PRESCRIPTION FOR PARTNERSHIP:

How New Models of Collaboration in Health Care Can Make Outcomes a Priority

PART II OF THE ONTARIO CHAMBER OF COMMERCE'S 2016 HEALTH TRANSFORMATION INITIATIVE

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The OCC is Ontario's business advocate.

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ISBN: 978-1-928052-31-9

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A LETTER FROM THE PRESIDENT AND CEO

In our first Health Transformation Initiative report, *Transformation Through Value and Innovation: Revitalizing Health Care in Ontario*, the Ontario Chamber of Commerce (OCC) established the research question that will drive much of our work through the course of this project: How can the private sector be a more productive partner in our health care system? In our second report, we tackle this question by looking at the concept of commissioning, an evidence-based approach to service design, procurement, and delivery that prioritizes outcomes over inputs. The findings of our report are based on a review of international best practice and conversations with key health innovators here in Ontario.

It may come as a surprise to some, but the private sector has long been an active participant in our health care system. In fact, the level of private sector involvement in Canadian health care is slightly above the OECD average - 12th highest overall, and greater than 22 other countries in the OECD.[1] Governments across the country have come to appreciate the value of leveraging the capacity of the private sector and thus have dispelled of the myth that private sector involvement in the health ecosystem is in opposition to a desire for equitable treatment. Re-evaluating our purchasing habits and service delivery models has the potential to improve the health outcomes of Ontarians both by enhancing quality of care and by achieving savings that can be reinvested into the front-line services most directly affecting patients.

Ultimately, the success of any private partnership should be assessed on how well it meets the goals of patient care and satisfaction – just as public sector participation should be similarly assessed.

Allan O'Dette, President & CEO
Ontario Chamber of Commerce

GLOSSARY

Alternative service delivery: A process of restructuring in which the public sector works with the private sector in the delivery of public services. Generally, government leverages private expertise, capital, process, and technology while retaining responsibility for policy and compliance through market stewardship.

Commissioning: A process of decision-making that begins with the establishment of robust definitions of needs and desired outcomes. Government then engages third parties in solution design and delivery, seeking to optimize outcomes by making the best use of all available resources.

Commissioner: Individuals who are assigned to guide the commissioning approach within the public sector. Commissioners can also be stakeholders from the for-profit and non-profit sectors, health care providers, and experts in relevant legal, financial or commercial matters.

Innovation: A new technology, technique, process, model, or other solution that adds value and provides a meaningful benefit over the status quo. The impact of innovation should be measureable.

Market stewardship: The role of government in designing and supervising competition in public service delivery.

Third party: Any non-government actor, including both for-profit and non-profit entities.

Public service economy: The combination of public, for-profit, and not-for-profit providers that deliver public services.

Value: In the health care context, value is a return on investment that considers patient outcomes alongside cost. It is demonstrated through long-term quality improvements and savings to the system as a whole, not just an immediate reduction in the cost of a good or service.

Value-based procurement: A strategic form of buying that leverages procurement processes to improve organizational and system outcomes.

INTRODUCTION

"Looking at the delivery of Canadian healthcare today, it is not realistic to question whether business should be present in our 'public' system. The question should be, where is the participation of business most likely to contribute to achieving the ideals and strategic objectives of our system?" – *The Role of the Private Sector in Canadian Healthcare: Accountability, Strategic Alliances, and Governance*, The Monieson Centre for Business Research in Healthcare, Queen's University School of Business

In our framework report, *Transformation Through Value and Innovation: Revitalizing Health Care in Ontario*, the OCC examined the difficult fiscal environment and evolving patient needs at the heart of our call for health system reform. We identified a fundamental question that could help crystalize thinking around how to create greater value and increased innovation: How can the private sector be a more productive partner in our health care system?

We tend to think of our health care as being exclusively public, but, in fact, government funds are distributed through a complex patchwork of arms-length entities, independent care providers, non-profit partners, and businesses. The Ontario health care system is considered a single-payer model, but it consists of many buyers operating within a network of Local Health Integration Networks (LHINs), hospitals, shared service organizations, and individual health care providers (HCPs).

It is increasingly obvious that the structure and complexity of this system has created quality of care challenges, in part because government is unclear about objectives. In the current model, each buyer is making decisions based on strict budgets and inflexible guidelines. Price is too often the primary, or only, measure of evaluation. A system-wide perspective is lost and interests are not always aligned. While some of this is understandable given fiscal challenges, the system does a disservice to its patients when it fails to implement value-based processes. Innovation is being locked out and adoption of new solutions is slow.[2]

Patients First, the discussion paper released in late 2015 by the Ministry of Health and Long-Term Care (MOHLTC), identified gaps in care within the Ontario health system. This included specific populations that are not well-served (e.g. Indigenous peoples, newcomers), the absence of population health considerations in system planning, and the overall fragmentation of health services. If the public sector was able to make decisions based on desired system outcomes rather than merely on cost or volume, they could better address these challenges by aligning and focusing stakeholders around those outcomes.

As health is unique in its impact on other socio-economic indicators, there needs to be more to our funding approach than just price-based considerations. The health sector is, globally, a booming and innovative market. If Ontario wants to deliver the best care to its citizens and take advantage of our home-grown talent in the health and human sciences sector, we cannot treat our health system as just a series of pre-defined tenders waiting to be filled. Ontario needs to move from a "cost-containment" philosophy towards a "value-generation" philosophy.[3]

This requires a re-orientation at a structural level, and a complete renegotiation of the relationship between decision-makers in the public sector and partners in both the for-profit and non-profit sectors. Through initiatives like the creation of an Office of the Chief Health Innovation Strategist and the release of *Patients First*, the government has recognized this and is moving to bring about system-wide reform through strategic planning, re-organization, and increased transparency and accountability. The will is there, now the question to be answered is :How?

The OCC believes that there is a means of approaching public/private interaction that could address these challenges and encourage a re-alignment of priorities commissioning. Commissioning is a way of focusing less on what is done and more on the results of what is done.[4] In this way, it is a means of putting patients first.

The National Health Service (NHS) Commissioning Assembly in England has identified a series of challenges their health system faces, which they are seeking to address through a commissioning approach. Here in Ontario, we are experiencing these same challenges:

- How to deliver better care for less;
- How to protect the fundamental principle of universal healthcare free at the point of delivery;
- How to shift the focus towards prevention;
- How to empower citizens with more control over their own care; and
- How to create a culture that is open to innovation and new ideas.[5]

If Ontario is able to re-orient its thinking towards patients through a model in which outcomes and value are at the centre of decision-making, we will be in a better place to ensure our system continues to deliver against the current and future needs of our citizens. By taking a collaborative approach to problem-solving, we can generate greater value for dollars spent, improve quality of service, spur demand for innovation, and encourage investment in local R&D.

What is Commissioning?

WHAT IS COMMISSIONING?

Commissioning is a process of decision-making that begins with the establishment of robust definitions of needs and desired outcomes. Government then engages third parties in solution design and delivery, seeking to optimize outcomes by making the best use of all available resources.

One of the most common points of interaction between the public and private sectors in Ontario's health care system is when public funds are used to purchase private goods or services, or are used in tandem with private capital to build new service or skills capacity. Today, this interaction largely unfolds in one form: the government releases a Request for Proposal (RFP) containing a pre-defined prescriptive solution to a public service need without input from vendors or the public. Vendors then submit bids, with minimal engagement with respect to the desired outcomes and the means to achieve those outcomes. Usually, the vendor with the lowest bid wins. The product or service is then delivered through a formal, short-term contract where payment is based on inputs and outputs (as opposed to outcomes). The vendor typically has no opportunity to suggest alternative solutions that may be more effective or, over the longer term, lower cost.

In contrast, commissioning is an approach to the acquisition and delivery of goods and services that begins with a definition of needs. This definition reflects not merely the immediate demands of a health care provider, but the larger health system and the people and organizations connected to it. An ideal commissioning scenario would reflect the best use of resources by "achieving good outcomes with people, using good evidence, local knowledge, skills and resources to best effect".[6] It can also be an integrative and risk-mitigating means of bringing innovation to the system, as stakeholders are encouraged to think of dollars expended as capacity-building investments, not just spending.

Instead of the public sector alone being tasked with identifying a solution, in a commissioning scenario decision-makers collaborate with interested parties in joint solutioning and examine new ideas or perspectives that may have not previously been identified. Commissioners agree upon the goals of the project, share and develop solutions, and ensure that those groups who will be affected by the commissioned product or service have buy-in. Discussions about cost become conversations about value, and true system needs reveal themselves.

A commissioning approach can be used to bring innovation to procurement and service delivery. This can be seen in tactics like strategic or value-based procurement, which entails an exploration of objectives and collaboration with third parties in place of prescriptive, inflexible RFP. Stakeholders are encouraged to look for solutions, not just to provide a pre-made widget for purchase; this could mean a new technology, co-developing an innovation with the public sector, or bundling goods and services to solve multiple inter-connected public health needs. Similarly, alternative methods of service delivery require the deep long-term public/private relationships that are characteristic of successful commissioning. A commissioning approach can encourage third parties to view their interactions with the public sector as an enabler of innovation, not a barrier.

Beyond reducing the pressure on the public sector to both design and enact a solution, commissioning also offers three key benefits:

• *Financial resources.* A major benefit, and often the driving factor in the decision to experiment with non-traditional public/private relationships, is the influx of new funding and the transfer of financial risk from the government to the private sector. By tapping into third party resources, the public sector is able to expand their ability to deliver on population needs while not risking their own capital on a new venture. They may also be able to link compensation to outcomes by transferring outcome risks to third parties, who either achieve predetermined objectives or see a reduction in their payment. These new sources of financial resources can free up public spending for other areas, and reduce government reliance on traditional borrowing.

• *Expertise.* By involving third party stakeholders early in the process, government can access their unique experience, business thinking, proprietary processes, or technologies. Unlike in a traditional public/private relationship, stakeholders in a commissioning model are not constrained by proposal guidelines and are free to offer alternative solutions; joint solutioning is part of the process. This means government is both made aware of, and given access to, private expertise that may have been shut out by established forms of interaction.

• *Capacity-building.* As the public sector now has access to the non-financial resources of third parties, they are able to build the capacity of their internal care and administration teams, resulting in greater productivity and expertise within government. Capacity may be built through training in business processes, like lean value enhancement or the balanced scorecard approach. Government may also be able to redistribute public servant capacity when it is needed elsewhere.[7]

As part of our Health Transformation Initiative, the OCC has identified two key needs within the Ontario health care system – value and innovation. Commissioning can be used to re-align decision-making around both of these needs.

Using commissioning to create value

Under a commissioning approach, the overall value of a spend is considered in place of an emphasis on price and cost. Value considers these inputs, but also reflects the efficacy of a purchase or service delivery process, and considers the impacts across the entire health system, not just one line item in the health budget. When outcomes are improved, the cost of delivering services can be lowered across the entire system.[8] That is how commissioning helps governments do more with less.

An example of an innovative tender that placed an emphasis on value comes from Sweden in 2012. The Stockholm County Council, a body that manages most of the city's hospitals, set out to purchase wound dressings but with an eye to system-wide outcomes. Their RFP included three hypothetical patient case studies, and asked vendors to calculate the total cost of treatment for each case – including the wound dressings themselves, the number of dressing changes, staff costs for these changes, transportation costs to patients' homes, and the expected complications. The winning bid came from a supplier with the highest-priced products, but which was able to demonstrate a lower total cost of care – and could document that with clinical evidence.[9]

Using commissioning to inject innovation

Commissioning is a means of creating long-term strategic alliances between public and third party entities. This could mean a joint venture partnership, or a relationship that goes beyond a pre-defined project. Some commissioning models involve structures that allow stakeholders to explore new processes, products, and technologies together. This unites organizations with different expertise and resources, resulting in a whole that is greater than the sum of its parts. Innovation comes not only from the access to, or creation of, new technologies, but also new approaches to solving problems or new processes for delivering care.[10]

Sweden provides another instructive example of commissioning. In 2014, Karolinska University Hospital issued a 14-year tender for imaging services. Their tender indicated that they wanted not merely to procure equipment (CT, MRI, and ultrasound scanners) but also the services themselves, including maintenance and upholding of technical standards. The winning bidder was Philips, as their proposal included the establishment of a local innovation hub focused on improving outcomes in ten high-priority areas. This meant that Karolinska was able to receive newer imaging systems (helping their patients more broadly), and become a leader in research.[11]

Overcoming the trust barrier

While commissioning has tremendous potential to create a productive, mutually-beneficial relationship between public and third party players in health care, there exists one major barrier: trust. In order to be successful, we must break down the "MOHLTC vs. industry" divide.[12] This means building collaborative relationships that are based on professional respect, aligned interests, and a recognition that we all support – and benefit from – a more effective universal health care system.

In order to achieve this, there must be a cultural shift. The public sector should focus on collaboration and joint solutioning in recognition of the value of third party experience and expertise. Similarly, third parties should approach government rules and processes as guidelines that allow for necessary accountability and transparency, rather than as immovable barriers. The complexity of our health care system requires greater collaboration than exists today.

Commissioning: A Toolkit Approach

COMMISSIONING: A TOOLKIT APPROACH

There are numerous forms of collaboration between the public sector and third parties that seek to inject innovation, improve value for investment, and evaluate based on outcomes. These include value-based procurement (VBP) and innovative service delivery, both of which are potential processes under a commissioning umbrella. What these approaches have in common is the applicability of commissioning principles to their design and operation, as each requires a needs-based collaborative approach to succeed. Commissioning offers an invaluable toolkit for that success.

Value-based procurement

In *Spend Smarter, Not More: Leveraging the Power of Public Procurement*, the OCC championed the modernization of procurement practices across all government ministries. Although progress has been made since that report was released in 2014, particularly with respect to changes at Infrastructure Ontario (IO), there is still untapped potential within the procurement framework currently used by the MOHLTC.

Traditional procurement is input-focused and prescriptive. Vendors provide a good or service and that contract is largely the limit of their interaction with the system. Relationships are short-term, arms-length, and with a limited scope as the expected solution to any given problem has been determined before the supplier gets to the table.[13]

Furthermore, procurement decisions are largely made on price, meaning the process "addresses neither quality nor the total cost of patient care".[14] As products are procured with budgets in mind, rather than performance, their wider impact on system cost or patient outcomes is not reflected in the selection process. If a product is difficult to use, poses a safety risk, or simply does not perform to expected standards, the consequences are generally felt on patient quality of life or HCP productivity, not the procurement budget.[15] Consequently, there is no incentive to change the selection process.

In contrast, value-based procurement is driven by real needs, particularly the needs of users: both the people who will be using the procured item (HCPs), as well as those who will be exposed to it (patients). If those perspectives are included in procurement decisions, information about real use patterns and experiences can be taken into account. Moreover, if vendors are exposed to front-line users, they may have a better grasp of what is needed to deliver health care effectively and may have a different answer to the buyer's question. Commissioning is the best means of linking users and vendors with buyers, as their informed perspectives are critical to defining a problem, identifying desired outcomes, and creating a collaborative solution.

Though the European Union (EU) is likely the jurisdiction with the most advanced VBP model, there has also been interest in the approach here in Ontario.[16] In *The Catalyst: Towards an Ontario Health Innovation Strategy*, the Ontario Health Innovation Council made two recommendations that explicitly reference the means with which public buyers can bring value and innovation into the health care system. These recommendations (along with all the others in that document) were accepted by the Government of Ontario. Now, the Ministry has established the Office of the Chief Health Innovation Strategist to make them a reality. This is a tremendous act of leadership, and a moment to capitalize on.

Recommendations from the Ontario Health Innovation Council include:

Recommendation 4: Accelerate the shift to strategic value-based procurement

- "The Council believes strategic procurement can better contribute to healthier populations, a more efficient health system, and the growth of Ontario's health technology sector."

Recommendation 6: Optimize the pathways to adoption and diffusion of innovation

- "The Council also believes that stakeholders throughout that innovation ecosystem can do a better job of coordinating the various pathways for adoption."

Service delivery innovation

In *Unlocking the Public Service Economy in Ontario*, the OCC evaluated the conditions necessary for successful alternative service delivery (ASD), including situations in which ASD provides potential for improvements in service quality, cost savings, and examples of where the private sector is already active (and proven) in the space. Service delivery innovation can bring some of the best features of a market to the public service economy, as it allows the government to harness a third party's funding, expertise, technology, and business models for the benefit of public sector goals.

Under innovative service delivery models, the role of government is generally to steward the public sector market by regulating and setting policy. The role of a third party is to deliver on its contract, one that specifies the fiscal and patient outcomes agreed-upon in advance. The successful execution of these roles relies upon outcomes-based contracting, where "compensation to the private entity has a component dependent upon some result".[17] This is a risk-sharing arrangement in which reimbursement is linked to real-world performance. Not only does this protect the government's investment, but allows it to hold third party contractors to greater accountability.

In order to issue an outcomes-based contract, public sector stewards must be able to determine their desired outcomes, and explore means by which they could be met. By using a commissioning approach to define needs and objectives first, the potential service providers will have a better understanding of the public sector ask and so can bring forward more tailored solutions.

There are a number of arrangements that fall under the category of innovative service delivery:

- *Alternative service delivery*: A process of public sector restructuring in which governments partner with a third party to deliver public services. Third parties provide capital, technology, and processes, while the government is responsible for policy, strategy, and compliance.
- *Joint ventures*: Public and/or private entities with complementary capacities join forces through financial, service delivery, research, or other means to realize outcomes. A joint venture may be chosen if the government has the technical expertise, but not commercial acumen, to achieve a goal.
- *Integration contract*: Similar to a joint venture, integration contracts are between private suppliers. In forming a consortium (particularly between firms of varying size), a major company takes on most of the risk and provides the financing, while a smaller organization provides the specific expertise needed to deliver services.
- *Public sector mutuals*: In this scenario, public sector employees bid to take over services they deliver, giving them ownership and control, so they can innovate and redesign based on their ground-level knowledge of client needs. The result is usually a positive impact on quality. The UK has approximately 70 public sector mutuals, delivering an estimated $1.8 billion in public services in specialized areas like community care.
- *Delegated Administrative Authorities*: DAAs are private companies that deliver government services, reducing costs and improving efficiency and regulatory outcomes while still allowing the government to retain oversight. A local example is Ontario's motor vehicle inspection and commercial vehicle safety enforcement arrangement.
- *Choice-based (voucher) system*: In a voucher system, it is the users who make decisions about service. Common in European health care systems, vouchers enable choice and promote competition. This means that patients – rather than service deliverers – are at the centre of the service relationship. The Ontario Health Insurance Plan (OHIP) is a form of choice-based system.[18]

Innovative service delivery and labour

One common challenge to new service delivery models is resistance from established HCPs or labour unions, even as a commissioning model brings them and the professions they represent to the table. Some governments and private providers have dealt with this issue pro-actively, by negotiating a Memorandum of Understanding (MOU) wherein existing employees maintain successor rights, remain in their union, are offered positions with the new provider that include the same or better benefits and pay, and keep their provincial pensions.[19] Generally, unions and professional associations should be kept informed of new processes the Ministry or its buyers choose to enact, particularly from a change management perspective. They need to be informed that a deal is happening, and their members need to be fully integrated and trained in a way that encourages feelings of ownership and investment in new procedures. If a change in service delivery is to be truly focused on putting patients and their well-being first, then HCPs and other front-line workers must be meaningfully engaged from the beginning.

Social Impact Bonds

When we discuss the creation of a sustainable health care system, part of what we mean by creating sustainability is reducing demand.[20] This necessitates enacting solutions that address the broader environment that has contributed to a patient's need for treatment. While they are only now beginning to be utilized in the health sector, social impact bonds (SIBs) may be a meaningful tool

for addressing the complex nexus of factors that impact population health.[21] As the starting point of an SIB is identifying a need, by design these bonds require a long-term multi-stakeholder approach, like commissioning.

SIBs are an attempt to address the inter-connected issues that drive problems in our society, by moving away from "silo'd" government action and fee-for-service arrangements towards comprehensive outcomes-based programming. The bond works when private investors fund a program to deliver improved outcomes against a variety of social, economic, and health measures. Programming is run by experienced non-profits and, after the achievement of set outcomes, the principal and interest are returned to investors based on the share of savings achieved by government.

SIBs address a series of issues:
- Government-funded social programs are generally not performance or results-driven;
- A fear of failure inhibits the public sector appetite for risk;
- Infrequent or poor measurement allows unsuccessful programs to persist;
- Consistent under-investment in prevention;
- "Treating the symptom" rather than the disease; and
- A lack of public capital.[22]

For this reason, SIBs could mitigate some of the challenges identified in *Patients First*, particularly those related to uniquely underserved populations and the lack of consideration for population health in system planning. An SIB may be valuable in addressing these issues because government funding is increasingly difficult to obtain and often not assured through the long period of time it takes to see results.

Ontario has begun to explore the idea of SIBs. The Ministry of Economic Development, Employment and Infrastructure has developed business cases for four pilot projects and is in the process of implementing these pilots. Already, the Government has identified benefits from the process, including intra-ministry collaboration and productive discussions with private organizations from across sectors.[23]

Case Studies

CASE STUDIES

The concepts of commissioning, VBP, and innovative service delivery are not new to Ontario, but change is slow and hard-fought within our health care system. Outside of health, Infrastructure Ontario has been a leader in alternative financing and procurement models. Today, their projects have a dedicated Commissioning Authority assigned to lead the process. This ensures that stakeholder objectives are achieved through planning, testing, and verifying.[24] IO's experience may therefore be one to look to across ministerial lines.

However, IO is but one example. The four examples below, from across Europe and here in Canada, illustrate how commissioning approaches can be utilized in a variety of scenarios and to address any number of challenges.

There are countless examples of innovative public/third party partnerships from around the world. What should Ontario consider when looking at other jurisdictions for best practices?

- Were better outcomes measurably achieved?
- What led to a program's success? What did they learn from their failures?
- What are the contextual or qualitative factors that impacted their design or their results?
- What are the conditions unique to this jurisdiction or sector? Are there similarities to Ontario against which we can map our approach?

United Kingdom: *The National Health Service (NHS)*
The NHS – particularly NHS England – has for years been making an effort to re-orient its entire system around patients, by focusing on the outcomes that enhance Britons' quality of life.[25] System leaders determined that to get where they want to go, the NHS needs to "work systemically" through defined problems and goals, create a "culture of rigorous testing" by being open to continuous learning and adaptation, and engage high-level leadership.[26] As part of this re-orientation, the NHS Commissioning Assembly was established.

A catalyst in this move towards commissioning was *A Concordat with the Private and Voluntary Health Care Provider Sector*, signed in 2000 between the UK government and the Independent Healthcare Association. An "enabling framework" for a new relationship between public and private, it begins with an uncompromising statement: "There should be no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it, when they need it."[27]

The Concordat encourages involvement of third parties at the early stages of care planning, and specifies that relationships between the NHS and private providers must represent good value for money for the taxpayer and high standards of care for patients. It also makes clear the responsibility of the commissioning body to ensure that desired standards are met, and the responsibility of the private sector to deliver against these standards. All providers – public and private – are held accountable to one universal standard: the safety and wellbeing of NHS patients, regardless of where they are treated.

As a result of this policy, there have been numerous small-scale successes seen across the UK. For example, a commissioning approach taken to procurement saw the refurbishment of five labs, allowing operations to run at full capacity, including providing for weekend preventative visits. Revenue increased, as did the share of cases performed.[28] In another part of the country, local administrators were able to bundle 20 contracts for musculoskeletal care into a single, five-year, payment-for-outcomes contract.[29]

The European Union
In 2014, the EU enacted a directive dedicated to supporting the adoption of VBP. EU Directive 2014/24 "aims to improve procurement by promoting quality and innovation while considering longer-term costs, as well as, for example, environmental and social factors".[30] It encourages greater interaction with the marketplace and closer collaboration between buyers and suppliers. The directive mandates that each member state convert it into

national law by April 2016, with the UK having been first to do so in February 2015.

The Directive centres on two concepts:
• *Value for money*: Value is thought of in terms of better care pathways, health outcomes, and socio-economic outcomes.
• *Quality/cost ratio*: This is the economic value that arises from more effective treatments and care. Over time, costly progressions of disease are prevented, as is further contact with the health system. Patients are healthier, and money is saved.

In order to deliver against these concepts, EU buyers are expected to choose the Most Economically Advantageous Tender (MEAT). In order to find the MEAT, buyers determine the desired criteria for an item or service (related to costs, desired patient outcomes, other benefits for stakeholders, broader social impact, etc.) and then assign a monetary value to each criterion. The value assigned reflects the willingness of the buyer to pay for each benefit, and the winner is calculated by deducting the "cost" of all fulfilled criteria from the price. Therefore, the bid with the lowest resulting dollar value (highest overall "real" value) wins. This is able to bring an objective, quantitative and widely understood unit of measurement to the process, without complex scores to interpret. A model in Spain that used a MEAT approach was able to decrease system cost by 25%, while increasing patient satisfaction by 20%.[31]

Canada: Health Insurance British Columbia
In 2001, the British Columbia Ministry of Health Services decided to explore alternative service delivery options for managing their Health Benefits Operations. They established an ASD Secretariat (now the Business Management Office), comprised of a small group of highly-specialized individuals, including an economic modeller, lawyers, strategic procurement staff, and "deal architects". These individuals had skills critical to taking a commissioning approach to ASD: they understood markets and had commercial expertise, such as project management, and contract design. This gave them the ability to understand the provider perspective, along with the needs of the Ministry.[32]

One means of including the provider perspective was to develop a Joint Solutions RFP (JSRFP) system, so to better integrate vendors in the problem definition and solution stage of a commissioned project. A JSRFP contains a description of the problem and the desired outcomes as defined by the buyer; the provider selection process then proceeds in tandem with solution creation. This means vendors have more independence in their suggestions and are able to draw on the expertise of government staff.

Out of this system came a successful ASD partnership between the Ministry and MAXIMUS Canada, to operate what would become Health Insurance BC, a provider of account and claims management for the health and pharmacare system. Beginning in 2005, this partnership resulted in a series of service improvements, including:
• The replacement of manual data entry and document management for registration and transactions;
• The consolidation and modernising of an aging telephone system into one call centre; and
• The creation of a new platform for the claims and enrolment systems.[33]

The success of these changes led to the government pursuing new avenues of ASD with MAXIMUS that had not been originally envisaged, including the development of the BC Services Card integrating health insurance, driver's licensing, and personal identification. The increased capacity of HIBC brought about by MAXIMUS' investments meant that they could integrate the services of three Ministries and two service providers into one card.[34]

Ontario: Southlake Regional Health Centre
Southlake Regional Health Centre in Newmarket, Ontario decided to pursue an innovative procurement experiment with a clear objective: "Develop a procurement model and vendor engagement strategy which fosters innovation and more holistic solutions to deliver better value for money and better patient outcomes". [35]

Administrators chose their cardiac department as the site of this experiment, as it is a high-spend area ($20 million per year, representing 8% of the hospital's total spend), is funded on a per-case basis, had itself previously experimented with innovative tendering, and almost all of their contracts were expiring at the same time. Traditionally, their RFP would be largely price-focused, centred on a specific supply, eliminate any value-add that couldn't be defined up-front, and come with little vendor dialogue.

As part of their overall objective, Southlake re-oriented towards improving value anywhere on the value chain, not just this specific supply. They brought together their internal team (including clinicians) to talk about major, long-term goals, such as wanting Southlake to be at the forefront of R&D and wanting to be the leading cardiac team in North America.

This set the stage for inviting outside stakeholders, using an expression of interest to comply with – but not be restricted by – the Broader Public Service Directive. Doing so created an open and transparent process that can be legally supported and defended, and one that provides structure for defining problems, outcomes, and eventually solutions. Most importantly, it created a relationship that does not begin and end with the formal vendor contract.

The cardiac department is now in a situation where not only are clinicians engaged in procuring the items they themselves will be using, but they have a greater understanding of the procurement process. And with outside stakeholders consistently engaged, Southlake is in a position to both acquire and develop innovative new technologies to meet their larger organizational goals.[36]

What do these case studies have in common?

While there are countless approaches to deploying commissioning, VBP, and innovative service delivery, most share commonalities that enable them to re-orient buyer thinking around outcomes and strengthen relationships between private and public players:

- The definition of value is broadened, usually in tandem with buyers taking a large-scale, long-term view of their desired outcomes.
- Though the role of the third party may differ from case to case, depending on the jurisdiction and organizational needs, collaboration always starts early and is continuous.
- The public sector approach is not prescriptive; solutions are not determined before stakeholders like HCPs and third parties are brought on board.
- Public sector participants (both administrative and clinical) are asked to differ from their traditional procurement or service delivery function (i.e. HCPs learning about procurement, administrators learning a new process). This means building new skills and capacities, or thinking about their role within the system differently.
- The public sector accepts a role as steward, relinquishing some control over decision-making and/or service delivery to its partners.

How to Commission Successfully

HOW TO COMMISSION SUCCESSFULLY

It is clear that there are considerable benefits to bringing a commissioning approach to our health care system. But how does a public sector entity go about making the transition to commissioning? How do they build the necessary skills, or even start a conversation that will change organizational cultures? While every approach to commissioning will be context-specific, we suggest a high-level process that is broadly applicable across a range of sectors:

1. Identify: Determine where you want to go and what is needed to get there

In order to determine the direction and objectives of a project, which stakeholders to involve, and what tools to use, commissioners should ask themselves a series of framing questions:

What are the organization's goals, both broad and narrow?

Where are there hotspots for change, such as areas with critical needs or where existing conditions present an opportunity?

What expertise are we not currently tapping into?

Are we able to quantify and measure outcomes?

If we procure this way, who is likely to respond?

Do we have the authority to make this change? The resources?

What are the current market dynamics and capabilities, in both the public and private sectors?

How can we obtain buy-in from front-line care workers?

Who will we be serving, and what are their needs and wants?

Why are we thinking about change?

Where will there be resistance?

The most important identification for the public sector to make is that of outcomes. A clearly defined set of outcomes will provide direction for the project, ensure stakeholders are on the same page, and allow for accurate assessment of success or failure.

2. Collaborate: Establish relationships and maintain them throughout the process

Public sector commissioners, once they determine the appropriate stakeholders to include, should draft expressions of interest or similar documents that define their problem, seek to validate their outcomes, outline their expectations, and make clear the relationship they are seeking. Such a document can also create a formal bond between all parties and, once stakeholders have committed to a project, serve as a basis for a long-term partnership.

These documents should also provide clarity in roles and responsibilities, identify the risk share, codify the governance structure, and outline the economic model. They should also be able to address expectations about accountability and transparency (i.e. through an accountability map). Critically, a balance in stakeholder voices should be struck, so that the public or buyer voice is not exclusive or dominant in decision-making. By establishing a fair playing field, it is easier for all parties to build trust.

There must also be alignment between funders and buyers. In Ontario, this could mean the Ministry, LHINs, hospitals, and shared service organizations. Alignment can take the form of financial support, a willingness to allow an organization to experiment by bending or changing rules, or just a pledge of support from high-level leadership. The more leaders on board, the easier it is to create the kind of structural and cultural change required to re-orient towards outcomes-based decision-making.

3. Invest: Set the stage for success

In order to create the resources, capital, and/or incentives

to allow a shift to take place, commissioners may have to change where money is attributed, shift staff to provide expertise needed for a particular project, or modify rules and policies to allow for reform. Conducting a current state analysis is a helpful first step, as it can identify opportunities and capacity, while a business case analysis will strengthen the case for change. Both tools can examine transference of risk, capital investments, service upgrades, and identify long-term benefits.[37]

Investment in resources also takes the form of building capacity within teams. All projects will need individuals with commissioning skills, which the public sector can either develop internally or hire from an outside expert source. Wherever they come from, commissioners should understand what the market looks like both in and outside of their service area, how to effectively and equitably use competition in the public service economy, and how to collaborate with many different stakeholders.[38]

Overall, investment should be made with four standards appropriately in place before commencing with a project:
- *Well-led*: Support should come from all partners, with support given to all partners. Change should be led by fair governance practices with end goals of patient health and system sustainability always top of mind.
- *Patient-centred and outcomes-focused:* Commissioners should recognize that changes will enable the system to deliver more than just fiscal value. These changes should be based around the people who use the services, not around the organizations that provide the services (which is the current view). Evidence should be used to make decisions, and a whole-system approach should be applied to evaluation.
- *Inclusive:* New processes or structures should be inclusive in both process and outcomes, which can be achieved by co-creating them with all appropriate stakeholders (patients/caregivers, HCPs, hospitals/clinics, LHINs, the Ministry, vendors, academics, etc.). A spirit of inclusivity creates meaningful opportunities for collaboration and leadership.
- *Promotes a sustainable and diverse marketplace:* The internal public service marketplace should emphasize value for money while developing the capacity to create that value continuously and competitively.[39]

4. Measure & Evaluate: Build an evidence base

In order to determine if outcome targets are met, commissioners must establish means and methodologies for data collection and analysis, including benchmarking. Proper measurement can help verify that all parts of a system are working as they should, and inform learning for the next iteration of a program. However, data collection resources may be fragmented or non-existent, leading to the problem of needing to create new systems before VBP or new services delivery models can be implemented. Rather than the public sector being responsible for building resources from scratch, however, partnerships with third parties (including post-secondary institutions) can provide dedicated and specialized capacity.

The other challenge is determining what an appropriate and measureable outcome looks like. While it depends on the nature of the problem, a possible starting point is the work being done by the International Consortium for Health Outcomes Measurement (ICHOM). The ICHOM brings together patient advocates, leading physicians, and researchers to define what they call "Standard Sets" of outcomes for each medical condition, along with an "implementation journey" for adoption by health system managers and providers. Currently, they have standard sets for 19 conditions, and aim to cover half of the global disease burden by 2017.

5. Share: Be a resource for change elsewhere

Just as there are examples from other jurisdictions to look to, Ontario has the potential to be a leader in the effort to inject greater value and innovation in health care globally. A pledge to share experiences (both successes and failures) with the public and other jurisdictions should be built into framing documents at the start of a project, to create accountability and to help build system-level action. Similarly, dialogue with counterparts from other organizations should be established and encouraged, to help prevent each entity from having to "re-invent the wheel" if they decide to experiment with commissioning.

In order to support this information-sharing, consistent data collection is vital, as empirical validation strengthens proposals for innovative projects in other sectors and jurisdictions. This data – both quantitative and qualitative – should also be published where possible, either through open data initiatives or partnerships with post-secondary institutions.

Potential barriers and challenges

When designing a commissioning structure, commissioners may encounter a number of barriers and challenges. These include:
- Risk aversion, including political and bureaucratic incentives to retain the status quo
- Incentives misaligned with goals, i.e. contracts and payments that focus on activity rather than results.
- Lack of appropriate data collection and dissemination capability (and therefore an inability to

benchmark, evaluate, and share).
• Complexity of organizational structures. As accountability and outcomes are shared across departments, Ministries, and stakeholders, the result is diminished feelings of ownership and impeded flexibility.
• A general lack of capacity, as commissioned projects may be resource-heavy where resources may not exist. They also may require a lengthy management process which becomes disrupted due to the natural cycle of changing government administrations.[40]
• An inability to scope a problem, or predetermined "solutions" masquerading as problem statements.
• The fickleness of the political cycle, including a lack of appetite for reform.

The best approach to combating these barriers is a current state analysis rooted in evidence, and assessed against those outcomes mutually identified by stakeholders and clients. This provides a clear case for change and demonstrates that the status quo is neither sustainable nor achieving desired outcomes. While this is not the only variable to overcoming challenges, it is the most important one, as evidence is the strongest panacea.

Advice for the private sector

The biggest hurdle to commissioning successfully is creating viable long-term relationships between the public and private sectors, particularly for-profit enterprises. It is the private sector, though, that has the greater hurdle to overcome in order to gain the trust and respect of their public counterparts. This hurdle may be mitigated in the following ways:
• Make clear your organization's shared beliefs and values, including demonstrating your goals outside of an exclusively business context. Your corporate values should reflect a public sector ethos.
• Demonstrate value with data, including building capacity for the public sector to collect and analyze data, sharing the data already collected, and providing appropriate ownership to the Ministry of relevant data.
• Provide the kind of business acumen that can help the public sector be better prepared for changing scenarios, i.e. with trend forecasting and other dynamics. Indicate how being nimble can protect the interests of the public. However, also recognize the expertise government brings to the table, and where you can learn from their experiences.
• Be willing to take on not only traditional investment risk, but also outcomes-based compensation risk. If a commissioned solution is expected to achieve a measureable outcome, third parties should be willing to accept that risk and be paid less if the outcome is not achieved.

Private organizations must also be sensitive to the political environment in which the government has to operate. As there is risk inherent in collaborating with the private sector in the health space (usually related to ideological/cultural concerns and criticisms), they should be able to demonstrate that, by engaging with the private sector, the government will receive a return on the political capital they have expended. The private sector should be ready to absorb some of this political risk in order to help achieve shared goals. Ultimately, they need to be able to demonstrate to the public that this collaboration was a good decision on the government's part.

CONCLUSION

As a result of well-established fiscal and demographic challenges, Ontario needs to start buying better health care, not just more health care. This means taking a value- and outcomes-based approach to the way we procure goods, deliver services, and make decisions within our system.

Commissioning is a model that could help create an evolutionary approach to the kind of large transformation our health system needs: by providing the building blocks for better public/private interactions, by helping define real objectives, and by establishing "big tent" collaborations for problem solving. The improved integration of private and public created by commissioning, value-based procurement, and innovative service delivery can generate capacity for the entire system by providing greater efficiencies, and therefore, greater value.

Where should Ontario start? There are excellent tools already available (such as the Commissioning Academy and the Council for Innovation Procurement in Health Care), and inspiring examples from comparable jurisdictions, health care providers, and the private health sector. However, this is not a time to reach for the low-hanging fruit. It is the areas with the most complexity that would benefit most from a commissioning approach. Starting with a high-level re-evaluation of the cultures and structures that drive our broken system, the commissioning toolkit can be a means to take back control over the complex problems we face.

END NOTES

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