Reimagining Commissioning for the Next Generation of Health Systems

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The core challenge facing modern health systems is not simply how to organise services differently. It is how to build frameworks capable of continuously adapting to changing population needs. For decades, commissioning has been synonymous with purchasing—translating needs into rigid contracts and provider boundaries. This article outlines why that model is obsolete and previews the architectural shift toward a distributed system capability.

Historically, healthcare commissioning served an essential purpose in an environment where individual organisations were the dominant units of design. However, healthcare value is not generated by isolated entities acting independently. Real value emerges organically through the continuous interaction of patients, clinical professionals, local communities, digital infrastructure, and collective institutional knowledge.

When health outcomes are produced by complex adaptive systems rather than singular brick-and-mortar facilities, traditional procurement models break down. The strategic horizon requires us to move beyond improving transactional efficiency within existing organisational boundaries. Instead, we must fundamentally reimagine how commissioning functions when embedded within an integrated ecosystem.

A Distributed Architecture: The Four Levels of Commissioning

Commissioning has not disappeared; it has been deconstructed. Rather than existing as a standalone bureaucratic function detached from the frontline, a modernised system integrates commissioning throughout four operational tiers:

- **Micro-Commissioning:** Occurs daily at the point of care. It is driven by individual clinical decisions, resource allocation, and personal choices about patient pathways.
- **Meso-Commissioning:** Focuses on the orchestration and co-design of clinical pathways and capabilities spanning across historical organisational boundaries.

- **Macro-Commissioning:** Sets the strategic tone, aligning population health outcomes, multi-year financial incentives, accountability metrics, and broad resource allocation.
- **Meta-Commissioning:** Curates the structural conditions that allow the entire system to thrive, including unified digital infrastructure, workforce strategy, estate utilisation, and interoperable clinical standards.

> *"The future question is no longer: 'Which organisation owns this service?' It is: 'What capability does this population require, and how should the system organise itself to create it?'"*

From Rigid Control to System Orchestration

Complex adaptive systems resist top-down command and control. Managing them effectively requires strategic alignment, real-time intelligence, and institutional flexibility. This alters the leadership paradigm for both commissioners and provider networks.

Strategic Commissioners assume the role of *System Architects*. They are responsible for analysing population health trends, defining shared strategic directions, creating the rules of engagement that incentivise appropriately, ensuring equity of access, and maintaining coherence across diverse delivery networks.

Conversely, **Provider Partnerships** act as *Market Orchestrators*. They are tasked with scaling clinical capabilities, dynamically aligning local resources, organising internal provider markets, coordinating patient pathways, and accepting mutual responsibility for collective population risk. Executive leadership can no longer be limited to managing single institutions; a leader's primary responsibility is now to foster and sustain the operational environments that enable continuous, system-wide improvement.

A New Relationship with Risk and Integration

Adopting a capability-driven framework requires a radical shift in how health systems manage risk. Conventional organisational risk registers typically capture the administrative or financial fallout of a crisis rather than addressing the systemic population vulnerabilities driving them.

Reframing System Risk: In a mature integrated health system, population risks belong explicitly to the system as a whole. Individual organisations remain accountable for the specific operational controls they maintain. This removes artificial ownership of complex, wicked problems and establishes a realistic model of shared accountability based on real-world influence.

Furthermore, this framework clarifies the true objective of integration. Structural integration is frequently treated as an end in itself, resulting in cosmetic organisational mergers that fail to shift outcomes. Integration is merely a mechanism. Its true objective is to build a system structurally capable of dynamically responding to population need.

The Ultimate Analytical Paradigm Shift

The future of health system design does not rely on a binary choice between preserving or dismantling commissioning bodies. Rather, it hinges on whether we expand our definition of commissioning from transactional purchasing to holistic system design. The ultimate measure of success is not whether organisations collaborate more frequently, but whether populations realise measurably better health outcomes.

OLD PROCUREMENT VIEW	NEXT-GENERATION SYSTEM VIEW
"Who commissions healthcare?"	**"How does a health system continuously commission itself to improve?"**
Commissioning individual services.	**Commissioning distributed capabilities.**
Commissioning isolated organisations.	**Commissioning integrated systems.**

Conclusion: The Path Forward

Transitioning from traditional purchasing to system self-commissioning requires more than a shift in rhetoric; it demands a total restructuring of power, resources, and institutional

mindsets. If we continue to measure integration by the number of joint committees or merged boards, we miss the point entirely.

The true measure of an integrated health system is its agility—its capacity to read shifting population risks, dynamically redeploy assets, and continuously refine its own architecture to optimise human health. Moving from an organisation-centric view to a capability-driven ecosystem is the only viable route to realising a sustainable, next-generation health system.

Challenging Questions for Your System

To test whether your health system is truly evolving or simply rebadging old transactional habits, ask your leadership teams these four uncomfortable questions:

1. The Accountability Paradox

If population risk truly belongs to the system rather than individual institutions, are our financial penalty frameworks and performance metrics designed to reward collective risk-sharing, or do they still penalise individual organisations when systemic bottlenecks occur?

2. The Freedom of the Frontline

If micro-commissioning occurs every day through clinical decisions, have we actually given frontline clinicians the real-time data, resource flexibility, and permission to adapt pathways dynamically, or are they still bound by rigid, macro-level procurement specifications?

3. The Power Shift

Are our current provider partnerships mature enough to act as genuine "market orchestrators" that can shift budgets and workforce across institutional boundaries based on population need, or are they still primarily protective of their own historical funding and estate footprints?

4. The Meta-Infrastructure Deficit

Do we possess the meta-commissioning infrastructure—specifically interoperable digital data and shared workforce standards—needed to track population health in real-time, or are we trying to run a complex, distributed ecosystem using fragmented, 20th-century institutional tools?