulties in defining, measuring and monitoring quality may also lead to an undue emphasis on price in commissioning processes. Obviously, this may in turn have detrimental effects on quality of care when the choice is being made for low price providers of care.

If quality is difficult to observe by the purchaser, but experienced by users, patient choice could potentially proxy quality measures (Chalkley and Malcomson, 1998). However, there are many challenges in measuring patient satisfaction and they are not necessarily aligned with optimal health outcomes. Monitoring quality (and costs) can be difficult and costly. Hence, it must be decided which type of monitoring is feasible and cost-effective in particular contexts.

Quality indicators hold the prospect of improving the performance of providers (EXPH, 2014a). Such quality indicators need to be carefully selected. For instance in Sweden, these indicators play an important role in the commissioning process. Providers may change their behaviour in relation to particular contracts. For instance, if contracts focus on particular aspects of quality (quality indicators), the focus of providers may shift to the selected quality indicators, reducing efforts to achieve those aspects that are not measured and captured in indicators (which may, nonetheless, be very important). This emphasises the importance careful design of contracts and definitions of quality, as well as monitoring their consequences and behavioural impact (McKee and Clarke, 1995).

(iv) Duration of contracts and relational contracts

The determination of the optimal duration of contracts is not straightforward. If contracts are too short, it may be difficult for potential entrants to justify investments required to provide particular health services, because of the risk that they will not be in the market long enough to recover these. Moreover, with short contracts, the transaction costs of new rounds of contracts and commissioning may be high for both the contractor as well as the contracted party. Too long contracts may lead to undesirable actions and situations where the contracted provider 'hostages' the market. It must be noted that the contract can be specified in such a way that, in case of undesirable behaviour, the contract can be terminated, even though the term of the contract has not yet ended. Hence, it is crucial that potential (benefits and) threats of contracting (private) providers are recognised up front and where possible dealt with in the contracts.

The optimal duration of a contract is context-specific. Long contracts can be granted where there are high investments in specific assets (e.g. hospital care). In Sweden, for instance, the St. Göran hospital in Stockholm was granted a seven-year contract, which recently was renewed as a ten year contract, although there are also alternative options such as franchising management (see Textbox 6). For other types of care (e.g. GP care), contracts with a duration of for instance 1 year may be more appropriate, but needs to be determined by also considering aspects like transaction costs, longer term investments, plannability of care and long term relationships. It needs noting that after such contracts end, they may well be renewed under similar conditions. The duration of the relationships between contractors and contracted parties may far exceed the duration of the contracts. In general, if specific investments for the contracted party are high, longer contract durations may be required. If contracts are long and require specific investments, commissioning may come close to public-private partnerships (EXPH, 2014d). Again, incentives must be provided that align the private health care provider with public health system goals. In this process, especially when it concerns non-standard, long term commissioning, contact between the contractor and potentially contracted parties, discussing these issues in order to come to workable contracts may be required.

Textbox 6: Case study St Göran Hospital

St Göran Hospital is one of seven emergency hospitals in the Stockholm County. It is the only hospital operated by a private provider.

St Göran was created as an independent publicly owned and operated company in 1994. The operation of the hospital (not the ownership of premises) was procured the first time in 1999. The contract was renegotiated with the same provider in 2005 and a new procurement was finalized in 2012 with the same provider. The provider has two contracts with the public payer, the Stockholm County Council (SLL): A contract on emergency and elective specialist care and a rental contract for the premises with the same time frame.

In 2010 when the last procurement process started, the production volumes of the hospital was 27,000 inpatients (85% emergency cases) and 155,000 outpatients visits (27% emergency cases). The contract was supposed to be revised and expanded during the contract period of 10 years due to the population increase in the Stockholm area. Before the political decision in 2010 on the new procurement, an analysis was made on the experiences so far of having a private provider operating the hospital.

Six reasons were given to continue with a private provider instead of turning it back to be a public provider:

1. The hospital was considered to have a leading role in developing "process quality" in emergency care and served as a source of inspiration to other emergency hospitals in the region. It had been awarded, together with another hospital, the ´Swedish Lean-award` in 2010.
2. In the National Quality Register SWEDEHEART they came out as number 1 in Sweden in managing Myocardial Infarction.
3. They had proven to be good at production management, by adapting produced volumes to contracted volumes in spite of big fluctuations in the demand for emergency care.
4. They had excelled in developing their DRG-registration, thereby giving a more sophisticated description of their health care production.
5. They had been able to keep a price/DRG advantage over the public hospitals.
6. Good scores on patient satisfaction and accessibility.

An extension to a ten-year contract was considered reasonable due to the fact that it is a very complicated and resource-consuming procurement both for the Commissioner (SLL) and for the bidders. Another reason for this long contract period was the projected growth of emergency care and new investments in the existing hospital structure, which would benefit from stability in the provider structure.

Additional reasons for the "success" of this public commission of a very sophisticated and high volume service may have been that the hospital was established as a well functioning provider before it was taken over by a private provider, and the culture of public service, which was established and developed by the private provider. Continuous follow-up during the contract period may also have contributed to alignment of values, objectives and expectations.

Risk

The issue of risk is strongly related to the issue of duration of the contracts. Both the contractor and the contracted party take risks by entering into a contractual arrangement. In this context, it is crucial to determine who bears what risk and what the appropriate way of dealing with these risks within the contracts is. For instance, the contractor (e.g. some public health authority or insurance company) faces the risk that the contracted party does not deliver the health services in the way the contractor intends. For instance, the costs may be higher than expected (if the price is capped in the contracts, this may be due to higher volumes) or the quality of services may be lower than expected. Note that quality is typically more difficult to define contractually than price (and less easily observed). Other types of risk include discontinuity of care if a contracted party leaves the market (e.g. due to bankruptcy) or coordination problems (e.g. different commissioned parties in one 'patient pathway' not cooperating effectively). The contracted party is also at risk. For instance, the costs of delivering the agreed services may be higher than expected and even higher than the price (see Textbox 7). A crucial aspect to consider in commissioning therefore is the transfer of risk, both in the short and longer run. Such risks need to be identified and included both in the decision *whether* to commission from private providers of health care, as well as *how* to commission.

Textbox 7: Private commissioning of a childbirth clinic in Stockholm

Background
Women have a choice of which hospital to deliver the baby since 1994, but the only alternatives were the different public providers. From 1 January 2009 it is possible for private providers to apply for accreditation to provide delivery services.[17] However, since this is a complicated service there had been no commissions until march 2014, when Stockholm County Council decided to commission delivery services from a private provider. The volumes of deliveries in Stockholm County have been increasing and reached a total of 29300 in 2014.

The commissioning
The cooperative company Praktikertjänst AB, owned by dentists, doctors and other health care personnel, decided to enter the market and was accredited. They designed a clinic with a planning volume of 3600 deliveries, a planned market share of about 12 per cent.

The contract
The accreditation specifies in detail the resources needed for acute care[18] and neonatal intensive care.[19]

[17] http://www.vardgivarguiden.se/AvtalUppdrag/avtalsinformation/Vardval-Stockholm/Forlossning/
[18] http://www.vardgivarguiden.se/avtaluppdrag/avtalsinformation/vardval-stockholm/forlossning/dokument/standard-for-resurser-inom-intensivvard-och-anestesi/
[19] http://www.vardgivarguiden.se/avtaluppdrag/avtalsinformation/vardval-stockholm/forlossning/dokument/standard-for-resurser-inom-sluten-neontalvard/

For acute care:
Specialists in anesthesia and intensive care with competence in obstetric anesthesia (direct access) and back up (30 minutes)
Specialist nurses in anesthesia and intensive care with competence in obstetric anesthesia (minimum 2 persons) and neonatal care (number dependent on number of capacity for neonatal care)
Operating room (direct access)
Acute cesarean section should be available within 15 minutes) plus back up
Post-operative care for mother and child and access to intensive care.

For neonatal intensive care:

- Specialist pediatrician (direct access)
- Specialist anesthesiologist (direct access)
- Neonatal specialist (30 minutes)
- Neonatal nurse specialist (30 minutes)

Payment was structured as a fixed price of 38.578 SEK per delivery. 2 % of this price was withhold, and paid later of agreed quality indicators were achieved.

The result
After roughly two years the clinic will be closed at May 31, 2016 at the request of the provider. The contract specified a 6 months notice period for closing, but the agreement with the purchaser was to close after 3 months. The main reasons for the closing down are severe financial loss; a total deficit amounted to 180 million on a turnover of 320 million SEK. The losses are explained suboptimal volumes, 3000-3300, combined with much higher than expected costs for rent of the new build premises, and for payments to specialist doctors needed as back up for complicated cases. To be accredited they had to have neonatal competence stand by 24 hrs and they had evidently no chance to hire all that competence, as they were not part of a full-service hospital. Therefore they had to enter very expensive agreements to secure the quality standards in the contract.

What can we learn?
The objectives for delivery services are to have a sufficient capacity to meet demand, and to deliver services of high quality responsive to preferences from the customers. The specific objective for private commission was to provide additional alternative for choice, while at the same time add capacity for an increasing number of deliveries in Stockholm County.
Building capacity is a long-term investment. The private provider had to make significant investments to start the service, and then faced the challenge to gain a share of market high enough to fill the capacity. With a payment per delivery, the provider carried the financial risk. An alternative payment model would have been a combination of a fixed budget and a payment per delivery, and quality indicators. That would have created a better balance between payer and provider. This would have given the provider higher revenue during the period it takes to enter the market and gain a sufficient market share.
The contract specifies in detail what resources are needed to fulfill specific quality criteria related to availability of intensive care and specialists in obstetrics. This is costly, but necessary also for attracting expecting mothers to choose the private provider. There are obvious potential advantages to locate a delivery clinic within a hospital with these services available. It may also be so that public clinics do not pay the full cost, but rather the marginal costs for use of these services. This cost and payment issue was not worked out in detail before the commissioning was started.

For a new provider the perception of quality is important since there is no historic record to rely on. There was a critique from medical specialists during the planning of the commission, and the occurrence of one death during the first year could have contributed to the perception. Perceptions of safety are very important and may have contributed to the suboptimal volume, even if most customers have been very satisfied with the service they have experienced.

An important feature of contracts therefore is how risk sharing is arranged. This is similar to what was discussed in the EXPH report on Public-Private Partnerships: "*… evaluate how much the risk transfer contributes to the objective of providing the necessary incentives to achieve the objectives*." This needs to be judged against the cost of the risk transfer. "*The usual presumption is … that cost savings and value from doing the project on time and without cost overruns are large enough so that they can pay the risk bearing by the private contractor and provide higher surplus to all participants...*" (EXPH, 2014d). If risks for the private party are capped (and thus remain with the public sector), the public sector needs to be compensated for this (for instance by lower prices). Textbox 8 provides an example from the UK.

Textbox 8: Risk sharing: the example of Hinchingbrooke Hospital

Hinchingbrooke Hospital is a district general hospital in the East of England. It was the first NHS hospital to be franchised to a private company, Circle Health, in 2011. Circle was given a 10 year contract to manage the hospital but, a year later, the hospitals financial situation worsened and Circle received a £4 million advance on its fees to ease cash flow problems. By the end of 2012 a National Audit Office report found that losses were significantly greater than planned and noted that the NHS, when judging the proposals, had not fully considered the risks involved, thereby tending to encourage overoptimistic bids.

The hospitals financial situation continued to deteriorate and, in 2014, the chief financial officer resigned. In January 2015 Circle Health withdrew from the contract, arguing that it was no longer viable under the current terms of the contract. However, the same day, it was revealed that the Care Quality Commission had recommended that it should be placed into special measures following a rating of "inadequate" on the questions of whether it was caring, safe, and well led. A subsequent review assessed it as the second least efficient hospital in England.[20]

The contract attracted widespread criticism at the time, on several grounds. First, Circle Health was presented as being similar to a well-known employee owned UK company even though its ownership structure was quite different, with the staff having very limited decision-making power. This was at a time when the UK government was emphasising the potential role of mutual organisations in delivering NHS contracts, even

[20] http://www.hsj.co.uk/topics/finance-and-efficiency/revealed-trusts-estimated-savings-potential/7001364.article

though, in reality, the process was being dominated by large multinational corporations.[21] Second, Circle Health's losses were capped at £7 million, a sum that would have been exceeded in the first nine months of 2014-2015, even though some commentators had expressed concerns about its viability from the outset.[22] This left the taxpayer exposed to subsequent losses, something heavily criticised by the House of Commons Public Accounts Committee.[23]

Commissioning from private providers who have to raise finance from the banking system deserves a special note. If the risks for these providers are high, they may be required to compensate their financers (banks or other institutions) by means of high interest rates, which may translate into high prices. Lowering the risk for the provider may lead to lower prices, but, at the same time, weakening incentives in general. Financing matters therefore (EXPH, 2014d)!

Short versus long term considerations

In commissioning (private) health care providers long term and short term goals must be balanced by the purchaser of care. For instance, it may be very attractive in the short run to contract low price providers of specific services, but this is not necessarily the best option in the long run. To illustrate this:

a. Providers may use predatory pricing to gain a high market share. After this high share is obtained (and other/old providers are pushed out of the market), prices are increased or quality standards lowered. If (re)entry of providers is difficult, this may lead to higher prices in the longer run (excessive rent) or lower quality in the longer run (health risks).

b. Entrants may set prices optimistically in order to gain market access. If these prices are not sufficient to cover costs, entrants may go bankrupt which can seriously affect the continuity of care (See Textbox 9 below).

c. When the provider needs to make specific investments to meet the specifications of the payer to provide the service, there may be problems in later phases of the contract or relationship. The provider may fear that such investments can be "expropriated" by the contractor through lower future prices, as the other side to excessive rents to private providers.

[21] http://www.bmj.com/content/349/bmj.g5150
[22] http://www.bmj.com/content/347/bmj.f4898
[23] http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-circle-withdrawal-from-hinchingbrooke-hospital/

Likewise, the contractor may feel that they are held hostage by one specialised provider and may not see alternatives to extending the contract if other providers cannot easily take over the market (after some time).

Procurement strategies therefore have to balance risk of too much competition today leading to exit of providers and become hostage of private providers in the future if entry is not easy – 'dynamic efficiency'.

A similar issue may arise when new private providers create and to some extent may duplicate infrastructure and capacity of the public providers. While this may lead to additional costs in the short term, in the longer term this could improve. This could either be through reducing the public capacity, or in fact, if the private providers do not outperform the public providers, by reducing private capacity. Duplication of capacity can therefore, even though sometimes expensive, also lead to more options for the commissioning bodies, including reversals of public to private provision, and better bargaining positions.

Textbox 9: Pricing of health services can be too low

Following a competitive tender, SERCO was awarded a contract for out of hours general practice in Cornwall, UK. However, an inspection by the regulator, the Care Quality Commission, found multiple failings, many arising from a failure to recruit adequate staff. Seven general practitioners were working for up to 13 hours a day, with an increased number of complaints about the service. SERCO had failed to train all staff in protocols for safeguarding vulnerable patients, with staff describing statutory staff training as 'hit and miss'. The company also admitted to falsifying records (http://www.theguardian.com/society/2012/sep/20/serco-nhs-false-data-gps).

There was also no effective system in place to monitor the quality of service that patients received. These criticisms led to SERCO withdrawing from the contract, leaving local general practitioners to step into the void (http://www.gponline.com/cornish-gps-back-out-of-hours-serco/article/1333705).

Following major failures in delivering a contract for community services in Suffolk, UK, SERCO decided that the contract was not profitable and withdrew prematurely (http://www.bmj.com/content/348/bmj.g1167).

The same fate befell a third contract, at Braintree Hospital, Essex, UK (http://www.nhsforsale.info/private-providers/private-provider-profiles-2/serco.html).

In each case concerns had been raised at the outset about whether the price being offered was viable and the commissioners were forced to launch new and expensive retendering exercises.

Commissioning private health care providers may involve complex and incomplete contracts, i.e., contracts that cannot completely specify all relevant (current and future) matters. Important aspects include asymmetric information and uncertainty regarding future external factors. This may result in hold up issues, as indicated above. This is especially the case in the context of "relation-specific" investments; investments that are specific for this particular contract but cannot be made to create value elsewhere. In such cases, longer-term contracts may be necessary to allow the provider to regain these specific investments. These often introduce new uncertainty and risk due to their duration. For relation-specific investments, arrangements sharing such investments or the involved risks, for instance splitting ownership and use of facilities, can be considered as a means of agreeing optimal contracts and overcome hold-up problems.

Explicit treatment of power asymmetries and power balance between the parties in contracts is important. Moreover, it must be determined beforehand how providers will be held accountable should they not provide the care expected or required. This may include limiting the transfer of profits over a specific period of time. This means that the contracts may need to be based on a clear vision of not only the short term, but also longer-term situation.

Long-term contracts can thus have advantages and disadvantages. Long-term contracts can potentially increase the continuity of care and lower transaction costs in the commissioning process. They may also lead to undesirable behaviour of the contracted party (if the contract does not contain means to address this). Moreover, the health care and political context may change during the contract, which can, potentially, require new contracts and conditions. Here, renegotiation is again important, as well as establishing a relationship between purchaser and provider that makes it possible to address changing context and understanding of the separate and mutual interests of each party.

Balance

The balance of positive and negative aspects of (increasing) commissioning private health care providers needs to be compared to that of purely public contracting or the current situation. In many instances, this process may entail attempting to find the optimal balance between public and private provision of health care. It needs noting that both markets and governments can fail. In a purely public system, inefficiencies and perverse or misaligned incentives due to imperfect contracts and soft budget constraints (i.e., hospitals have budgets but governments will bail out hospitals that do not manage

to balance costs and benefits) may exist.[24] Interestingly, Wright (2016) recently not only showed the welfare and behavioural implications of soft budgets in public hospitals, but also that the introduction of a private hospital reduces the size of any 'bailout' and increases welfare. Other potential problems include the possibility that, where there is a lack of competition, public providers may become relatively irresponsive to heterogeneous preferences of patients. Hence, one may feel that one could strive for an optimal mix of public and private providers of health care.

Commissioning private health care may have benefits but also has costs. Depending on the structure of the market these costs can be high. Next to the process of negotiating and designing the contracts, the process of signing and renewing contracts can be costly (Ashton et al., 2004). For instance, in the Netherlands, where contracts between insurers and GP practices are required, transaction costs of contracting can be (perceived as) very large or the feeling of real negotiations quite low. This is not only the case in terms of the contracting process, but also in terms of the follow-up (including billing, administrative duties, monitoring quality, etc.). These costs need to be set against potential benefits of commissioning.

Private and profit?

Most of the issues stated above are equally valid for commissioning from public or private health care providers. Nonetheless, some specific issues with private providers need to be acknowledged. First of all, the goals of (for profit) private providers may be different from public providers. If making a profit is an aim (potentially amongst many), this may (but need not) lead to particular types of behaviour, potentially not in line with the goals of the public health care system. Second, ownership structure of a private health care provider should be analysed. Specific forms of ownership may be expected to give rise to rent seeking behaviour, which needs to be factored in the process of commissioning and balancing expected costs and benefits from commissioning. A third issue is the financial status of private providers. It is important to ensure that contracting takes place with sound and stable partners, following adequate due diligence, especially when continuity of care depends on their presence.

An important and societally potentially sensitive issue is whether and under which conditions to allow the distribution of profit made by private providers. In The Netherlands, for instance, this is currently the topic of much debate in the context of hospital care (Plomp et al., 2013). Letting profit flow to private parties is sometimes seen as 'leakage' of public money to private entities. If profit margins are high, this may signal

[24] It needs noting that aid to private hospitals that are in financial problems can also occur.

forms of market failure, excess possibilities to make high profits (e.g. selection of patients) or simply an improved efficiency of new entrants. In the latter case, the efficiency gains could be distributed more evenly in the future and be of benefit to all parties involved. 'Hit and run' profit seeking should be avoided as much as possible, for instance through contractual arrangements indicating periods of time after which profit may be distributed or claw backs in case of exits.

From theory to practice

Given the above, which stresses the context dependency of optimal commissioning procedures and outcomes, the practice of how to commission is crucial. The next paragraph highlights some experiences in that respect (without in any way attempting to be exhaustive).

1.3. Practical considerations

In this section we will give some further insight into practical considerations that arise in commissioning, drawing on some examples from different European countries. A complete overview of European experiences is difficult to provide, since there are no systematic sources monitoring the extent to which private providers are commissioned within the EU, let alone systematic evaluations of the successes and failures in this respect. This underlines the need for European countries considering (expanding) the role of commissioning of (private) providers in their health care system to optimally prepare themselves for this policy change and to learn from other countries' experiences.

It is uncommon to have completely publicly operated health care systems. But in certain subsectors this may *de facto* have been the case hitherto. In such cases, when starting to commission from private health care providers, it is important to be clear about the expected impacts of doing so. A checklist may help in this respect. We provide an example below.

Textbox 10: An example of a checklist for commissioning

1) Specify the main reasons for and expectations from commissioning.

2) Is private commissioning expected to lower costs?
   If yes, explain why (i.e. the mechanism for lower costs)

3) Is private commissioning expected to deliver higher quality of care?
   If yes, explain why (i.e. the mechanism for higher quality)

4) Is private commissioning expected to deliver more innovation?
   If yes, explain why (i.e. the mechanism for more innovation)

5) Is private commissioning expected to deliver higher quantity / better availability of services?
   If yes, explain why (i.e. the mechanism for higher quantity/better availability)

6) How will private commissioning affect competition between providers and provision of care by incumbents?

7) How does private commissioning affect coverage of the population for the services included?

8) How does private commissioning affect the breadth of services to the population?

9) How does private commissioning affect the financial protection of the population relative to the included services?

10) Were patients involved in the commissioning process and how will commissioning affect their choice options?

11) How long (in months) does the contract with private providers need to be in order to recover specific investments by the private party?

12) What are the main risks of commissioning private providers from the perspective of the payer, patients and private providers? (Include short term and long terms issues and aspects like continuity of care, bankruptcy, risk selection, etc.)

13) How will the outcomes of the commissioning process be monitored?

14) Do you have a professional administration to select providers and for the management of the contractual relationship, including ability to collect, monitor and analyse data relative to the prices, quality and access to care of the included services?

Moreover, it is important to invest in appropriate purchasing structures and strong commissioning bodies. This is crucial to the success of the commissioning process and thus to the improved functioning of the health care system. If commissioning is new for those involved, it is advisable to start on a small scale and in a relatively simple environment to gain knowledge and experience. Moreover, it is advisable to attract knowledge from other sectors or countries where commissioning is more common. After having gained experience with commissioning, larger scale and more complex commissioning may be performed, which can then benefit from earlier experience.

Expertise is important. Hence, choice of scale of purchasing (and therefore of purchaser) is important as well. For instance, municipalities may be relatively small for specific types of commissioning. In such cases not only the required expertise about the commissioning process as well as the health care commissioned may be lacking, but also the bargaining power may be relatively low. Such considerations need to be addressed explicitly in a decision to engage in commissioning activities. In Portugal, for instance, a central agency, SMPS, was created to establish purchasing agreements on behalf of the Portuguese NHS – see Textbox 11. See also the Swedish example in paragraph 1.3.2. There, a total separation between purchasers and providers was introduced in 1991, which applies to all providers, private as well as public.

Textbox 11: Commissioning in Portugal

The Portuguese NHS has an entity (SMPS, EPE - Serviços Partilhados do Ministério da Saúde), created in 2010, that performs the role of purchaser on behalf of the NHS. SMPS establishes broad purchasing agreements, which are then used by NHS providers of care to buy from private providers. The main areas of attention for centralised purchasing are pharmaceuticals, consumables, medical devices and several medical services. The use of online platforms has been central to the activities of SMPS. It also does acquisitions of non-health goods and services such as IT equipment, telecommunications, software licensing, etc.

SMPS operates in two different ways, depending on the type of good or service. On the first, it sets the general agreement, and the actual acquisition is done in a decentralised way by the NHS health care provider. In the second option, SPMS acts on behalf of NHS organisation and does the acquisition under the rules of public procurement.

SPMS on a report about their activities mentions two different sources of savings from doing commissioning of private services: it obtains better conditions (prices and non-price) by volume purchasing, and it lowers the transaction cost to the NHS of doing the acquisition (especially in the cases where it buys on behalf of the NHS). SPMS estimates an overall savings in 2014 from its activities of 94,7M € (71,8M € in health goods and services, 22,9M € in non-health goods and services). Savings related lower costs of acquisition procedures were 6,4M € and better conditions (lower prices) accounted for 88,3M €.

Two examples of specific savings are in pharmaceutical products (savings of 37M € on total purchases of 441M € bought, an 8% savings rate) and consumables (8,9M € savings in a total expenditure of 37,8M €). All data refer to 2014.

Source: Serviços Partilhados do Ministério da Saúde, EPE "Relatório de Aferição de Poupanças de 2014" (Savings report), April 2015

Available at http://spms.min-saude.pt/wp-content/uploads/2016/01/SPMS-Relatório-de-Poupanças_2014_2.pdf.

If possible and relevant, a first step towards commissioning private providers of health care is to facilitate patient choice between public providers. This already creates a context in which patients have choice and public providers may need to compete for patients. Then, in a next stage, private providers could enter into the commissioning process and, possibly, the market. Note that commissioning need not entail a full market, but can also pertain to specific services and products within that market.

Commissioning is something that needs to be learned and be done professionally – both from the angle of the provider and from the angle of the purchaser. Learning from experiences in other sectors and other countries may help, but it may also require time and experience to build up the required expertise. It is important to professionalise this process on both ends, in order to enable optimal outcomes.

A caveat is necessary. Commissioning involves the expenditure of large sums of public money and, as with all forms of procurement, there is scope for inappropriate behaviour. In principle, this behaviour can range from corruption, for instance in the form of bribes to win contracts, to more subtle behaviours, such as the award of contracts to organisations that the commissioner in some way has an interest in, either directly (e.g. because they are owned by relatives - sometimes at arms' length – or employ relatives) or indirectly (the contract winning organisation has ties to organisations in which the commissioner has an interest). An even more subtle issue is the "revolving door" phenomenon, whereby those commissioning services do so in the knowledge that, in the future, they may be employed by organisations from whom they are commissioning. Thus, appropriate safeguards, including enforceable codes of conduct, are necessary as a prerequisite for implementing commissioning. Since trust is an important issue in this context, especially when for profit firms are involved, it is crucial to avoid any (suggestion of) misconduct by (public or private) contracted parties. Careful monitoring at all times must be ensured.

1.3.1. Public opinion

Public opinion may be biased against private providers (Pollock, 2004). Some frequently mentioned arguments against commissioning from private providers include the fear, in some cases justified by experience[25], that (for profit) private health care providers may reduce quality to increase profits, may leave the market and threaten the continuity and

[25] See e.g. http://www.theguardian.com/society/2012/sep/30/pathology-labs-takeover-failures and http://www.bbc.co.uk/news/uk-england-cornwall-25362545

availability of care[26], increase expenses for patients and carers (e.g. through charging for parking, TV, phones, etc.), select profitable patients and services leaving more expensive patients to other providers, may be less inclined to invest in preventive actions[27] and more inclined to induce questionable or unnecessary demand[28]. Moreover, the intrinsic motivation of (for profit) private health care providers has been questioned in public debates and intrinsic motivation may indeed be important, also for performance in terms of better outcomes and lower costs (e.g. Douven et al., 2015).

Regardless of whether such opinions are valid in a particular setting, they should not be ignored. In this context, the political economy of commissioning private providers in countries with mostly public provision of healthcare needs to be mentioned. There may be differences in visibility and perceived responsibility in public failure versus private failure in provision of services. This may provide additional reasons to aim for commissioning from private providers. On the other hand, public opinion in countries with dominant public healthcare provision ('selling the health care system to profit seekers') may lead to reluctance to introducing private providers in (particular parts of) the health care system. PR and lobbying aspects can be relevant here as well. Countering these types of criticism, for instance through sharp quality control of private providers and using independent external review committees assessing performance of public and private providers may help.

1.3.2. Country example: Sweden

In order to highlight the use of and experience with commissioning in different countries, the examples of Sweden and, in the next section, the UK, are highlighted in some more detail.

[26] Iacobucci G. Serco plans to pull out of clinical service provision in the UK. BMJ 2014; 349: g5248 & Cheng TC, Haisken-DeNew JP, Yong J. Cream skimming and hospital transfers in a mixed public-private system.Soc Sci Med. 2015 May;132:156-64

[27] Redfern J, Hyun K, Chew DP, Astley C, Chow C, Aliprandi-Costa B, Howell T, Carr B, Lintern K, Ranasinghe I, Nallaiah K, Turnbull F, Ferry C, Hammett C, Ellis CJ, French J, Brieger D, Briffa T.Prescription of secondary prevention medications, lifestyle advice, and referral to rehabilitation among acute coronary syndrome inpatients: results from a large prospective audit in Australia and New Zealand. Heart. 2014 Aug;100(16):1281-8

[28] Hare KB, Vinther JH, Lohmander LS, Thorlund JB.Large regional differences in incidence of arthroscopic meniscal procedures in the public and private sector in Denmark. BMJ Open. 2015 Feb 24;5(2):e006659

Private providers

In Sweden, the 21 county councils (in some cases called regions) are responsible for health care. They have regional parliaments, elected every four years, with taxation rights. In addition to their tax income, they receive contributions from the state.

There are no restrictions in Sweden for private providers of health care as long as the services are also privately paid. There are three possibilities to become a private provider with public payment. The two main ways are through either procurement or accreditation with a contract with a county council as described below. Since 1994, there is also the possibility for private doctors and physiotherapists to work as private providers on a fee for service basis through a national reimbursement schedule. When this was introduced in 1994 there was free entry to the market, but since 1995 new establishments need to have a collaboration agreement with the county council they are working within. Since 1995 very few such agreements have been signed. Therefore, new entrants to this private market typically have to take over an established practice. Presently, there are about 1,000 doctors and 1,500 physiotherapists working under this system.

This latter system has been criticised by competition authorities from Sweden and the EU, since these replacements are not subject to procurement laws. County councils have also worked actively to transform these providers to fall within the commissioning system. The main reason for this is to achieve better control of prescriptions of drugs and medical services by the doctors now working on fee for service basis. There also has been a public inquiry, which recommended that this system should be abolished by 2018. So far, however, this recommendation does not seem to be followed by the Swedish policy makers.

Historical development

In the 1980`s health care authorities were characterized as being rather rigid political organizations managed by annual budget allocations. Politicians predominantly took the role of service producers, rather than articulating the needs and preferences of the served population. After a long period of expansion, increasing cost and higher taxation there was a need for policies for increased efficiency, rationalisation, for more professional management and for politicians to develop the role of patients/citizens advocates.

To meet the popular demands for a better accessibility and a freedom of choice, together with the need for financial restraints, many county councils developed strategies for an increased diversity and competition created by procurement and freedom of choice. One

example of this was the so-called Stockholm model, introduced in 1991, which had, as a key characteristic, a complete separation between purchaser and providers.

The county councils have the option to contract private providers to perform tasks that they are responsible for according to the law (3§ HSL 1982:73). However, there has been controversy about this, mainly about transfer of ownership of hospitals for acute care, the role of for profit providers, in particular investor owned chain operators with head quarters in tax shelters, if contractors should be allowed to have privately paying patients in addition (which is not allowed for public providers), and how to create similar conditions as far as possible independent of the form of operation or ownership (SOU 200231 and SOU 2003:23)

Expectations about improved productivity and efficiency were also part of the reform. DRG-systems to measure production and to pay for performance were developed and became an important tool in procurement strategies. This made it possible to compare for example price per DRG point produced between public and private providers, and became an instrument to measure performance and compare and follow up contracts.

The DRG system was mainly used in hospitals, but similar instrument for measurements and payments in ambulatory care were developed as well. Gradually strategies and techniques for procurement from either new providers or already existing 'production facilities' for primary care or specialist care were developed. For primary care the long-term problem in Sweden had been to recruit enough doctors to the public health care centres. Commissioning from private providers was an instrument to provide incentives for making primary care a more attractive employment opportunity for doctors. The process developed gradually and the competence for commissioning was built up in the purchasing organization. An important factor in the development process was that the same instruments were used for allocating resources to public and private providers within the organization. That provided an opportunity to benchmark different producers, and to make sure that private and public providers were competing for patients on equal conditions.

The diversity created a need to develop new planning and governing methods within a county to make sure that the different goals about control of costs, high quality, incentives for innovation and responsiveness to patient preferences and equality in the distribution of care and health were observed and managed.

Current situation

Private providers of primary health care now account for 43% of the total volume calculated as patient visits, but this figure varies a lot between the counties and regions. The Stockholm region in many ways has pioneered in the development of commissioning to private providers and increasing the empowerment of patients. It currently has a private provider share of primary care of 65%. For geriatric care the share is currently estimated to be around 60-65%.

Nationally private providers of ambulatory specialist somatic care hold a market share of 24% and private providers of ambulant specialist psychiatric care hold a 30% market share of public tax financed and politically controlled health care. The corresponding figures for the Stockholm region are higher.

For Sweden in total, 13% of health care financing went to private providers in 2013. Until 2007-2008 all the diversity was created via procurement strategies, either procurement of operational responsibility for a primary care centre or procurement of additional production resources for specialist ambulatory care or elective surgery to increase accessibility of care, shorten waiting lists and achieve lower DRG-prices. Maximum volumes were often set to avoid overproduction and cost expansion. While it was a clear objective to increase productivity and volume of services, control of total cost remained and remains an overall restriction. This could partly be achieved by the payment system, for example capitation payment in primary care, but restrictions on the number of patients that could be treated by a defined producer, for example a medical specialist, were also part of the contract.

At the start of the introduction of commissioning, price was the dominant criterion for the selection of providers in these procurements. However, gradually the weight of price was reduced in favour of quality criteria. For instance, during the years using procurement in Stockholm, the weight of price has been reduced from 80% to 30%. A full analysis of positive and negative effects of these procurements has not been made, but there seems to be a common understanding of positive effects and positive examples as well as negative effects and examples.

Care types

In Stockholm, geriatric care has been contracted via procurement for many years now and this has led to a price reduction in geriatric care with the private providers, which, in turn, had positive spin-off effects on the public providers. Ophthalmology, especially cataract surgery, is another area where a procurement strategy to lower prices and

increase accessibility, reducing waiting lists has been successful. Orthopaedic, elective surgery is another area where the procurement strategy to reduce prices, shorten waiting-lists and move production out of emergency hospitals have been regarded as successful. A common characteristic of these services is that they are examples of "process industries" where outcome and the production process can be defined and outcome measured relatively easy.

Contract duration and other issues

Short contracts were quite common in the first years of active contracting via procurement. In most cases, the reason for this was probably an uncertainty about the results and a lack of experience with the processes involved. Short contracts increase the risk for the provider and also have a tendency to negatively affect the continuity of care, both in relation to other caregivers and to patients. A provider who has invested in a good quality and good interaction with other caregivers in the care chain as well as in good patient quality scores can lose its contract in the next procurement. Over time, contract duration has tended to increase. Every renewal of a contract and any new procurement takes a lot of effort and resources, not the least because of the need to sophisticate the criteria list to focus more on quality issues.

Legal issues and rather time-consuming legal processes delay much procurement. The delay can easily take more than a year. This will of course lead to planning and delivery problems for the purchaser organizations. For private providers bidding in public procurements can be very resource consuming and require financial stability.

Research and education might also be negatively affected by procurement strategies that that split production between many providers. Volumes left in public research-oriented organizations might be suboptimal for research and education. Clinical education can sometimes be outsourced but minimal volumes for academically linked public organizations must be granted.

Accreditation, fixed payment and consumer choice

Because of the problems listed above, and a political will to further empower patients and citizens, a few communities and county councils started to develop accreditation systems for elderly care and primary care. Free establishment with accreditation and freedom of choice in primary health care was introduced as a national law in 2008.

Candidates that fulfil the requirements set by each county council are accredited. Remuneration per listed patient is set at a fixed level and not tendered. Often, these

tariffs are set a bit lower than the level previously used for the publicly owned entities. The annual fee (capitation payment) is commonly based on a weighted scale depending on age and socioeconomic criteria. The goal of these weighted fee scales was to make it as interesting to establish a primary care centre in a socioeconomic problem area as in a more affluent area. Some county councils have used fees per visit as an incentive to improve accessibility. Patients list themselves to the primary care centre they choose and can change to another if they are not satisfied.

These new free establishment strategies have also been used for specialist care in the last 5-10 years, also to avoid the juridical problems that are often linked to procurement. The Stockholm county council has currently 32 treatment areas open for accreditation.

Criteria for accreditation have undergone constant development, building on experience, and now constitute a large catalogue of requirements. They include financial stability and a declaration of ownership, including history of conduct (versus tax laws for instance). Providers should also be able to show that they have a sophisticated quality management system and that clinical practice is in line with national guidelines. They are all obliged to report quality both nationally and regionally.

County councils, regions and communities can choose between procuring welfare services by tendering procedures or by introducing a model of freedom of choice. In the freedom of choice model, the service user chooses between accepted providers (both public and private) but the county council, region or community are responsible for financing. The accreditation model (free establishment and freedom of choice) in specialist care has been most frequently used in the Stockholm area and has primarily been used for elective surgery and ambulatory care in for example orthopaedic surgery and ophthalmology but also in palliative home-care.

The general problem with accreditation is that it has a tendency to increase volumes and thereby cost for specialist services. Treatment areas most suitable for accreditation seem to be those where indications are well defined and where there is no demand from patients for less strict indications. Good examples are orthopaedic surgery, ophthalmologic surgery and amongst non-surgical disciplines, logopedics.

Positive and negative incentives are often introduced to improve efficiency and outcomes. For example, fines if patients are too easily referred from primary care centres to specialist care, and bonuses in case of good results in quality measurements or a good coverage in quality registries.

Challenges for the future

The challenge for the payer organizations (political elected parliaments and boards) is to develop more sustainable fee structures, positive and negative incentives and, last but not least, end-point requirements, to make sure that care is distributed equally under a total financial control. At the same time they have to try to set up systems that are competition neutral between private providers and their own public provider organizations.

Research, development and education require special attention with a need to preserve sufficiently high volumes for education clinics and clinical research. Another issue arising from increased diversity is the need to create a good infrastructure to be able to share medical records information, as many patients have many contacts with different providers of care, both public and private.

The rapid development and growth of the private provider sector has attracted a lot of venture capital and the market has undergone a significant consolidation to a few dominating companies. One of them has now even been introduced on the Swedish stock market. This development has led to a political controversy whether profits and dividends should be allowed for private providers in the welfare sector. Such discussions must take place in the broader context of an increased patient empowerment, an increased accessibility, maybe an increased quality and maybe an increased efficacy.

1.3.3. Country example: United Kingdom

The tax-funded National Health Service in England provides near-comprehensive services to all residents that are free at the point of use (apart from some charges for dentistry, eyesight tests, and for prescriptions dispensed outside hospitals, although with many exemptions). Provision of health care is predominantly by public sector providers in the secondary care, i.e. specialist and hospital, sector and by privately-owned medical practices, dental practices and community pharmacies in the primary care sector. Policy discussion, and controversy, has mainly been around increasing the role of privately owned providers of health care in the secondary care sector, although also, to some extent, about the entry of large for-profit chains to the primary care sector.

Clinical Commissioning Groups

The large majority of NHS health care services are planned and purchased (i.e. "commissioned") by 211 Clinical Commissioning Groups: public bodies that cover those patients registered with general practices, normally, but not necessarily covering a geographically defined area with a population (average size around 250,000). The Clinical Commissioning Groups are allocated funds in proportion to their population size and according to a nationally-applied formula to assess each area's relative need for health care. Highly specialised services are commissioned by a single national (public) body: NHS England.

Historical development

NHS organisations have for decades commissioned a small proportion of secondary care services from private providers, both for-profit and not-for-profit. In around half of the country, private clinics provide terminations of pregnancies, where the local NHS-employed obstetricians are unwilling to do so. Privately owned providers have been a mainstay of hospice care for patients requiring palliative care; a major provider of certain specialised mental health services; and also of long-term nursing care for frail elderly people. When waiting lists became too long and there was temporarily insufficient capacity in public hospitals, private hospitals were often contracted to provide limited numbers of routine, non-emergency, surgical procedures to NHS funded patients (Goddard and Sussex, 2002). In the last 15 years, government policy has generally, though with fluctuating degrees of enthusiasm, been favourable to increasing the role of private sector providers in delivering NHS funded health care in England.

This policy has been developed in parallel with the introduction (from 2003) of activity-based (DRG-type) funding of much hospital care (Farrar et al., 2009) and the explicit enablement of a degree of patient choice of provider of (NHS funded) non-emergency care (Dixon and Robertson, 2011). The single biggest expansion of private sector provision occurred under the controversial Independent Sector Treatment Centre (ISTC) programme, initiated in 2002. The rationale was to increase capacity where waiting times were longest and to stimulate innovation and improved performance generally (Turner et al., 2011), achieved by offering guaranteed payments and very favourable financial terms.

Since January 2006, NHS patients in England requiring referral to a specialist for routine non-emergency treatments were entitled to a choice of five providers. Since April 2008 their choice has been expanded to any qualified provider ("AQP"), public or private,

willing to supply to NHS quality standards at the nationally fixed price.[29] In subsequent years, local NHS commissioners have been required to expand AQP to a variety of community-based (i.e. non-hospital) services. The choice of which services to include has been left to local NHS commissioner discretion, but examples include musculoskeletal services for back and neck pain; physiotherapy; continence services; and adult hearing services. NHS commissioners also have the discretion to use competitive procurement, i.e. competitive tendering, to select service providers where AQP does not apply. This option has been taken up with varying amounts of enthusiasm around the country, and examples include pathology services and sexual health services.

Services commissioned from private providers

Overall, the range of services being commissioned from the private sector is now quite broad, as the following additional examples, shown in Textbox 12, provided by the NHS Partners Network[30] show:

Textbox 12: Examples of commissioning in the NHS

Service	Description	Claimed benefits and pitfalls
In Health's Direct Access Diagnostics	In Health runs the service for 29 of the 32 London CCGs. Offers an appointment within a maximum of 13 days from referral. Releases hospital capacity. 7 days access and choice of location.	Being involved in the design of diagnostic services across London rather than involved at one point only for one specific tender allows better understanding, more integration and a better coordinated response.
Dental treatment in North West England	There was a waiting list of 43,000 patients. Oasis put in place a programme to support accessing dental care and within 14 months, the waiting list had been cleared.	

[29] The term "any willing provider" originated in the NHS in England in 2009, when the then Labour government opened up services to private competition. In 2012 the term was changed to "any qualified provider" but the concept remained essentially the same, with all providers, public and private, being required to meet quality criteria established by the care Quality Commission, responsible for inspections of providers. However, neither term has any clear legal basis. The term "any willing provider" is also used in legislation in some American states, sometimes interchangeably with "any authorised provider".

[30] NHS Partners Network is the trade association for a wide range of private sector providers of health care services to NHS patients: http://www.nhsconfed.org/networks/nhs-partners-network

	Improvements in capacity are supported by innovation in terms of online booking and operating services seven days a week, eight until eight where needed.	
Urgent care centres in London	Greenbrook provides various urgent care centres in London. It puts urgent clinicians at the front and over 99.5 per cent of patients are seen and discharged within four hours, against the overall A&E target of 95 per cent.	Working with NHS and private providers helps improve the service.
Recovery at Home Virtual Ward	In 2014, 21 pioneering NHS Trusts across the UK were using Healthcare at Home's Recovery at Home model, which treated 15,000 patients, made 175,000 patient visits, saving 130,000 bed nights and creating 379 virtual beds – the equivalent of a small NHS acute Trust.	Giving the powers to the NHS Trusts to deliver services in different ways can lead to savings and improved care.
Care Home pilot	The Practice conducted a six month pilot scheme across seven care homes to improve integration with primary care for the residents of care homes, aiming to reduce the number of patients unnecessarily admitted to hospital, particularly towards the end of life. The pilot focused on an integrated GP and medicine management service which provided care planning, routine visits and out of hours urgent care support, amongst other things. This innovative way of working resulted in a 40 per cent reduction in hospital admissions across the period, a 17 per cent reduction in general prescribing, with 89 per cent of residents who died while the pilot was running doing so in their place of choosing.	Pilots allow for innovative service designs. However, it is not always easy to find the funding to continue with a service found to work in a pilot.

Source: NHS Partners Network (correspondence, January 2016)

No evaluation of the impact of NHS commissioning from the private sector has yet been carried out. There have been some notable failures, highlighted in the media and referred to earlier in this Opinion (see e.g. Textboxes 8 and 9). But those failures are not peculiar to private providers. The same media report failures in contracts with publicly owned providers seeking to provide appropriate quality care within budget. The currently emerging story of the failure after 8 months of a £725 million (€900 million), 5-year contract for care of people over-65 in the community, between Cambridgeshire and Peterborough CCG and the 'Uniting Care' partnership of two publicly owned providers, appears to demonstrate comparable failings to the tendering process involving Circle / Hinchingbrooke Hospital described earlier (Textbox 8). The investigation by NHS England (Stout, 2016) reports that:

"*In summary;*
• *There were too many information gaps around community services,*
• *The financial envelope of the CCG for these services could not be reconciled to current expenditure levels,*
• *There was an additional VAT cost,*
• *The mobilisation period was not sufficient to make the planned financial savings that were required in the first year,*
• *The contract value was not absolutely agreed at the date the contract commenced.*
• *The contract should not have commenced on 1 April 2015. It should have been delayed until these issues were resolved.*"

There is an "NHS Standard Contract" which NHS commissioners in England are required to use whether commissioning from private sector or public sector providers of health care services. There is no distinction made in any of the key terms according to the ownership of the provider. This contract is discussed in detail in the next paragraph.

1.3.4. Contracts

A key point in the commissioning process is the contract. In order to give more practical insight as to what such contracts typically entail, we discuss here both some general features as well the key points from the NHS England standard contract.

In terms of general features, it appears that many contracts have a structure that allows to cover the following items[31]:

1. Provide a rather extensive background description on the basic goals and contest for the services that should be provided
2. Provide a very detailed description of the services that should be provided, which of course varies with the type of service
3. Provide detailed requirements for reporting of inputs, throughputs and outputs, including information on costs
4. Contracts often include both unit price and volume. Volume arrangements typically differ per type of service.

In the UK, a standard NHS contract is available. The key points from that contract are highlighted below in Textbox 13. Note that in the context of the NHS in England the "exact points requested from providers" are at the discretion of the commissioner who is letting the contract. At the point where there is competition/contest between multiple bidders to win the contract, those points should be identical regardless of the ownership of the bidder, so as to ensure a "fair playing field" in the competition/contest. Once a preferred provider has been identified there is scope for limited bilateral negotiation between commissioner and provider, but any additional details being agreed at that stage would not necessarily be made public.

Text box 13: Key Points from the NHS England 'NHS Standard Contract 2015/16' (March 2015)

Background
The NHS Standard Contract is mandated by NHS England for use by NHS commissioners (meaning all 211 Clinical Commissioning Groups and NHS England) for all contracts for NHS-funded health care services other than primary care. This is regardless of whether the providers are public sector, private not-for-profit or private for-profit; i.e. it is supposed to enable a 'level playing field' for all potential providers. The Standard Contract and supporting documents are on the NHS England website at: https://www.england.nhs.uk/nhs-standard-contract/

Standard Contracts have been provided for many years. They are lengthy and detailed and specify where local commissioners (CCGs) have discretion to negotiate, but they may not override the general terms of the Standard Contract. The Standard Contract is for commissioning by a single commissioner bilaterally with the provider, and for

[31] www.vardgivarguiden.se/avtalsuppdrag/avtalsinformation/upphandling

commissioning by a group of collaborating commissioners (with one acting as the coordinating commissioner) – this latter approach is encouraged.

The contract is legally binding between NHS commissioners and all types of private providers and NHS Foundation Trusts. Agreements between NHS commissioners and (non-Foundation) NHS Trusts are called "NHS contracts" and are not legally binding (i.e. disputes cannot be resolved in the courts).

The Technical Guidance notes that although the contract "is a key level for commissioners in delivering high-quality, safe and cost-effective services", it cannot achieve that without an "effective relationship between commissioner(s) and provider" [para.24.1]. Interestingly the Technical Guidance notes that "the contract is not intended as a lever to micro-manage providers" and "commissioners should only request information from providers that is reasonable and relevant, with consideration given to the burden of provision of the information" [para.24.2].

Contract duration

Duration can be any length, there is no default duration, though in practice most NHS contracts are for one year (for each financial year). Commissioners decide locally. Guidance is given, though, in the "Technical Guidance" document:

"*Where commissioners are seeking, through competitive procurement, transformative solutions requiring major investment and service reconfiguration, contracts with a duration of five to seven years may often be appropriate. We would advise commissioners not to offer contracts with a duration longer than seven years, other than in exceptional circumstances*."

"*Where no competitive procurement is undertaken, increased flexibility in contract duration can still be considered, but we would advise commissioners to think carefully before placing contracts with a duration longer than three years*."

Contract extensions are allowed, but are advised to not be longer than two further years, and no more than one extension per contract.

Specifying the services to be provided and the outcome desired

For the most part, service specifications are the responsibility of the local commissioners to develop, rather than being fixed nationally. Exceptions are when NHS England is the contractor (which is a national level by definition), which covers all "specialised services". Service specification includes:

1. the patient/client groups it is to serve
2. the broad outcomes required from the service
3. any key links with other services
4. any generally applicable service standards, whether set locally or nationally (e.g. by NICE)
5. quality requirements – including any subject to incentive payments
6. location of the service (if it is relevant to specify that)

Technical Guidance para. 31.7: "*A specification should not be a detailed operational policy for a service; specifications that are no longer than 4-5 pages may be sufficient, especially if they focus on the outcomes required from the service rather than the inputs*."

Quality of Care
Technical Guidance para.34.1: "*The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience*." Para.3.4.2: the Standard Contract:

"*…requires providers to run services in line with recognized good clinical or healthcare practice, and providers must comply with national standards on quality of care*".
There are financial penalties for breaches of national standards

"*…sets clear requirements in respect of clinical staffing levels (GC5)*."
[NB. General Conditions section 5 does not specify any staffing numbers/rates just general principles to be followed in deciding staff numbers and qualifications.]

requires adherence to national guidance on hospital food standards (SC19), infection control (SC21), safeguarding service users against abuse or improper treatment (SC32), the care of dying people (SC34), and the duty of candour (SC35) i.e. being open when notifiable safety incidents occur

requires providers to put in place "policies and procedures which will support high-quality care", including: clinical audit (GC15 and SC26); involvement of, and handling feedback from, patients, carers and staff (SC10); and handling of complaints (SC16), patient safety incidents and 'never events' (SC33).

There are also data provision requirements, for monitoring (and national statistics).

Payment
Payment is agreed locally, except for services covered by the prices in the National Tariff, which have to be adhered to where they exist and which cover about 60% of hospital income and hence about a quarter of total NHS spend. Payment is required to additionally include some "CQUIN" (commissioning for quality and innovation) incentive payments equal to 2.5% of contract value.

Patient selection
There is a specific contractual requirement on (all) providers – Service Condition 6.5.1 – that all providers must:

"*accept any Referral of a Service User made in accordance with the Referral processes or Pathways set out or referred to in the Service Specifications and/or any Prior Approval Scheme and in any event where necessary for a Service User to exercise their legal right to choice*"

Thus providers are prevented from overt patient selection, e.g. cream skimming.

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- NHS England, (March 2015). NHS Standard Contract 2015/16 – Service Conditions. NHS England: Leeds.
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As also mentioned in Textbox 3, specific questions regarding financial stability, including aspects like credit rating, proof of financial stability, ownership and history of conduct may be posed, some of which are especially relevant in the context of private providers. The issue of whether, when and how to allow distribution of profits also needs to be addressed. General rules or contractual agreements should specify this.

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1.4. Conclusions and recommendations in relation to the Mandate

In this section, we will highlight some of the main messages from the previous paragraphs and relate them to the questions posed in the mandate. Moreover, we will make recommendations in relation to commissioning of (private) providers within the European Union.

Conclusions

It is clear that commissioning from private providers is a policy option that can be used in the pursuit of the goals of a health care system. Given the developments in many health care systems in which a split of providers and purchasers has been established, commissioning, including that of private providers, appears to have become more common. In that context this policy option needs to be carefully compared to alternative policy options and evaluated in terms of costs and benefits, both short and long term.

Whether benefits outweigh the costs depends on many contextual factors, such as the health system characteristics, the current situation of health care provision[32], market structure, type of service commissioned, observability of quality, specific arrangements in the contract, etc. Commissioning can induce competition, also between public and private providers, both for the market and in the market (EXPH, 2015a). In many cases, the policy question may not be whether or not to commission private providers, but how to do so and how to find an optimal mix of providers.

It needs to be explicitly noted that commissioning from private providers is not a panacea for all problems health care systems may face. Moreover, it does not transfer the responsibility for an adequately functioning health care system to the private providers. The relevant authorities remain responsible for this, also when commissioning from private providers.

There are no general rules for the optimal use of commissioning in different sectors, circumstances or countries. These decisions and evaluations need to be tailor made. Both the planning and contracting phase require expertise, also on the side of the public buyer. Often, the success or failure of commissioning can be determined by details in the different phases of the commissioning process. It is crucial to define clearly what is to be commissioned and to decide how to monitor the costs and effects from commissioning.

Success or failure of the commissioning process can depend on many factors, and this requires experience and professionalism on both sides of the negotiation table. Hence, the Panel stresses the need for strong commissioning bodies and well-designed commissioning processes whenever countries choose to use commissioning from (private) providers as a policy instrument. This is a prerequisite and requires clear structural investments in order to make the commissioning process a (lasting) success.

Engaging private providers in the provision of publicly financed health care, especially for profit providers, requires additional information (on, e.g., ownership and financial stability) and potentially (if the market is not optimally structured) additional regulation (e.g. regarding distribution of profits, cream skimming, etc.).

In general, commissioning private, or public, providers may prove especially successful if:
(i) it is possible to clearly specify the required service, including quality levels, in a contract;
(ii) it is possible to attract sufficient numbers of interested providers (in the short and long run);
(iii) if it is credible that both parties will stick to the contract, and
(iv) the payer and providers are aligned in terms of values and mission, also stimulated through the incentives of the payment system and verifiability of the characteristics of the service provided and if the parties are more experienced in commissioning and interact.

Starting commissioning is easier when a well-defined and well-functioning market exists, but commissioning can also help in creating one. Moreover, building up experience with commissioning and interactions between purchasers and providers can improve the commissioning process over time.

[32] The comparator matters: commissioning (private) providers as an alternative to a purely public provision of care has other implications (also legal) than when the alternative was purely private (e.g. fee for service based) private provision.

Recommendations in relation to the Mandate

Below, we specifically address the questions posed in the mandate:

- *What procurement strategy should be used?*

From the above, it needs to be clear that there is no single dominant procurement strategy. In each case, the design of the procurement strategy needs to reflect first and foremost for the exact context in which the commissioning takes place, taking into account issues like how well the commissioned products and services can be described and their quality measured. This is for example different for elective cataract surgery than for palliative care services. Issues such as the market structure (number of competitors, price structure, etc.), investments required by the providers, ability to monitor inputs, outputs and outcomes, transaction costs of the procurement to both sides, the ability to attract interested private parties on a continuing basis, and the role of unverifiable elements that influence the value of the service or product provided need to be specifically addressed, both for the short and long term. Duration of contracts is an important issue as well. This highlights the need for careful design of the commissioning process, contracts and follow-up on a case by case basis, as well as professional and knowledgeable commissioning bodies.

- *How should risk be assessed and shared?*

Risk sharing is not an objective of private commissioning, but commonly is a part of it. If private commissioning intends to bring the forces of competition to increase efficiency of provision, then private parties usually bear risk as part of the incentive payment scheme. Reducing too much the risk faced by contracted parties may undermine incentives that were the reason to set up the private commissioning in the first place. Too high risks may lead to a lack of willing providers or to problems of bankruptcy and discontinuity of care later. Thus, the question should be phrased as which risks the commissioned side needs to bear in order to have the right incentives. This needs to be determined in the context of a specific commissioning procedure and evaluated.

- *How should prices and quantity of service be specified to ensure adequate coverage, access, and sustainability?*

This question needs to be addressed in the planning phase of the commissioning procedure. In the absence of a clear answer from the public side, the commissioning procedure risks failure. It needs to be clear which elements are fixed (and verifiable) and

which elements will the private commissioning procedure stimulate competition on. There is no single answer to the question, as different types of services will require different solutions for the commissioning procedure to yield the expected benefits. An important part of developing adequate commissioning strategies is the development of adequate payment systems, which gives incentives for quality, cost-effectiveness and control of costs. This holds both for commissioning from private as well as from public providers.

- *How should quality standards be set and measured to safeguard patients?*

Defining, measuring and monitoring quality often can be difficult in health care (EXPH, 2014a). This may lead to a situation in which the focus, also in commissioning, is on better observable aspects such as prices and numbers of patients treated. However, this risks lowering quality of care, patient health and the performance of the health care system. Hence, much attention needs to be given to defining and monitoring quality. When quality can be observed, competition based on quality can be stimulated. If it cannot be easily observed, it needs to be ensured (e.g. through inspection and collection of relevant outcome parameters) that providers act in line with the values of the payer and patients.

Relevant outcome and quality indicators need to be determined on a case by case basis. Learning from previous experiences (i.e. expertise of commissioning body), experiences in other sectors and other countries can help. When investigating the option of (expanding) commissioning of private providers, the (potential) impact on quality, both in the short and long run, needs to be explicitly addressed.

- *What are the potential issues in transitioning from fully public provision to mixed public/private provision?*

Transitions in health care are never easy. It is important to be clear about why the transition (in this case commissioning private health care providers) is considered in the first place. The Checklist on page 60 can be an aid in specifying the expectations regarding commissioning. The (potential) benefits and risks need to be specified and the risks mitigated as much as possible through the process of commissioning. It needs to be stressed that in commissioning and evaluating commissioning, the focus should not only be on the short run, but also on the long run. Short run (or short sighted) goals such as limiting expenditures may reduce quality, may endanger continuity of care and may risk higher costs in the long run (also through creating market power). Moreover,

coordination of multiple (types of) providers can be difficult. In that context, it needs to be avoided that specific types of services (like disease prevention) or specific groups of patients, such as people with double diagnoses (mental health problems and addiction) or people with multi-morbidity, exist for which no one has the proper responsibility.

Professionalism in the commissioning process is highly important, but needs time and practice to acquire. It needs to be ensured that the required capacity (in terms of quality and quantity) is available to manage and monitor the whole commissioning process. The need for professionalism also makes it important to learn from other sectors and other countries in a transition. Moreover, it emphasises the importance to start commissioning in those sectors where this is deemed less difficult and only later, if at all, in sectors where it is considered more difficult. It is recommendable to start commissioning on a small scale (as a pilot) and then, if shown to be successful, scale up. It is crucial to also take into consideration the legal context.

Finally, sequence matters. If countries want to use commissioning, they need to ensure that some of the prerequisites, including the ones mentioned above, are sufficiently fulfilled to start (pilots with) commissioning. This includes the design of an adequate payment system, definition of key parameters to monitor and the monitoring process.

- *Are there good examples of making this transition?*

It seems fair to say that most transitions in this area have both good and bad examples, successes and failures. However, in some countries, like the UK and Sweden which were highlighted in this report, but for instance also the Netherlands and Portugal, there is quite some experience with commissioning from private providers. It is important to learn from these examples and the knowledge in these countries, in order not to repeat avoidable mistakes.

In general, the costs of a transition can be high and operating a system in which commissioning and contracting plays an important role (induced by purchaser-provider splits) also involves structural transaction costs related to, e.g., negotiations and contracting. The expectations regarding savings and costs, in the short and long term, need to be as realistic as possible, in order to avoid misperceptions.

- *Would there be room for specific EU action here and what would it be exactly?*

The EU could facilitate more knowledge in this area and the spread of this knowledge to EU Member States currently considering expanding or introducing commissioning from private providers in their health care sector. At present, the knowledge base regarding optimal commissioning, optimal mixes of private and public providers as well as success and failure factors is relatively limited. Increasing knowledge and sharing experiences may also help to manage expectations regarding the effects of commissioning of health care services on quality, costs, availability etc., and make the decision to introduce commissioning more evidence based. Also comparable figures on private commissioning across European countries is lacking.

Hence, the Panel strongly recommends systematically collecting data on and evaluating the use of commissioning private health providers. Issues surrounding freedom of information as well as transparency regarding prices and outcomes need to be considered in this context as well.

EU action, facilitating the integration of markets and cross-border competition, may enlarge the pool of candidates to each commissioning procedure. In this case, since each provider faces more competition, the number of providers may eventually decrease, but prices may also decrease (and/or quality increase) by pressure of the extra competition. Of course, the exact outcomes depend on the conditions for competition to work being fulfilled, a pre-condition to use commissioning to obtain better prices or quality.

When Member States wish to introduce commissioning, it could be recommended to use the checklist for health care reforms (See EXPH, 2016).

The legal aspects of commissioning also require attention. Not only within Member States in relation to European legislation, as highlighted in paragraph 1.2, but also in relation to legal issues on sharing information (data protection directive), creating a level playing field between private and public providers, and in relation to cross-border care when private providers from other countries are commissioned (e.g. to increase availability and reduce waiting times).

To conclude, commissioning health care services from private providers can be a useful instrument in attaining health care goals. However, whether it is better than other instruments in a particular situation depends on many aspects, including the commissioning process itself. This Opinion hopes to contribute to improved policy making regarding whether and how to commission health care from private providers within the European Union.

LIST OF ABBREVIATIONS

A&E	Accident and Emergency
AQP	Any Qualified Provider
CCG	Clinical Commissioning Groups
CQUIN	Commissioning for QUality and INnovation
DRG	Diagnosis-Related Group
EPE	Entidade Pública Empresarial - Public entreprise (Portugal)
EU	European Union
EXPH	Expert Panel on effective ways of investing in Health
GP	General Practitioner
HM treasury	Her Majesty's Treasury (UK)
ICT	Information and Communication Technology
ISTC	Independent Sector Treatment Centres (UK)
IT	Information Technology
LOU	Public Procurement Act (Sweden)
LOV	Act on Freedom of Choice System (Sweden)
NHS	National Health System
NICE	National Institute for Clinical Excellence (UK)
P4P	Pay for Performance
PPP	Public-Private Partnership
PR	Public Relations
SCP	Structure–Conduct–Performance
SEK	Swedish Krona
SLL	Stockholms Läns Landsting - Stockholm County Council
SMPS	Serviços Partilhados do Ministério da Saúde (Portugal)
SWEDEHEART	Swedish Web-System for Enhancement and Development of Evidence-Based Care in Heart Disease Evaluated According to Recommended Therapies register
SWESPINE	Swedish National Spine Register
TFEU	Treaty on the Functioning of the European Union

UK	United Kingdom
VAT	Value Added Tax

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