

A review of the effectiveness of primary care-led commissioning and its place in the NHS

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Sally Wyke is Director of the Scottish School of Primary Care and has twenty years experience in health services research in the primary care sector. She was a key member of the team that undertook the evaluation of total purchasing in the UK (Mays, Wyke, Malbon and Goodwin (eds) 2001; Wyke, Mays et al, 2003) and has led several other research programmes in the organisation of primary care. She works with members of the Scottish Executive Health Department and NHS Boards to make research evidence accessible to the policy development process.

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Executive summary

This report sets out the findings of a review of the evidence on the effectiveness of primary care-led commissioning and its place in the UK National Health Service (NHS). The principal aim of the review was to identify the organisational and process factors associated with effective primary care-led commissioning and also their relevance to other approaches. The project was funded by The Health Foundation and took place over the period February-August 2004. Our suggested definition for primary care-led commissioning, based on this review of the evidence and our understanding of contemporary health policy, is as follows: *'Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients' needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct the health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients.'*

Assessing the impact: a review of the evidence

The selection and application of future models of commissioning needs to be informed by lessons from past experience. Our review of the evidence on the impact of primary care-led commissioning can be summarised as follows:

- There is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services.
- Primary care-led commissioning (where clinicians have a clear influence over budgets) can however secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress, as was seen within GP fundholding.
- There is research evidence to show that primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services, stimulating new forms of peer review and quality assessment within and across practices, enabling new forms of specialist primary care, and building new community-based alternatives to hospital care.
- Given an opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding working practices in the local health system, as demonstrated by many of the innovations secured through total purchasing projects.
- Primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role, as demonstrated through GP commissioning and fundholding.
- Primary care-led commissioning increases transaction costs within commissioning.

Improving primary care-led commissioning: applying the evidence

Research into primary care-led commissioning has tended to focus on monitoring and assessing the implementation and early development of new commissioning schemes. Thus there is an extensive evidence-base on the organisational features, process factors and contextual characteristics associated with more or less effective primary care-led commissioning. What the evidence tells us about facilitating effective primary care-led commissioning is as follows:

- There is no 'ideal' size for a commissioning organisation – different population bases are needed for commissioning different services.
- Adequate levels of management support are vital to the success of commissioning, as was vividly demonstrated by the experience of total purchasing, where schemes with higher levels of support were seen to be more effective in terms of outcomes.
- Timely and accurate information is required for commissioning – NHS routine data could be exploited to a much greater degree as a source of analysis of patient flows and pathways.
- Real and meaningful clinical engagement in commissioning is crucial, the power of this is demonstrated by the experience of Bradford North practice-based commissioning scheme, NHS Collaboratives and the IPAs of New Zealand.
- There is a careful balance to be struck between ensuring clinical engagement and assuring appropriate public and management accountability for commissioning decisions.

- Primary care-led commissioning organisations have struggled to engage patients and the public in a meaningful way.
- Local health commissioning/funding bodies face a difficult challenge in enabling primary care-led commissioners to have the headroom to commission according to local as well as national priorities.
- Whilst commissioners need to have effective strategic relationships with providers, they also need to have the ability to shift activity elsewhere – ‘contestable collaboration’.
- Commissioning organisations need a degree of stability in the wider policy context – they have never been given a sustained chance to prove their worth.
- A single organisational solution to commissioning is neither possible nor appropriate.
- To achieve this, commissioning organisations need a degree of organisational stability. Providers have had relative stability for some 15 years whereas commissioners have been subject to numerous major imposed reorganisations.
- Commissioners need new and more advanced forms of support, in particular in developing a range of skills and competences such as the stratification of patients according to risk, commissioner-led advanced case management, predictive modelling of high user patients, handling and analysis of routine data, and more refined assessment of service quality and outcomes.
- Policy makers need to ensure that commissioning organisations have sufficient headroom and freedom to develop and implement local as well as national commissioning priorities. This is vital if local clinicians are to feel engaged with commissioning and service development activities.
- Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all points along the commissioning continuum, and in particular within those approaches closest to the patient.
- The legitimacy and accountability of commissioning organisations needs to be made clear within whatever blend of models is applied within a health economy, and needs to be balanced with the necessary engagement of clinicians.

Messages for policy makers and managers

In concluding the study, a set of messages for policy makers and managers is distilled, and specific challenges are made to the health systems in each of the four countries of the UK.

- There is little evidence to show that any primary care-led (or other) commissioning approach has made a significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers.
- Primary care-led commissioning has been shown to be effective in the area of primary and intermediate care and in encouraging greater responsiveness in elective hospital services. There is significant potential to build on this experience of service development and innovation, this time within a stronger framework of public accountability and national health priorities.
- Primary care-led commissioning may be effective as part of a continuum of commissioning models, and particularly appropriate for ‘simple’ and community-based chronic disease management and primary care services. Other models of commissioning are required for more specialised and complex services, including the development of more integrated forms of service provision based on managed care techniques and approaches together with care pathways. The challenge for funding organisations is rigorously to select an appropriate blend of approaches and to be clear about how, and for what reasons, that selection has been made.
- There is a need for more systematic assessment of the impact of models of health commissioning, including the examination of their ability to achieve specific service and patient quality objectives which can be monitored in a rigorous manner.

What then does this analysis of the research evidence about effective commissioning and service development have to offer the health systems of the four UK countries?

Challenges for the English NHS

- Can PCTs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?
- Can space be created for the development of local commissioning models and priorities when PCTs are faced with an extensive set of national targets and performance indicators? Is the NHS prepared to tolerate the local variation that will result from this ‘letting go’?
- How will clinicians be re-engaged in the commissioning process, given the evidence that this has been largely lost over the past few years? What if local practitioners do not want to take up practice-based commissioning? How will this process of development be resourced?
- Is there real interest in commissioning to reduce health inequalities and to achieve public health outcomes? If so, is the current set of approaches to commissioning adequate to this part of the commissioning task?
- How will the experience and learning from service redesign and modernisation activity be integrated fully into the commissioning process?

- How can local people be properly involved either as citizens or consumers in commissioning and have a true voice in determining health priorities?

Challenges for the Northern Ireland NHS

- Are local health and social care groups (LHSCGs) feasible as a method of commissioning, given the current political context in Northern Ireland?
- Can LHSCGs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?
- To what degree is it possible (or desirable) to have a system based on a purchaser-provider split in a health system which is tightly integrated and geographically coherent?
- Is it possible to create the space for the development of local commissioning models and priorities when LHSCGs and boards are faced with an extensive set of national targets and performance indicators?
- How will GPs be re-engaged with the commissioning and service planning process?

Challenges for NHS Scotland

- Is the right set of incentives in place to achieve the changes required through community health partnerships (CHPs)?
- How will primary care based and secondary care clinicians be engaged in planning processes for CHPs? What are the incentives for them to engage?
- Is there a 'right size' for CHPs? Is there potential to consider lessons from the development of other primary care organisations on the right size for planning and delivering different services?
- Is there no scope for contestability of provision of any services in Scotland? Where does patient choice enter the system?
- Why not enable a greater range of incentives and levers within the health system through delegating budgetary control to a range of subsidiary organisations rather than simply to acute and primary care operating divisions?
- For example, why not allow NHS boards to experiment with different approaches to commissioning based on CHPs such as practice-based, care pathway and commissioner-provider commissioning at CHP level (devolving the entire capitated budget to CHPs in some areas), or to managed care networks?

Challenges for NHS Wales

- In the context of an overall policy of community engagement and partnership working with local government as the key levers for addressing health inequalities, how will the health service delivery agenda be tackled?
- What will be the response to public concern about waiting times for treatment? Is there scope for increasing

contestability of provision of acute elective services in Wales? Where does patient choice enter the system?

- Is there scope for a broader range of commissioning models, including the use of practice-based commissioning to engage clinicians and the development of national targets for key service delivery areas?
- Which commissioning models will be used to reconfigure health services when there is no evidence to date that a public health commissioning approach is likely to achieve this?

1 Introduction

This report is based on a project carried out over the period February to August 2004 and explores the present and future place of primary care-led commissioning in the continuum of commissioning approaches in the UK NHS. The report also considers the place within such a continuum of more recently emerging approaches to service provision that seek to integrate the planning and delivery of services in different ways.

This chapter begins by setting out definitions and rationale for commissioning and primary care-led commissioning. It goes on to outline the evolution of primary care-led commissioning and alternatives in the UK, and the main factors in the policy environment that have influenced these developments. The aims and objectives of the project, and the methods used for the research complete this chapter.

What is primary care-led commissioning?

Terms such as ‘commissioning’, ‘purchasing’ and ‘contracting’ entered the NHS lexicon in the late 1980s with the introduction of the NHS internal market and the purchaser-provider split. The internal market of 1991 was designed to introduce competition between strong monopolistic health care providers. In the absence of consumers with the necessary information and expertise to act as a countervailing force, there was a need for an informed, critical agent, the purchaser, who could act for the patient as well as ensuring that the public’s goals for the health sector were achieved. Purchasing was seen as the opposite of passively paying the bills for the care which providers had chosen to provide. Instead, services were to be specified up-front on the basis of quality and value-for-money, and only those who could meet the requirements would be asked to provide the service.

‘Commissioning’ was the term used in the later 1990s for an activity that was argued to be more sophisticated and strategic than purchasing, encompassing an assessment of the health needs of the population, the buying of services to meet those needs, and a range of strategic efforts to promote health (Ovretveit, 1995). The term ‘primary care-led commissioning’ appeared soon after, reflecting the emergence of a range of different approaches to the purchasing and commissioning of health services that involved GPs in key leadership and decision-making roles – approaches that had their origins in the introduction of GP

fundholding in 1991. Our suggested definition for primary care-led commissioning, based on this review of the evidence and our understanding of contemporary health policy, is as follows:

‘Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients’ needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct the health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients.’

In this definition, primary care-led commissioning inextricably involves decision-making power over the use of resources devolved either to individual practices or to groups of practices, along with associated accountability for the use of those resources. The term need not include the contracting stage of the commissioning process as long as the decisions on needs and services are shaped directly by primary care clinicians taking responsibility for the use of resources. Primary care commissioners can also have responsibility for the commissioning of primary care, as in English PCTs, though this presents potential conflicts of interest.

Primary care-led commissioning is distinguished from schemes which use incentives in the form of budgets and/or performance targets and payments to encourage general practices to deliver particular forms of primary and ambulatory care. These are often referred to as practice-level commissioning (such as in Bradford North – see page 28), but are really budget management or performance-related reimbursement schemes. If the use to which the budget is to be put is determined by another party, this cannot be seen as a form of commissioning.

Rationale for primary care-led commissioning

From its first manifestation in the shape of individual practice-level GP fundholding in 1991/92, the principal rationale given for devolving purchasing responsibilities and resources to primary care providers was that, when given some budgetary control, primary care clinicians would be well placed and motivated use their knowledge of the needs of their patients and of the range of services to bring

about improvements in some or all of the specialist and referred health services used by their patients. Primary care-led commissioning was also seen as a way of challenging specialist and hospital providers and bringing about a shift in the balance of power within the system so that a primary care perspective and community-based alternatives to hospitals would be given greater consideration when resource allocation decisions were taken (NHS Executive, 1994).

The continuum of commissioning models in the UK

Primary care-led commissioning should not be considered in isolation from other approaches to commissioning and planning, but rather seen as being part of a continuum of models to be selected and used by funding and commissioning bodies, as appropriate to local health needs and service configuration. As will be seen in chapter 3, the evidence tells us that primary care-led commissioning has particular potential in relation to primary, intermediate and some secondary care services.

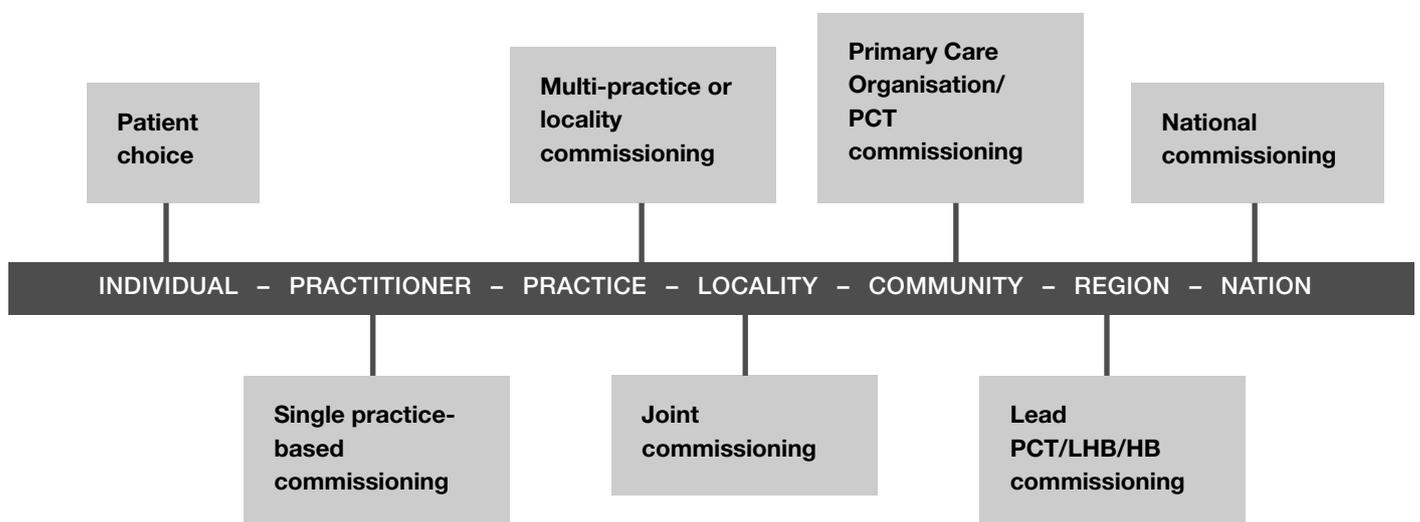
For those clinicians and managers with the responsibility for selecting methods for carrying out needs assessment, resource allocation, service purchasing, and service review (those working in primary care trusts, health boards, health and social services boards, local health boards), the 'menu' of commissioning models is shown in figure 1 as a continuum of approaches from the individual patient level to that of a whole nation's population.

Primary care-led commissioning in the UK

Chapter 2 sets out the development of primary care-led commissioning in each of the four countries of the UK over the period 1990-2004. What is clear is that since the election of the Labour government in 1997, there has been an increasing divergence of health policy between the constituent parts of the UK, and in particular in relation to primary care-led commissioning. The NHS in England has largely retained the purchaser-provider split, focusing health commissioning within primary care trusts (PCTs) that also have responsibility for providing community services. The NHS in Scotland has abandoned the internal market and competition in favour of system-wide integration of commissioning and providing within NHS boards. The NHS in Wales has developed public health-led and locality-focused commissioning through local health boards (LHBs) with an emphasis on user, voluntary sector and statutory local government involvement. In Northern Ireland, NHS policy developments have stalled since the suspension of the devolved Assembly, although local health and social care groups (LHSGs) have been established to facilitate greater primary care involvement in commissioning.

This divergence of policy within the UK NHS indicates that there is no consensus as to whether the separation of commissioning from providing is desirable, and if some separation is positive, where and how it should be arranged. In general, markets and a clear separation of commissioning and provision appear to operate well when there is potential for competition, when investments do not tie providers to specific buyers, when the product or service

Figure 1: The continuum of commissioning levels in the UK



is relatively straightforward and there is little uncertainty about what will need to be provided and when few economies of scale apply (Figueras et al, forthcoming). There is argument as to whether, and if so, to what extent, these conditions exist in health care.

In areas of care where these features are not present or present to a lesser degree, attention has shifted towards network models of coordination. This may involve long term contractual relationships or formal partnerships which retain a commissioner-provider separation, but encourage joint decision making. Long-term, relational contracts are used to try to reduce the transactions costs of markets while retaining an element of contestability. They can be seen as a 'third way' between extreme forms of market organisation and centralised 'command and control' planning. In other health systems, as in Scotland, it may lead to full integration between the commissioning and providing sides of the system with or without budgetary delegation.

There is increasing evidence from economic studies and theory that in the sorts of markets that characterise much, but probably not all, health care, partnership and relational contracting appear to work better than more divisive forms of market-like behaviour which emphasise competition as the main driver of efficiency improvement, as long as there is always the possibility that a provider could be replaced in the event of poor performance (Forder et al, forthcoming). Smith and Goodwin's (2002) review of the evidence on effective commissioning concluded similarly that what was needed in the NHS was what they termed 'contestable collaboration', meaning that for most services and for most of the time collaborative relations with providers would work better than divisive strategies, but that for some services, and on occasions, the ability to take business elsewhere, or the threat of it, would be needed. Such conclusions suggest that there may be scope for different arrangements for developing and procuring different types of health services – some based on market or market-like models and others based more on vertical integration and collaboration between purchasers and providers.

Recent developments in the four countries of the UK show elements of all three approaches to the organisation of the health care system: markets, networks and hierarchies. Put crudely, England is pursuing a mix of market and network approaches, depending on the service in question, while Scotland is pursuing a mix of hierarchical and network approaches. Wales is largely networked with some residual elements of a more market-like approach. Northern Ireland is yet to determine its way forward. Chapter 2 presents developments in the four countries in more detail.

Other policy changes affecting the context of primary care-led commissioning

On the provider side of the NHS, there had been fewer important changes with a likely impact on primary care commissioning until comparatively recently. However, in the last two to three years, in England, but not in Wales, Northern Ireland and Scotland, a number of potentially significant changes have occurred, as follows:

- Diversification of the range of public, private and third sector providers commissioned by the NHS.
- Development of new forms of provision such as primary care walk-in centres, one-stop centres, and private and NHS owned diagnostic and treatment centres for elective surgery.
- Changes to the system of hospital reimbursement with a new case-based payment system where reimbursement of activity is made by commissioners to providers at standard national prices, called 'payment by results'.
- Renewed interest in competition between providers within a mixed economy of care including newly autonomous foundation trusts and an expanding range of independent sector provision.

A new General Medical Services contract has been introduced in all four countries of the UK, designed to enable new forms of primary care to emerge, including private sector involvement in NHS primary medical services, and new intermediate care and out-of-hours care providers.

Aims and objectives of this research

The principal aim of this review of commissioning in the UK NHS was to identify the organisational and process factors associated with effective primary care-led commissioning. A subsidiary aim was to identify specific examples of effective methods and tools to enhance the commissioning and service development process.

During field work it became apparent that the original project focus exclusively on primary care-led commissioning was not helpful if the project was to continue to have UK-wide relevance, since even primary care based commissioning was now only a feature of the English NHS. Indeed, commissioning as a distinct activity with its own organisational base, had been abolished in the Scottish system and was much downplayed in Wales and Northern Ireland. The contribution of primary care-led commissioning could only be assessed by discussing the range of other approaches currently in use in the UK or which might develop. As a result, the focus of the project broadened to consider the future of commissioning in general and its alternatives.

Methods used for the research

In order to achieve the project aims and objectives, the following activities were undertaken.

Literature review

The systematic review of published literature on primary care-led commissioning took the form of an overarching review supplemented by five specific modules based on project objectives. An electronic literature search was undertaken using HMIC, HELMIS, Medline and Embase databases. The descriptors and keywords used are listed in Appendix A. The results are summarised in table 1.

In addition to the 1,507 references identified from the electronic search, a further 180 references were suggested by members of the research team and added to the database. The resulting 1,687 references were then rated using the categories shown in table 2. Three members of the research team each rated one third of the total.

In addition to this search activity, references cited by other literature reviews were collated with the ten references rated as comprehensive literature reviews (see Table 2) and suggestions by members of the research team, to form a list of 37 'key' references. These publications are listed in Appendix B and formed the core of the literature review.

Preparation of summaries of research relevant to project objectives

Based on the literature reviews, the research team prepared summaries of research deemed to be relevant to project objectives. In addition, summaries of research related to independent practitioner associations (IPAs) in New Zealand, managed care in the USA, partnership and planning in Scotland, and commissioning in Wales were developed to feed into the report as a whole.

Informant interviews

The research team carried out a set of 34 semi-structured interviews with managers, clinicians, academics and policy makers chosen on the basis of their significant experience of primary care-led commissioning in the UK. Interviews explored the following broad themes relevant to the main objectives of the research:

- understanding of the term 'primary care-led commissioning'
- experience of working within or alongside primary care-led commissioning
- the factors considered to facilitate effective primary care-led commissioning
- the factors considered to inhibit effective primary care-led commissioning
- the impact that primary care-led commissioning was deemed to have had

Table 1: Electronic literature search results

<i>Database</i>	<i>References found</i>
HMIC and HELMIS	1,027
Medline	278
Embase	652
TOTAL	1,957
TOTAL (excluding duplicates)	1,507

Table 2: Rating categories and the number of references allocated to each category

<i>Rating category</i>	<i>Number of references allocated to each category</i>
Comprehensive literature review	10
Sample or population survey	48
Study based on analysis of routine data	27
Multiple or single case study (peer reviewed or monograph/research papers)	155
Evidence and theory-informed commentary (papers, books, expert opinion, think-pieces, certain editorials)	316
Primary research based on opinion – opinion surveys, qualitative studies etc	30
Government policy and guidance	104
Opinion leaders, news reports, case descriptions, anecdotes, editorials	327
Not relevant	670
TOTAL	1,687

- examples of good practice related to effective primary care-led commissioning
- views on the future for primary care-led commissioning in the NHS.

It should be noted that the interviews were tailored to reflect the policy context of each of the four UK countries. See Appendix C for details of those interviewed.

Stakeholder workshops

Early findings from the literature review and interviews were tested out with health and social care stakeholders in two feedback workshops held in June and July 2004. The attendees at these events included, where possible, those who had taken part in the interviews, along with additional commissioning stakeholders as agreed with The Health Foundation. A list of attendees is attached at Appendix D. Drafts of final project outputs were shared with the same stakeholder group for comment and testing for 'service reality'.

Development of recommendations

Following the completion of the literature review, supplementary modules, interviews and feedback events, the research team carried out extensive analysis of all project data and drew this together into this report. As part of this process, time was spent in developing recommendations for future research and policy development in the field of commissioning in the UK. These recommendations are set out in chapter 6.

2. Primary care-led commissioning: the UK context

KEY POINTS

Since 1997, there has been considerable divergence between the approaches to health commissioning taken by each of the UK countries.

In England, the purchaser-provider split has been largely retained, and primary care trusts have become the main local commissioning body (yet they are also providers of community and primary care services), currently charged with developing new forms of devolved practice-led commissioning.

In Northern Ireland, local health and social care groups have been created as a method of creating effective clinical and public engagement in the commissioning process. The groups have, however, struggled to secure GP involvement, and the overall development of commissioning is hampered by broader political uncertainty.

In Scotland, the quasi-market was abolished and commissioning and providing roles integrated. Newly introduced community health partnerships are expected to breathe new life into primary care-led services and are viewed as key forums for determining local health and social care priorities and plans.

In Wales, the purchaser-provider split has been retained, albeit with a strong emphasis on partnership working with local government and the engagement of local communities, and health planning and commissioning being focused on 22 local health boards.

This chapter sets out an overview of the ways in which the commissioning function has evolved in each of the four countries of the United Kingdom over the period 1990-2004. Table 3, at the end of this chapter, summarises differences and similarities in approaches between the four countries.

England

In 1991, the Conservative Government introduced its market reforms of the NHS, based on a 'purchaser-provider split' with two models for the purchasing of health services from hospital and community providers. The first, based on

health authorities, focused on the population and its health needs. The second, based on general practice, was oriented towards patients and how services could be improved by allocating a budget to GPs in individual practices (GP fundholding).

During the 1990s, some GP fundholders came together in networks known as multifunds or fundholding consortia, often as a way of enabling smaller practices to participate in the fundholding scheme, but also to create organisations that could pool resources to avoid competition, share financial risks, and develop a stronger voice for local primary care purchasers (Mays and Dixon, 1996). At the same time, non-fundholding GPs started to work together in GP commissioning groups as a means of gaining influence over health authorities' purchasing decisions, yet without what they saw as the potentially perverse incentives of holding budgets at practice level (Shapiro et al, 1996; Glennerster et al, 1998). The range of commissioning models became more varied following the government's decision in autumn 1994 to develop a 'primary care-led NHS' (Department of Health, 1994). One of the consequences of this initiative was an extension to the model of GP fundholding in the form of the total purchasing pilot scheme. Within this scheme, volunteer fundholding practices, either alone or in groups, were delegated a budget by their local health authority to purchase potentially all of the hospital and community health services for their populations. The overall effect was to increase still further the variety of commissioning models.

In December 1997 the new Labour government set out its ten-year vision for the English NHS in a White Paper *The New NHS – Modern, Dependable* (Department of Health, 1997). The purchaser-provider split was retained and overall responsibility for commissioning health services remained with health authorities. Elements of health care commissioning such as the purchasing of community health services were devolved to 481 new primary care groups (PCGs), these taking the place of all previous fundholding and primary care-led commissioning schemes. Membership of a PCG was made compulsory for all GPs and primary care professionals. The government defined three core functions for PCGs (NHS Executive, 1998) these being:

- to improve the health of the population in the PCG;

- to develop primary and community health services within the PCG;
- to commission secondary and tertiary services for the population in the PCG.

PCGs were always intended as transitional bodies en route, over a period of ten years, to the development of primary care trusts (PCTs), statutory bodies that would combine the management of local primary and community services with a much extended role in commissioning of health services for the local population. The first PCTs went 'live' in 2000. The impetus to move from PCG to PCT was increased following the publication of *The NHS Plan* (Department of Health, 2000) which signalled that all PCGs would become PCTs by April 2004. In July 2001, the pace of change was increased further when *Shifting the Balance of Power* (Department of Health, 2001) announced the move of all PCGs to PCT status by April 2002, the abolition of all 100 health authorities in England, and the creation of 28 new strategic health authorities.

Since 2003, the PCT has been the main local public health, commissioning, and primary care development organisation in England. Criticism of PCTs has tended to focus on their increasingly management-focused or 'corporate' strategy and culture as they have become mainstream NHS bodies, accompanied by the falling away of much clinical engagement and support (Smith and Walshe, 2004; NHS Alliance and NCGST, 2004; Lewis, 2004). On the other hand, given that PCTs now have responsibility for primary care, it is perhaps inevitable that they should have developed a more formal relationship with individual practices and practitioners to ensure greater probity than their predecessor bodies which did not have this role as paymaster for primary care. The need to re-ignite clinical enthusiasm for PCTs and to encourage further devolution of commissioning responsibility has been recognised by government, with the recent announcement of a new policy of practice-based commissioning, but, this time, within the accountability structure of the PCT (Department of Health, 2004a).

The introduction in 1991 of a purchaser-provider split in the English NHS along with the 'wild card' (Glennerster et al, 1994) of GP fundholding set in train a course of events that few could have foreseen at the time. Fifteen years after the announcement of the NHS internal market, the purchasing/commissioning function continues to exist within the English NHS, along with renewed policy interest in enabling primary care-led commissioning via the holding of budgets at practice or locality level.

Northern Ireland

The NHS internal market was not introduced into Northern Ireland until 1993. As in England, GP involvement in

commissioning was encouraged and a plurality of commissioning agencies developed, including fundholders (from 1993), total purchasing pilots (from 1996), and primary care commissioning group pilots (from 1998). Health and social services boards remained as the overall commissioning agencies.

Towards the end of 1997, research sponsored by the Health and Social Services Executive concluded that the internal market and contracting in Northern Ireland had demonstrated a number of weaknesses including a lack of competition due to the small size of the market, inadequate information flows and systems, and a lack of clarity about purchaser and provider roles (Health and Social Services Executive, 1997). Furthermore, an evaluation of Northern Ireland total purchasing pilots in 1997 suggested that commissioning had only been effective where providers had agreed with proposals for service change, whilst the administration costs of these new organisations were a cause for concern (Department of Health and Social Services, 1997).

Despite these evaluations, in 1999 *Fit for the Future* (Department of Health and Social Services, 1999) presented a commissioning vision that was similar to that of PCG/Ts in England, with the development of primary care co-operatives (PCCs) which had responsibility for assessing health and social care needs, developing local plans for improving health and well-being, and taking a central role in the commissioning of services. Each would hold a devolved budget and be responsible for commissioning health and social services for their population. A number of primary care commissioning group pilots were established to test the new approach. Evaluation of these pilots concluded that they had succeeded in implementing a number of new service developments (particularly at practice/primary care level) so increasing service options and accessibility (McCay and Donnelly, 2000) and improving prescribing practice (McLeod, 2002).

The establishment of the Northern Ireland Assembly occurred soon after *Fit for the Future* was put forward. Initially, the Assembly revisited the fundamentals of care delivery and actively debated two potential models for the future. The first was an English-style internal market led by primary care organisations; the second a Scottish-style regional planning system merging purchasers and providers (Greer, 2001). The *Fit for the Future* model of primary care-led commissioning appears to have been the preferred option, but outline proposals for the future organisation and commissioning of health and social services in Northern Ireland were subject to a continual process of establishment, suspension and re-establishment. The uncertainty about the political future in Northern Ireland

thus led to a policy vacuum in which no firm decision about the future of health care commissioning could be made.

Fundholding and GP commissioning were eventually replaced in April 2002 with the creation of 15 local health and social care groups (LHSCGs). LHSCGs were established to create a mechanism for primary care professionals and local communities to play an effective role in the commissioning of services, including the management of a delegated budget for some services, while remaining subcommittees of their local HSSB. LHSCGs comprise multi-agency representation – including representatives from acute hospital trusts – but have struggled to secure GP involvement. This is not because GPs are against the concept of LHSCGs but because GPs are in dispute with the DHSSPS over the form, function and remuneration arrangements for LHSCGs as laid out in central guidance. Whilst boycotting management boards, GPs are, however, increasingly participating in LHSCG activities at local level in the planning and delivery of services commissioned by LHSCGs.

To date LHSCGs have concentrated on improving the range and quality of primary care services in their localities, involving local stakeholders in their decision making processes, and developing the capacity to commission some local services. The proposal is that LHSCGs will assume responsibility for the commissioning of services using delegated budgets, in the longer term. However, the organisational future of health care commissioning in Northern Ireland remains unsettled due to the broader political situation.

Scotland

Prior to 1997, Scotland's health policy had strong similarities with that of England and Wales, and the internal market was introduced in 1991. Health boards had responsibility for purchasing health services from provider trusts, but GP fundholding was embraced rather less enthusiastically than in England. Other forms of commissioning, such as locality commissioning, were more welcome, so that by the time of the 1997 general election, Scotland had a similar mosaic (Smith et al, 1998) of commissioning models to England.

The Labour victory in 1997 signalled devolution for Scotland, and a distinct path for health policy. *Designed to Care* (Secretary of State for Scotland, 1997) shared common goals with the White Papers produced in England and Wales, but put in place quite different organisational structures with different responsibilities to achieve them (Hopton and Heaney, 1999). Partnership and planning replaced the internal market, competition and commissioning as the means to provide integrated, high quality, services. The aim was to move towards 'a planned

public service nationally organised and locally delivered' (Woods, 2001, p3). The number of acute hospital trusts was reduced from 47 to 28 and 13 PCTs were introduced from April 1999. The PCTs covered the population of the health boards, were accountable to them, and were responsible for the planning and delivery of community health services, services for priority groups such as older people and people with disabilities, mental health services and general practice services. They were expected to encourage the formation of local health care co-operatives (LHCCs) – non-statutory, voluntary groups of general practices that could hold budgets for the costs of GP pharmaceuticals, but with no other nationally prescribed responsibilities. Health boards allocated resources to acute and primary care trusts and were responsible for overseeing the planning process.

'Partnership and planning' were given renewed emphasis with the publication of *Our National Health* (Scottish Executive, 2000). This signalled a move from health boards and trusts to single NHS organisations in each geographic area by April 2004, with local authority representation on the NHS boards and single local health plans for which NHS boards would be accountable to the Scottish Executive Health Department. *Our National Health* also placed emphasis on social inclusion, on reducing inequalities in health, on standards and performance of services monitored through external assessment, and on public involvement in planning services as a way to increase their responsiveness to patients' needs and choices.

Vertical integration has been encouraged in Scotland through professional networks called 'managed clinical networks'. They initially developed amongst secondary and tertiary services such as cancer care, and had little primary care input. However, by 2000, the first local managed clinical network for cardiac services had been introduced which included primary care (Baker and Lorimer, 2000). Horizontal integration of health services was promoted through giving their management to PCTs and through local health care co-operatives (LHCCs). With no national blueprint, LHCCs developed very differently in different parts of Scotland (Hopton and Hill, 2001) but most focused on issues relating to the delivery of better, and more consistent, quality of care and on clinical governance. Horizontal integration between health and social care services was promoted by the 'Joint Future Agenda'. This gave local authorities and health boards responsibility for developing community care services with joint management arrangements, jointly managed budgets, joint governance, joint accountability and joint performance management arrangements.

The NHS Reform (Scotland) Act 2003 legislated to remove NHS trusts and to establish new community health partnerships (CHPs) from 2004. NHS boards hold

capitated budgets for health care, but most delegate further to acute and primary care 'operating divisions'. By April 2005, CHPs are expected to develop from LHCCs but are seen as a vehicle for integration between both specialist and acute health services and with social care. They are expected to take a variety of approaches to achieving this integration, including service planning and use of professional care networks, but also contractual, financial and planning mechanisms (Scottish Executive Health Department, 2004).

Overall, organisational policy in Scotland since 1997 has shifted the NHS progressively towards becoming a planned series of more vertically integrated, territorial organisations, each embracing the full range of NHS services and local authority social care, thereby removing local commissioning as a separate activity and particularly the notion of primary care-led commissioning.

Wales

Before devolution in 1999, the Welsh health service was often seen as an adjunct to the English NHS. Thus the purchaser-provider split and GP fundholding applied to Wales, albeit with some organisational differences (NHS Wales Directorate, 1990). As in Scotland at the time, the application of market principles to health care was embraced with less enthusiasm than in England, although the introduction of the purchaser-provider split saw the emergence of GP fundholding and the establishment of nine district health authorities with responsibility for purchasing on a population basis. In 1996, following publication of *A Fresh Start* (NHS Wales Directorate, 1995), the number of health authorities was reduced to five.

Following the Labour victory of 1997, the Welsh white paper, *Putting Patients First* (Secretary of State for Wales, 1998) closely followed the intentions outlined in the English and Scottish white papers. The Welsh approach saw the abolition of GP fundholding and the creation of 22 local health groups (LHGs), which were to be coterminous with local authority boundaries and 'primary care-led' (NHS Wales, 1998a, 1998b). However, LHGs were only to form advisory sub-committees of the health authorities, which retained overall commissioning responsibility.

In 2001, the Labour-Liberal Democrat Welsh Assembly Government produced a national plan for health and the NHS in Wales, *Improving Health in Wales: A Plan for the NHS and its Partners* (Welsh Assembly Government, 2001). The major, and somewhat unexpected, element of this plan was the abolition of all health authorities and the creation of 22 local health boards as statutory bodies (Osmond, 2001). This led to a period of major organisational change, at least amongst commissioners, which resulted in the establishment of LHBs in April 2003. LHBs were charged

with six main areas of responsibility, similar to those of English PCTs:

- Corporate and clinical governance
- Securing and providing primary and community health care services
- Securing secondary care services
- Improving the health of the community
- Partnership
- Public engagement

Improving Health in Wales instituted a statutory requirement for health and social care agencies to work together as the major lever for change (Welsh Assembly Government, 2002). This reflected the strong influence of local government on the Welsh Assembly Government and was coupled with an equally strong emphasis on the need to reduce health inequalities as outlined in *Better Health Better Wales* (National Assembly for Wales, 2000). The role of public health was enhanced by the creation of the National Public Health Service and the Wales Centre for Health. The reorganisation was completed by the creation of Health Commission Wales, responsible for commissioning specialised health services. Wales also has 13 integrated NHS trusts, plus one all-Wales ambulance trust. The performance of LHBs and trusts is managed by three regional offices which are agencies of the newly reorganised Department of Health and Social Care within the Welsh Assembly Government.

Prior to devolution, the Welsh experience of commissioning was not dissimilar to that of England, with a variety of different models of commissioning emerging. Since devolution the approach to commissioning has become much more standardised. With a similar political climate to Scotland, it is interesting to note that Wales has retained the apparatus of the internal market and a commitment to a commissioning model. This is, however, public health commissioning 'classic Labour' style, designed to push forward the Welsh political agenda of social inclusion and tackling inequalities. Overall, since devolution, the focus in Wales has been on involving local government and the public strongly in commissioning within the NHS in order to develop a more health-focused and less disease-driven service. However, the Welsh health service has come under sustained criticism (Audit Commission, 2004; Talbot et al, 2004) with particular focus on Wales' performance on waiting times and the 'unsustainable' configuration of hospital services (Welsh Assembly Government, 2003). The challenge for Welsh commissioning will be to marry the public health model with achievements against the service delivery agenda.

Summary

The organisational arrangements and policy levers put in place by the four UK countries have been influenced by a set of implicit values about the relative desirability of using competition and the market compared to consensus and partnership as a means to achieve improvements, as well as by the particular emphasis they have placed on different goals at different times. The similarities and differences between the planning and commissioning functions in the four UK countries are illustrated in table 3 below.

Table 3: Comparison of health systems in four UK countries, 2004

	England	Northern Ireland	Scotland	Wales
<i>Main mechanisms for achieving quality, integrated, services</i>	Wide range of mechanisms including commissioning in a quasi-market, national service frameworks, targets, star ratings of trusts, external inspection and audit	Internal market with emphasis on involving clinicians and local communities in commissioning through local health and social care groups (LHSCGs)	Partnership and planning supported by quality frameworks and external inspection by Quality Improvement Scotland, targets and audit	Internal market, but with focus on partnership with local authorities. National service frameworks and Healthcare Inspectorate Wales as key part of overall quality management.
<i>Organisation responsible for commissioning or planning</i>	Primary care trusts (PCTs)	Health and social services boards and LHSCGs as sub-committees of HSSBs	NHS boards	Local health boards (LHBs)
<i>Extent of commissioner/provider integration of health care</i>	Separated for secondary and tertiary care Integrated for primary and community health services and most public health services	Separated for community health services, social, secondary and tertiary care Some integration through LHSCG membership and commissioning	Integrated for all services	Separated for community health services, secondary and tertiary care Integrated for primary care and public health, with exception of Powys LHB (integrated for secondary care)
<i>Focus on primary care-led commissioning</i>	Retained via PCTs and to be renewed with policy of practice-based commissioning and patient choice (with GP advice)	Retained via LHSCGs	Abolished	Replaced by partnership-led commissioning with public health, local and community engagement.
<i>Mechanisms for integration of health and social care</i>	Complete budgetary integration in a small number of care trusts, but mainly through PCTs' statutory duty to collaborate with relevant local authorities	Health and social services provided by single health and social service trusts and commissioned by single HSSB.	Performance management of local councils and NHS boards to deliver 'Joint Future Agenda' targets for management resource integration and outcomes from care	Statutory requirement for LHBs and coterminous local authorities to work together

3 Assessing the impact: a review of the evidence

KEY POINTS

There is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services.

Primary care-led commissioning (where clinicians have a clear influence over budgets) can however secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress, as was seen within GP fundholding.

There is research evidence to show that primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services, stimulating new forms of peer review and quality assessment within and across practices, enabling new forms of specialist primary care, and building new community-based alternatives to hospital care.

Given a sustained opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding working practices in the local health system, as demonstrated by many of the innovations secured through total purchasing projects.

Primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role, as demonstrated through GP commissioning and fundholding.

Primary care-led commissioning increases transaction costs within commissioning.

By summarising the evidence available in the literature, this chapter attempts to provide an overview of the impact that past primary care-led commissioning has had on two sets of outcome measures as follows:

- **The impact on indicators of performance**, such as waiting times and access, elective referral rates, non-elective acute hospital admissions, and prescribing.

- **The impact on system outcomes** including equity, efficiency and appropriateness, cost containment, provider responsiveness, responsiveness to patients and the public, and health outcomes.

The chapter then considers those service areas in which previous primary care-led commissioning organisations appear to have had the greatest 'positive' impact in relation to these performance indicators and outcomes.

The nature of the evidence

Analysis of the impact of primary care-led approaches to commissioning is problematic, as researchers had to contend with three practical difficulties:

- 1 Over time, the scope and remit of primary care-led commissioning has changed from being voluntary, small-scale, GP-led purchasing of mainly elective care services to large-scale, organisation-led commissioning for most hospital, community and primary health care services. As a result, it has not been possible for researchers to make straightforward comparisons between primary care-led commissioning and other forms such as health authority commissioning.
- 2 The pace of change has meant that research has generally focussed on process factors, such as the development of management systems, rather than outcome measures such as health improvement. As a consequence, any analysis of the impact of the different commissioning forms has been limited.
- 3 There were other policy changes during the same period which make it difficult to identify the specific impact of primary care-led commissioning on outcomes.

Taking into consideration these caveats, the following sections summarise the evidence.

The impact of primary care-led commissioning on indicators of performance

Waiting times and access

Access to care has been a long-standing concern of managers and policy makers in the NHS. During the internal market in the 1990s, fundholding practices were claimed to have achieved shorter waiting times for elective admissions compared to non-fundholding practices. Since most activity was funded via health authority block

contracts, contracting at the level of individual cases for selected elective procedures provided sufficient incentive for hospital trusts to negotiate waiting times and prices with individual fundholding practices (Propper et al, 2002; Propper et al, 1998). For example, a BMA survey of 247 short stay units in 1993 found that 42% (73/173) were offering fundholders advantageous arrangements, and that 24% (41/173) were providing faster admissions for fundholding patients (Beecham, 1994).

While there was little robust quantitative analysis at the time (Dowling, 1997), a recent study of data from one health authority covering 1993 to 1997, concluded that fundholding practices were able to secure reductions in waiting times of about 8% for their patients requiring procedures included in the scheme, compared to all other patients (Propper et al, 2002). These waiting times relate to the period from the decision to admit to admission, but, arguably, the impact of fundholding budgets on GPs' decisions to refer is also important. There is anecdotal evidence that some fundholder referrals were delayed due to budgetary constraints (Bagust, 1994). More recent research comparing the period before and after the abolition of the fundholding scheme has shown that fundholding status reduced the waiting times of fundholders' patients by 5-8% and that these practices would probably have had higher waits than non-fundholders had it not been for holding a budget (Dusheiko et al, forthcoming).

Total purchasers also sought to secure better access to services for their patients, one example being a pilot which wanted to improve patients' access to child and adolescent mental health services chose. To achieve this, the pilot used its commissioning budget to employ a full-time consultant psychiatrist, part-time psychologist and two CPNs to provide a more accessible service closer to where its patients lived, including telephone access to talk to the consultant for parents. The new service was made possible by competitive tendering of the service and bringing in a new provider willing to meet the requirements of the TPP (Goodwin et al, 2000).

In the light of subsequent target-driven progress in England and Scotland in reducing maximum waiting times, the fundholders' achievement in securing comparatively shorter waiting times may appear modest. It did however show that primary care-led commissioners could make an appreciable contribution to improving performance at a time when waiting times were not falling. More important were the wider benefits in terms of strengthening the link between clinical decisions made by GPs and their financial consequences, and some shifting of the balance of power away from secondary care.

In 2001, the National Performance Framework in England was extended to include performance ratings for acute trusts, which is being rolled out to other types of NHS trust. The publication of trust performance using the star ratings has afforded a very high status to the role of national targets. The political prominence given to measurable targets for the NHS was balanced by recognition that a range of other issues had to be addressed (Audit Commission, 2003), including inappropriate adjustments to waiting time data (National Audit Office, 2001a), and consultants' concern about their freedom to decide relative waiting times on the basis of clinical priority (National Audit Office, 2001b).

Building on the experience of the English National Patient Access Team (NPAT) and their programmes such as the National Booked Admissions Programme and the Cancer Services Collaborative, *The NHS Plan* gave increased emphasis to the use of programmatic service improvement, or 'redesign', initiatives as a mechanism for reducing waiting times and improving access. The Cancer Services Collaborative was the first NHS programme to adopt the Breakthrough Series (BTS) Collaborative model. This approach to service improvement has been highly influential. Collaboratives have been run across a wide range of services and developed into national roll-out programmes in key services. While subject to limited evaluation, the early collaboratives and similar topic-specific service improvement initiatives have tended to generate a wide range of outcomes, demonstrating potential, but with overall performance often falling short of expectations within the limited timescales provided (Bate et al, 2002; Ham et al, 2002; Robert et al, 2003). Key lessons include the need to effectively engage clinicians and the need to recognise that changing working practices takes longer than commonly expected (Ham et al, 2003a).

Elective referral rates

Evidence on the impact of fundholding on patterns of referrals is mixed (Goodwin, 1998). Mays et al (2000) concluded that the majority of studies undertaken in the 1990s comparing fundholders and non-fundholders indicated little difference in referral rates between fundholding and non-fundholding practices and no indication that budgets had impinged on referral rates (e.g. Coulter and Bradlow, 1993). One more recent study found that fundholders in one health authority increased referrals during their preparatory year before their budgets were set to the extent that elective admissions increased by about 7% (Croxon et al, 2001). An even more recent study, looking at the period before and after the abolition of fundholding showed that fundholding incentives did reduce fundholder elective admission rates by 3.3% and accounted for 57% of the difference between fundholder and non-fundholder elective admissions (Dusheiko et al, 2003). This

is likely to be the most reliable indication of the impact of budgets for elective care.

Case studies of the best organised independent practitioner associations (IPAs) in New Zealand which have strong similarities with fundholding collectives in the NHS in the 1990s have shown the ability of IPAs to make major savings against historic budgets for services such as laboratory tests and investigations in the first year or so of budget management (Kerr et al, 1996). It was clear that once GPs had the incentive to control their use of laboratory tests in order to release resources for other developments of benefit to their patients and had information on their utilisation, they were able to change behaviour without harming their patients.

Non-elective acute hospital admissions

It is generally agreed that the original fundholding scheme had no effect on non-elective (emergency) hospital services which were outside the scope of the budget held (Dusheiko et al, 2003). A key objective for a third of the first-wave total purchasing projects (TPPs) was to reduce inappropriate non-elective acute admissions and length of stay by introducing alternative services outside the scope of the original GP fundholding scheme (McLeod and Raftery, 2001). Eleven of the 16 pilots pursuing this objective were successful in reducing emergency-related occupied bed days by significantly more than comparable practices in the same area. In some cases, this was against a background of *rising* emergency admissions in the local area (Mays et al, 2001). Despite reducing admissions and bed days, the TPPs were generally unable to persuade their acute providers to alter their contract volumes accordingly in order release resources for the future. However, there were exceptions. One TPP renegotiated its cost and volume care of older people contract to make savings in the hospital sector to fund increased use of a GP hospital used by the practices. The scheme succeeded in reducing acute geriatric admissions by 6% in the first year, releasing resources for other uses, since the GP hospital service was on average £1,200 per patient less costly for the admissions averted (Goodwin et al, 2000). TPPs used a variety of mechanisms to reduce their dependence on local hospitals. In general, those pilots that targeted length of stay reduction employed discharge planning and liaison nurses to go into hospitals and more active rehabilitation, while those focusing on reducing admission rates in the first place tended to develop hospital at home schemes, various forms of intermediate care and extended the scope of local community hospital provision.

Overall, the experience illustrated the potential shown by a small number of highly determined GPs and managers to change longstanding working practices, given an opportunity to innovate. It also highlighted the difficulty for

primary care commissioners in persuading acute hospitals to release resources. Had the political context been more favourable, and the initiative been allowed to mature, more of the TPPs' potential might have been realised.

Prescribing

Prior to 1991, expenditure on GP-prescribed pharmaceuticals was not cash-limited or subject to practice-level budgets, and this resulted in wide variations in prescribing costs and rates of expenditure growth between practices. Fundholding provided an opportunity for GPs to take responsibility for managing their prescribing activity within a budget, the overall aim being to limit growth in prescribing costs. The evidence suggests that fundholding practices were able to make what were largely 'one-off' savings in spending (Baines et al, 1997) through a relatively narrow and well established range of techniques which included increased use of generic prescriptions, the use of practice formularies and feedback to practitioners of improved prescribing information. However, once these strategies had been implemented, prescribing cost growth among fundholders reverted to that of the non-fundholders. Studies of New Zealand IPAs reported larger savings against national trends than in the UK of 8-23%. IPAs used their savings to provide new, high priority services and to invest in building up the infrastructure of primary care (Malcolm, 1997; Malcolm et al, 1999).

In April 1995, a national prescribing scheme for GPs was introduced. The scheme entailed incentive payments for practices, of up to £3,000 per GP in return for compliance with budgetary limits. 'Non-fundholders were found to respond to incentives in the predictable fashion, i.e. similarly to fundholders' (Baines et al, 1997, p19). However, it was also noted that the response to financial incentives was stronger when a change in prescribing behaviour produced tangible benefits to both the practice and the GP. Thus, fundholding was viewed as having had a greater impact than the national prescribing scheme.

Subsequent improvements in prescribing practice have been supported via a range of initiatives. The GP commissioning groups, and their successors, appointed prescribing advisors to support GPs across localities, developed group-wide formularies and incentive schemes, and viewed prescribing as a key area of primary care and peer development (McLeod, 2001, 2002; McLeod et al, 2000). Prescribing practice has also benefited from the Collaborative model, as implemented by the National Medicines Management Collaborative. Guidance relating to prescribing has also become more explicit via the work of NICE and the NSFs.

Primary care services

The early experiences of PCGs provide evidence of the impact of primary care-led commissioning on primary and intermediate care. For example, Harrow East and Kingsbury PCG developed PCG-wide diabetic service. A community-based diabetes specialist nurse was appointed to offer support and training to practices and assist in implementing protocols for diabetic care across the PCG area. Along with an additional podiatrist, specifically for older Asian people with diabetes, the specialist nurse and a dietician led group education/information sessions for diabetics in community clinic in order to promote self-management (Regen et al, 2001).

Carlisle and District PCG developed an admission avoidance scheme in which a multi-disciplinary community support team received referrals from both hospital (to facilitate discharge) and community settings (to prevent admission). Following assessment and acceptance on to the scheme, clients received two weeks' intensive intervention in their own homes in order to promote independence. Four hundred and seventy clients were referred to the service in 2000, and reductions were reported in admissions, bed days and the number of home care packages required by social services (Regen et al, 2001).

With similar objectives, Mid-Devon PCG set up a nurse-led 'reablement' service based on a six bedded unit in local social services Part 3 accommodation. Clients came onto the unit for a maximum of six weeks where they were supported to live as independently as possible, and had rapid access to a range of services including psychology, speech therapy, occupational therapy, physiotherapy, community nursing and social services (Regen et al, 2001).

The impact of primary care-led commissioning on system outcomes

Equity

Practice-based purchasing through GP fundholding is generally accepted by commentators to have increased inequities and led to two-tier access to care (Audit Commission, 1996; Goodwin, 1998; Mays et al, 2000). This is confirmed by considerable differences observed in waiting times between fundholding and non-fundholding practices (Kammerling and Kinnear, 1996; Dowling 1997; Corney, 1999; Propper et al, 2002). Total purchasing pilots were also revealed to have created inequities in access to care compared with non-TTPs (Mays et al, 2001). Nonetheless, as primary care-led commissioners grew in size and became population-based collectives, it was argued that they were more likely to be capable of promoting equity (Smith et al, 2000; Regen et al, 2001; Wyke et al, 2003). The inequities created by fundholding and total purchasing pilots were inevitable given that both initiatives were voluntary and not taken up by all general

practices. In any system, there are likely to be differences in performance between commissioning organisations (e.g. PCTs or LHBs) which may affect the ability of some patient populations to access services of adequate quality.

Efficiency and appropriateness

Primary care-led commissioning was intended to encourage greater efficiency by assessing the health requirements of their local populations and contracting for more appropriate care. The research evidence suggests that *all* primary care-led purchasers and commissioners changed patterns of service provision, primarily through developing new forms of service in primary, intermediate and community care settings (Coulter, 1995; Audit Commission, 1996; Goodwin, 1998; Smith et al, 2000; Mays et al, 2001; McClelland et al, 2001; Regen et al, 2001; Smith and Goodwin, 2002; Wilkin et al, 2000, 2001, 2002; Wyke et al, 2003). However, some studies suggested that the costs of some of these primary care-based services were often higher than the equivalent hospital-based services (Goodwin, 1998). Moreover, the quality of the new forms of service which resulted from primary care-led commissioning has not been examined in comparison with alternative models, so their relative appropriateness cannot be assessed.

Cost containment

There is strong evidence to suggest that large numbers of small practice-based purchasers (such as fundholders) inflated transaction costs compared to a small number of larger commissioning agencies (such as health authorities) (Audit Commission, 1996; Goodwin 1998; Mays et al, 2000; Bevan, 1998). A plurality of different types of purchasing organisation risked increasing system-wide transaction costs even further (Mays and Dixon, 1996) as a result of a larger number of contracts and the need for budgetary management capacity within more organisations. However, as primary care-led commissioners have grown in size and reduced in number, the evidence suggests this has *not* resulted in any significant economies of scale (Place et al, 1998; Mays et al, 2001; Smith and Goodwin, 2002). Assessing the evidence has been difficult, due to the growing range of functions of these new, larger primary care organisations, but the literature suggests that the costs associated with organisational management, the development of new organisations, and the co-ordination of activities between larger numbers of professionals and practices have replaced the greater contracting costs associated with a larger number of smaller commissioning agencies.

Provider responsiveness

Provider responsiveness to the demands of commissioning agencies before the development of PCG/Ts improved in *some* cases as a result of primary care-led purchasing, but

generally only at the margins of activity (Goodwin 1998; Le Grand et al, 1998; Mays et al, 2000). Providers working with PCG/PCTs in England have also been responsive, for example in developing 'care pathway' approaches to services, but particularly where proposed changes have reflected national priorities laid out in national service frameworks (Regen et al, 2001; Wilkin et al, 2002). A common problem faced by all primary care-led commissioners has been shifting resources from secondary care to fund intermediate and primary care-based alternatives. On the other hand, there is no sign that other commissioners, such as health authorities, found it any easier to extract resources from the hospital sector in line with their commissioning priorities than their primary care-led counterparts (Le Grand et al, 1998).

Responsiveness to patients and the public

There is some evidence that patients generally approved of the service changes brought about by primary care-led commissioners. However, effective patient choice of provider and influence by patients and the public over the nature of services was not a strong feature of any of the primary care-led commissioning approaches (e.g. see Mahon et al, 1998; Dixon et al, 1998; Florin et al, 1999; Regen et al, 2001; Wilkin et al, 2002). For example, GP fundholders may have altered their preferred referral hospital or specialist, but they rarely offered their patients a choice of hospital or specialist. The evidence suggests that primary care-led commissioners had yet to develop any effective mechanisms to promote patient choice and influence before the most recent patient choice initiative in England. The requirement to respond to and accommodate patient choice will be a key challenge to the new practice-based commissioners who will take over devolved commissioning resources in the English NHS in 2005.

Health outcomes

All studies of the effect of primary care-led commissioning have been restricted in their assessments by significant changes of policy and the rapid development of new forms of commissioning, as well as the problem of attributing any changes observed to a particular form of commissioning as against other causal factors. As a result, none of them provides any real evidence on the impact of primary care-led commissioning on health outcomes compared with other approaches to commissioning.

The contribution of primary care-led commissioning to service change

It is clear from the major evaluation studies that primary care-led commissioning has tended to work best when selective and focused on developing primary and intermediate care rather than taking responsibility for the entire commissioning budget or range of services (Mays et al, 2001; Wyke et al, 2003). It is scarcely surprising that

primary care providers are most effective and most motivated as commissioners to bring about service change and development in areas close to primary health care and which they are most familiar with as clinicians. Negotiating service changes with hospital specialists has not been a strong point of any of the primary care-led approaches studied to date.

Summary

There is evidence from the UK and New Zealand to show that primary care-led commissioning can improve resource use and develop services in positive ways in primary and intermediate care. Unfortunately, there is little comparative evidence on the performance of the different approaches to primary care-led commissioning and on primary care-led commissioning versus other, larger scale approaches such as health authorities.

4 Improving primary care-led commissioning: applying the evidence

KEY POINTS

There is no ‘ideal’ size for a commissioning organisation – different population bases are needed for commissioning different services.

Adequate levels of management support are vital to the success of commissioning, as was vividly demonstrated by the experience of total purchasing, where schemes with higher levels of support were seen to be more effective in terms of outcomes.

Timely and accurate information is required for commissioning – NHS routine data could be exploited to a much greater degree as a source of analysis of patient flows and pathways.

Real and meaningful clinical ownership of and engagement in commissioning is crucial, the power of this is demonstrated by the experience of PCGs, Bradford North practice-based commissioning scheme, NHS Collaboratives, and the New Zealand IPAs.

There is a careful balance to be struck between developing clinical engagement and assuring appropriate public and management accountability for commissioning decisions.

Primary care-led commissioning organisations have struggled to engage patients and the public in a meaningful way.

Local health commissioning/funding bodies face a difficult challenge in enabling primary care-led commissioners to have the headroom to commission according to local as well as national priorities.

Whilst commissioners need to have effective strategic relationships with providers, they also need to have the ability to shift activity elsewhere – ‘contestable collaboration’

Commissioning organisations need a degree of stability in the wider policy context – they have never been given a sustained chance to prove their worth

A single organisational solution to commissioning is neither possible nor appropriate.

Research into primary care-led commissioning has tended to focus on monitoring and assessing the implementation and early stages of development of new approaches to commissioning. As shown in the previous chapter, studies exploring specific and longer term outcomes are much harder to come by. However, there is an extensive research base on the organisational features, process factors and contextual characteristics associated with developing more or less effective primary care-led commissioning. What is striking about this body of literature is the regularity with which themes and lessons related to effective primary care-led commissioning recur. This chapter presents a summary of the research evidence according to the following dimensions of primary care-led commissioning:

- **Organisational features** – including size, accountability and legitimacy, resourcing, incentives, and information;
- **Process features** – including clinical engagement, degree of devolution and ownership, strategic relationships, methods of commissioning and contracting; and
- **Contextual factors** – national policy context, local policy context.

Organisational features

Size

Debate within the research literature about the ‘ideal’ size of a commissioning organisation centres on the trade-off between the need to have critical mass to have commissioning ‘clout’ and achieve economies of scale in relation to management support, and a desire for sufficient local focus to enable sensitivity to localities, practices, primary care staff, and local people (Smith, 1997; Bjoke et al, 2001; Lewis, 2004). Whilst the practice or locality is generally regarded as the appropriate level for determining patterns of primary and intermediate care delivery, a population base of 100,000 is suggested as being the minimum for commissioning general acute hospital services, and 500,000 is proposed for specialised hospital services (Le Grand et al, 1998). A number of studies conclude that there is a need for a ‘horses for courses’ approach to determining appropriate levels of commissioning with some form of matrix of approaches enabling the trade-off between leverage and local sensitivity to be made according to the specific service concerned (Smith, 1997; Bjoke et al, 2001; Smith and Goodwin, 2002). Analysis of PCG/Ts cautions that bigger is not

necessarily better for commissioning organisations, and that there are potential diseconomies of scale from needing to co-ordinate and manage large organisations (of over 100,000 patients) that seek to be sensitive to local professionals and communities (Bjoke et al, 2001).

Accountability and legitimacy

The accountability of all NHS commissioning organisations to their local populations is generally considered to have been weak, despite significant attempts on the part of health authorities and some primary care organisations to develop strategies for user and public involvement (Dixon et al, 2001; Elbers and Regen, 2002; Milewa et al, 2003). The centrally managed nature of the current NHS and commissioners' upward accountability for their use of tax-financed budgets inevitably means that mainstream commissioning organisations focus primarily on targets and performance measures set by government, over and above locally determined objectives. This was clearly demonstrated by the national shift in emphasis after PCGs were established towards implementing the English NHS National Service Framework objectives (Regen et al, 2001; Wilkin et al, 2001), compared with the diversity of aims and objectives pursued by their predecessor GP-run bodies (Smith et al, 1997). As with size of commissioning organisation, there appears to be a trade-off: the greater the degree of managerial accountability required by a statutory organisation, the less the freedom to innovate and the more diminished the sense of identification with the mission of the commissioning organisation on the part of professionals, and GPs in particular (Smith and Walshe, 2004; Barnett, 2001). One GP interviewee expressed the view of many other interviewees as follows:

'We now have to operate in accordance with turgid, government, performance management agendas – we are forced to be corporate rather than creative.'

As noted in chapter 1, one of the key assumptions underpinning primary care-led commissioning is the engagement of primary care professionals, as advocates for their patients, in the process of needs assessment, resource allocation and service purchasing and development. This does, however, raise a fundamental issue about the legitimacy of GPs and other health professionals to advocate for patients and the local population. The literature suggests that whilst GP and other primary care professional engagement is crucial to effective commissioning, it is not enough by itself, and certainly not in relation to the assurance of appropriate public governance of commissioning (Dixon et al, 2001; Milewa et al, 2003).

A criticism of GP fundholding was its relative lack of formal public accountability to the local population, particularly in the case of fundholding organisations created by groups of

GPs (Goodwin, 1998). Any return to practice-led forms of commissioning, along with a greater focus on a plurality of models of commissioning (possibly in private or third sector ownership) will call for new forms of sophisticated and flexible governance that at once satisfy the requirements of stewardship of public money with the interests of diverse commissioners and their populations.

Resourcing

Research evidence supports the hypothesis that the more successful primary care commissioning organisations have higher levels of management and other professional support (Malcolm et al, 1999; Wilkin et al, 2001; Weiner et al, 2001; Regen et al, 2001; Mays et al, 2001; McClelland et al, 2001; Dopson and Locock, 2002). The national evaluation of total purchasing pilots showed a statistically significant association between a pilot's ability to achieve its commissioning objectives and its per capita management costs (Mays et al, 2001, p85). Adequate management support is considered to be vital if primary care commissioning organisations are to gain the confidence of secondary care colleagues in purchasing negotiations, and of their constituent practices which expect the organisation to properly support primary care-led commissioning activities. UK commissioning organisations, in general, have had low levels of management support when seen from an international vantage point (Weiner et al, 2001), and the issue of commissioning capacity is regularly cited as a reason for the perceived lack of progress with commissioning in the NHS, given the wide range of responsibilities given to commissioning organisations (Light, 1998a; Smith and Goodwin, 2002; Dopson and Locock, 2002; Roche, 2004; Commission for Health Improvement, 2004). There is no doubt that core commissioning activities such as population needs assessment, service specification and development/redesign, priority setting and resource allocation, contract negotiation and service monitoring need proper management and other expertise. In addition, with the increasing interest in using managed care techniques from the USA as part of NHS commissioning, a range of new skills are called for including: linking the discipline of managed care with programme budgeting processes and Payment by Results; developing staff, clinician and patient awareness of new approaches to care management; developing new incentive structures; analyzing and then risk stratifying local population groups; developing predictive models of likely health care needs and usage; articulating how the policies of managed care and *Patient Choice* might work together (Chambers, 2004). Light (1998b) identifies the following requirements for commissioning organisations to be successful, based on US experience:

- Sufficient clout (for which size may be relevant, depending on the service) to take on powerful specialty hospitals;

- Technical skills, knowledge and infrastructure to challenge ineffective or inefficient practices;
- Time and training to carry out complex tasks (e.g. working with providers to redesign their services);
- The ability to improve quality and efficiency, and reduce variations, in primary care itself.

Incentives

The importance of aligning incentives within primary care-led commissioning is well documented in the literature (Le Grand et al, 1998; Dudley et al, 1998; Dowling, 2000; Kralewski et al, 2000; Croxson et al, 2001; Propper et al, 2002; Spooner et al, 2001; Smith and Goodwin, 2002). This evidence shows that GPs can be motivated to improve service quality and to make better use of the available resources, given the correct incentives. This was underlined in many of our interviews – for example, one respondent noted:

'You cannot underestimate the importance of appropriate incentives for the innovators to be able to bring about change. We are now trying to re-engage these innovators, explore incentives, find the resources, share risks, and look to devolved approaches again [in PCTs].'

Whilst there continues to be disagreement within the primary care community as to whether GPs (and other primary care professionals) need to hold a real versus an indicative budget in order to commission effectively, there is a consensus from the interviews carried out for this research that GPs have become disengaged from much of commissioning, planning and development activity and that further delegation of responsibility along with associated information systems and incentives is required (Lewis, 2004). It is hard to see how a commissioning organisation can successfully bring about the changes it desires when providers are resistant unless that organisation has control over the use of resources. Even if a primary care organisation does not 'hold' the budget or part of it, it must be able ultimately to direct its use. In government policy (Department of Health, 2004a) and in external analysis (Smith and Goodwin, 2002; Lewis, 2004; Roche, 2004), it is acknowledged that different forms of incentives (financial and non-financial) are required for specific areas of service and levels of commissioning, once again underlining the message that a single organisational solution to 'commissioning' is neither possible nor appropriate.

Information

A lack of appropriate information to inform the commissioning process was cited by almost all our interviewees as being a key inhibitor to effective primary care-led commissioning. This finding is supported in the literature (Regen et al, 1999; Mays et al, 2001; Regen et al, 2001; Wilkin et al, 2000; Wilkin et al, 2001; Wilkin et al, 2002; Roland and Smith, 2003) and is accompanied by a growing sense of frustration that this research lesson never

seems to be learnt by the NHS. Issues flagged as being of particular concern include the provision of detailed public health data analysis for population needs assessment, the collecting of practice-level data of consistent quality, and the nature of data received from hospital providers, for example, on their patients' use of secondary care. The new GMS contract has strengthened incentives for quality-related activity data in primary care. Light (1998b) argues strongly on the basis of US experience that NHS commissioners need clear, routine measures of benefits and quality of care if they are to have any idea whether the increasing volumes of service that they are purchasing are doing any good. He advocated building on the Health Plan Employer Data and Information Set (HEDIS) used by US purchasers to assess the performance of their providers and other innovations such as the Primary Care Assessment Survey (PCAS).

There is also a growing body of literature that calls the bluff of NHS managers in this regard, demonstrating that careful analysis of even the currently available data can helpfully identify key commissioning challenges such as the small number of patients making the greatest use of non-elective hospital services (Ham et al, 2003b). Similarly, retrospective analysis of fundholding data and hospital activity in recent years also demonstrates the potential to use existing data to inform decision-making (Propper et al, 2002). The new financial flows regime in the English NHS is predicated on a belief that it will enable contestable commissioning on the basis of quality rather than price. It remains to be seen if NHS commissioners, and the information resources at their disposal, are up to this challenge (Dixon, 2004; Walshe, 2004).

In the USA, one response to purchasers' lack of data about service quality and outcomes has been the pursuit of quality-based purchasing (Dudley et al, 2004). Purchasers have sought to address the perennial problem of lacking outcome data by establishing incentives for providers that stimulate or inhibit certain behaviours with the aim of improving quality. The two main types of incentives being used are performance-based payments and reputational incentives arising from the public release of data. There are a number of ongoing studies of quality-based purchasing in the USA, including ones where health care funders have made an ongoing commitment to an incentive strategy, enabling longer-term studies of the impact of these new purchasing approaches. Multiple quality measures are used as part of the purchasing process, across a variety of conditions and distinct patient populations. The whole aim of the approach is to try and determine if investments in quality by providers can be recouped by purchasers through improved services (Dudley et al, 2004). Such approaches as these are worthy of careful tracking by UK commissioners, as the approaches potentially offer solutions to the challenges of having robust information and

securing leverage over secondary care so frequently encountered in the NHS.

Process factors

Clinical engagement

There is extensive research evidence to support the link between direct and meaningful clinical engagement in commissioning and the achievement of desired commissioning objectives (Mays and Dixon, 1996; Ham, 1996; Light, 1998a; Malcolm et al, 1999; Robinson, 1999; McClelland et al, 2001; Regen, 2002; Wilkin et al, 2002; Dopson and Locock, 2002; NHS Alliance, 2003; Lewis, 2004; Smith and Walshe, 2004). The literature suggests that GPs and other health professionals identify more closely with organisational goals, participate more actively in governance and are more satisfied with the way the organisation is being managed if they have played some part in setting up or shaping a primary care organisation. For example, it is striking how much more satisfied GPs in New Zealand IPAs were with the organisation and management of their organisations than GPs in English PCTs in recent years (Barnett, 2001; Commission for Health Improvement, 2004). IPAs developed spontaneously, are outside the government sector and operate in ways that are compatible with the culture and ways of working of general practice (e.g. GP board members are elected by their peers). PCTs are statutory authorities with boards of appointees closely integrated into the performance management hierarchy of the NHS, and therefore less likely to be perceived as 'belonging' to GPs.

The extent to which GPs are best placed to lead all aspects of the commissioning of care for all services has been increasingly questioned, in the literature and in our stakeholder interviews, with an emerging view that their involvement is best used in areas where they can have a more direct influence, including primary care and community services development, chronic disease management, intermediate care, and general hospital services. The role of GPs as providers of elements of chronic disease and other care appears to be a useful basis for them to work closely with secondary care colleagues to develop new and more integrated forms of service provision (Ham, 1996; Coulter, 1996; Mays et al, 2001; Smith and Goodwin, 2002; Lewis, 2004). The perceived loss of clinical engagement within English PCTs, and from the Scottish health system in general, was the strongest message to be conveyed to us by those in England and Scotland interviewed for this study and was cited as the main challenge facing those charged with making a success of commissioning in the NHS. One respondent with a rich line in mixed metaphors commented: *'We've been squashed badly – we need to unleash the energy back into the system to rattle it into action.'*

Given that this review of the evidence is mainly concerned with primary care-led commissioning, 'clinical engagement' is generally considered in the literature as being associated with GPs and other primary care professionals. However, evaluations of approaches to commissioning repeatedly stress the importance of primary and secondary care clinicians being engaged within the commissioning process (Regen et al, 1999; Smith et al, 2000; Regen et al, 2001; Wilkin et al, 2000; Wilkin et al, 2001; Mays et al, 2001; Wilkin et al, 2002; Dopson and Locock, 2002) and the need for primary care organisations to have effective strategic relationships with secondary care providers (see below). Indeed, a key lesson from the literature on quality improvement in healthcare settings is that it is foolhardy to attempt to impose changes to working practices on clinicians without securing their engagement both to the objectives sought and the processes used to achieve them (Joss and Kogan, 1995; McNulty and Ferlie, 2002; Ham et al, 2003a).

Degree of devolution and ownership

The tension between central health system-wide priorities and targets and those developed at a local level by clinicians and managers working with local people in commissioning organisations is well documented in the literature (Wilkin et al, 2001; Mays et al, 2001; Regen et al, 2001; Peckham and Exworthy, 2003; Smith and Walshe, 2004). Research into PCTs has highlighted the frustrations felt as a result of having to work within a tightly defined central performance management framework that requires adherence to national targets and performance indicators to the detriment of locally agreed priorities (Wilkin et al, 2002; Dowling and Glendinning, 2003; Commission for Health Improvement, 2004; Smith and Walshe, 2004).

The trade-off is not, however, simply one of national uniformity versus local diversity. The population-patient axis has to be considered too, with commissioning organisations having to work out how far planning and commissioning decisions should focus on the needs of individual patients as opposed to the public health challenges of wider populations (Ham, 1996; Mays et al, 1996; Balogh, 1996; Le Grand et al, 1998; Smith et al, 1997). In all such trade-offs, risks and benefits have to be taken into account, with the risk of losing local and clinical engagement being of particular note in any shift towards central or national agendas.

Strategic relationships

There are two key sets of strategic relationships required of commissioning organisations, namely those with providers and those with other commissioners. The importance to commissioners' effectiveness (whether seeking to be primary care-led or not) of being able to develop long-term relationships with local providers of health and social care

recurs in research studies (Regen et al, 2001; Mays et al, 2001; McClelland et al, 2001; Wilkin et al, 2002; Dopson and Locock, 2002). Such relationships are considered important as a basis for integrated planning and service development work across primary and secondary care, across health and social care, and within primary and community services. These relationships are, however, vulnerable to organisational and policy change, and the tendency of the NHS to embark on structural reorganisation every two to three years is a major threat to cross-organisational and sector working (Fulop et al, 2002; Smith et al, 2000; Mays et al, 2001; Smith et al, 2001; Walshe, 2003).

There is also a strand of literature that suggests that relationships within a health system such as the NHS can be too cosy, resulting in inevitable inertia (Enthoven, 2000; Light, 1998a; Stevens, 2004) and that there is a need for a greater degree of contestability or 'bite' between commissioners and providers. Debate about the appropriate degree of contestability for a health system typically focuses on the transaction costs of such competition, the need to assure equity of service provision, and how to handle 'exit' from the market (Forder et al, forthcoming). The consensus in the literature seems to be that effective primary care-led commissioning depends on the development of 'contestable collaboration', a subtle balance between continuity of relationships with providers and the possibility of shifting resources elsewhere (Smith and Goodwin, 2002).

In all commissioning models, the need for effective relationships between commissioners is considered to be crucial (Mays et al, 2001; McClelland et al, 2001; Wilkin et al, 2002; Smith and Goodwin, 2002; Dopson and Locock, 2002; Lewis, 2004). Respondents in our study emphasised the need for good working between GPs and practices if they in turn are to proceed from a position of strength and consensus in practice-based commissioning negotiations with other providers. Similarly, appropriate collaboration underpinned by robust governance arrangements is necessary to 'lead commissioning' or joint commissioning schemes. The problems inherent in trying to find single structural solutions to the complex challenges of commissioning call for more of a matrix or network approach to the development of the strategic relationships across organisations (Goodwin et al, 2004; Smith and Walshe, 2004), one that enables clinicians and managers to carry out longer term service development work at the appropriate organisational level and without the distraction and turmoil of merger and reorganisation.

Methods of commissioning and contracting

The specific methods of commissioning and contracting chosen for use in a health system each bring with them a

range of risks and benefits. GP fundholding demonstrated at once the benefits of having more detailed information and micro-level clinical influence on the purchasing of services (Dowling, 2000; Propper et al, 2002), and risks in terms of higher transaction costs and a tendency to focus on practice rather than wider priorities (Audit Commission, 1996; Goodwin, 1998). On the other hand, cost and volume approaches to contracting appear to lead to system inertia, particularly in relation to the purchasing of secondary care services (Le Grand et al, 1998).

The return to a market-based system of commissioning in the English NHS in the form of Payment by Results (Department of Health, 2002) using a national tariff is an attempt to focus purchasing decisions on quality rather than cost, although the potential risks of gaming by secondary care providers are considerable, as is the risk of PCTs feeling powerless to use the flexibilities to bring about service redesign across primary and secondary care (Dixon, 2004; Walshe, 2004). Whatever the approaches to commissioning and contracting used within a health care system, there will be a trade-off between transaction costs (with a desire for value for money in a publicly funded system), ensuring the necessary skills are available to the system, and achieving appropriate sensitivity and flexibility in relation to the shaping of specific services.

Contextual factors

The principal sources of evidence on the contextual factors that have affected PCLC organisations' performance to date are the national evaluation of total purchasing pilots (Mays et al, 2001; Wyke et al, 2003) and the two national evaluations of PCGs/PCTs in England (Regen et al, 2001; Wilkin, et al, 2002). These evaluations attempted to explain how the local context affected the ability of primary care-led commissioners to achieve their goals. Some aspects of these contexts, such as the degree to which health authorities devolved responsibility and resource to local primary care commissioners, and their relationships with providers, have been discussed in the above section on process factors. The context of primary care-led commissioning can be seen as having national and local dimensions.

National policy context

The evidence from studies of PCTs suggests that they need a degree of stability and continuity of management and organisation to make progress in using their commissioning powers to improve local services (Smith et al, 2000; Wilkin et al, 2000; Mays et al, 2001). New primary care-led commissioning organisations are prone to focus internally in the initial stages and then to look to make service developments in primary care. It takes longer for most of them to develop relationships with secondary care providers, and to begin to influence these organisations.

This is hindered by frequent organisational change within the system when imposed from above rather than occurring as a response to local conditions and experience. There is very clear evidence from the progress made by total purchasing pilots in the late 1990s that as soon as it became apparent that there was a likelihood that the NHS market would be dismantled and, in particular, that GP-led purchasing would be abolished if a Labour government were elected, the TPPs immediately found it much more difficult to persuade NHS trusts to make desired service or resource shifts.

Since then, there have been other developments that have the potential to reduce the influence of primary care-led and other commissioners over the system as a whole. For example, the recently announced rolling out of the patient choice initiative in England sends out a powerful signal that the individual user is intended to drive the choice of provider, at least for some services, rather than an agent commissioning services for groups of patients and populations. This could be a very important contextual feature in the future for local commissioning, implying either a contradiction between different policy streams or some resolution in which some services are 'spot' purchased at individual patient-practitioner level, or at practice level, and others are commissioned at a population level within the same PCT.

Another strand of recent policy change with major implications for primary care-led and other forms of commissioning relates to attempts in England to reform the provider side of the health system to make it more responsive as set out on page 7. Though it could be argued that making the hospital sector more flexible should assist commissioners in their work to improve services, the focus on providers could be to the detriment of investing in stronger commissioning organisations. Also, developments like foundation hospitals could make it even more difficult for commissioners to influence hospitals to alter their services. Foundation trusts will be able to mobilise a local constituency of support through their governors and local 'members' to counteract the influence of the commissioners who, as yet, do not have the public profile or support.

Local policy context

Evaluations of total purchasing and PCG/Ts identified a wide range of local contextual factors supportive of, or militating against, effective primary care-led commissioning (Mays et al, 2001; Wyke et al, 2003; Wilkin, et al, 2002; Smith and Goodwin, forthcoming). Arguably, two of the most important local contextual features for a service commissioner are the extent of provider and service choice available locally and regionally, and the quality and configuration of primary care provision. Providers have to

feel that they are not invulnerable to being replaced, and primary care needs to be sufficiently developed to take on new and expanded services commissioned as part of overall service changes.

The importance of a history of effective local GP engagement and collaborative working recurs in the literature as a key facilitator of innovation (Smith et al, 1997; Regen et al, 1999; Mays et al, 2001; Wilkin et al 2001; Regen et al, 2001). In carrying out this review of the evidence concerning primary care-led commissioning, it was striking how many of the examples of good practice in commissioning cited in 2004 are located in health economies that previously demonstrated achievements through total purchasing, GP commissioning and other schemes.

Summary

This chapter reveals a strong evidence base concerning the contextual, organisational and process factors associated with effective primary care-led commissioning. What is clear is that much is known about what facilitates effective primary care-led commissioning. In the next chapter, we describe and evaluate the various models of commissioning currently evident in the NHS, and suggest an approach to selecting an appropriate local mix of commissioning models.

5 The continuum of commissioning models in the UK

KEY POINTS

Seven models of commissioning were identified in this study, ranging from individual patient purchasing through to national purchasing.

Three approaches to service integration were identified – care pathways, professionally-driven networks and provider-commissioner integration – these being considered important for commissioners to consider alongside the continuum of commissioning models.

Many of these commissioning models are complementary, and depend on the existence of an overarching body that will allocate resources and select appropriate models of commissioning. Such bodies face three key strategic decisions:

- How should the choice of commissioning models be made, and on what basis?
- To what extent should organisational forms that integrate commissioning and provision be developed as part of the overall commissioning/planning process?
- What is the appropriate blend of commissioning models for the local health economy?

The combination of approaches to commissioning to use in each local health economy should be the result of an explicit assessment process. In the absence of comparative research on the performance of each, we set out the likely criteria for making such a selection and provide an indication of how the approaches might typically perform against the criteria.

There are also a number of other potential future approaches to commissioning and service development/provision that are likely to be considered by commissioners as part of an expanding spectrum of methods for improving and developing health and health services.

The continuum of models of commissioning

This research has revealed a continuum of organisational approaches to health services' commissioning currently in operation (see figure 1 on page 6). This chapter differentiates, describes and analyses these models of commissioning. To make this analysis, a set of evaluation criteria are used, as developed by stakeholders at workshops held as part of this research project and codified by the research team in light of the literature on commissioning. A key challenge for local commissioning organisations (primary care trusts, health boards, health and social services boards, local health boards) is how to select an appropriate combination of commissioning models according to local health needs and service configuration. In this chapter we propose a rigorous process to inform this choice. The chapter ends by outlining some other potential approaches to commissioning and provision which may become relevant to the UK, but which have so far not been implemented.

Evaluating models of commissioning

The evaluation criteria applied to the models of commissioning are the ability to:

- shape different types of services, each exhibiting different levels of complexity and scope for contestability
- offer a degree of choice of provider, contestability, and responsiveness
- manage budgets and financial risks, including delivery of financial plans
- minimise administration and transaction costs
- develop and sustain clinical engagement
- address health needs and tackle health inequalities
- improve and govern clinical quality.

The following analysis focuses on areas of particular strengths and weaknesses and does not attempt a full consideration of each approach against each criterion. Two summative tables are included at the end of this chapter (page 34), providing a visual assessment of the overall performance of each model of commissioning. It is important to remember that while the assessment of each approach draws on the research evidence, there is little or no evaluative research on any of the approaches except English PCTs and no comparative studies of different approaches. Thus the bulk of the analysis is based on what

might be expected from the performance of earlier approaches and ex ante theorising.

Model 1: Individual patient purchasing – ‘Patient Choice’

Description

This approach is a form of ‘spot’ purchasing in which patients, with or without the assistance of their GPs, decide which service provider to choose from a number available. It is designed to encourage a responsive, consumer-oriented system of health care and goes a step further than traditional NHS purchasing or commissioning that is based on the concept of the ‘agent’ of the patient, be that a GP or NHS manager. If patients act alone within a patient choice scheme, they are effectively paying directly for services using an NHS ‘voucher’. This can be taken to its logical extreme, with patients being given actual money to purchase care. Whilst this may seem revolutionary, it does already happen to a limited extent within social care in England. Within the direct payments scheme, users, typically people living with disabilities or other long-term health conditions, are given money to use for buying services such as personal care and home support. This can be viewed as the most user-focused form of commissioning.

NHS individual patient purchasing typically focuses on non-urgent outpatient, day case and inpatient services for which GPs (or patients themselves) have the opportunity to use information about the quality and availability of care to advise their patients on their choices. The system is similar in mechanism to the system employed in Denmark where patients are allowed to make an informed choice of provider using a sophisticated information technology system at the point of consultation that enables them to compare providers on issues such as quality of outcomes or waiting times. The Danish model does *not* give budgets to practices to commission services, however. Examples of patient-purchasing models currently include the *Patient Choice* pilot initiatives in England in which patients referred for elective surgery are guaranteed to be offered a choice of providers with waiting time guarantees.

Evaluation

The ability of patients to directly select their service provider is highly associated with maximised patient choice and responsiveness. Free choice of provider by patients will, in theory, increase the contestability of services between alternative suppliers. Patients are perhaps less likely than health service commissioners to take account of established patterns of referral and extrinsic incentives (such as a need to maintain a delicate financial balance within a wider health economy). As a result, such a commissioning approach may prove highly dynamic. In theory, providing cash for direct payments is likely to be

more efficient than providing care as long as the user has good information on the services on offer since the user can choose the package of services that best meets their needs (Wittenberg et al, 2002). Individuals may be able to arrange care more quickly than a third party since they have a strong incentive to do so.

However, in practice, a number of factors may mediate this dynamism and efficiency. Some older people, for example, may not have the ability or the information to make informed choices and they may not be able to find anyone suitable to act as their agent. Where users rely on a professional, such as their GP, to broker or organize their care, this risks losing the distinctiveness of the approach, though it may mean that extrinsic incentives continue to play at least some part in decision making. It is also likely that the dynamism of such an approach to commissioning will be dependent on the effective supply of alternative providers. In rural areas, in particular, this diversity may simply not be available.

This approach lends itself most successfully to care sectors where pre-planning can be applied, for example, in elective surgery and on-going chronic care. Patient choice of highly specialised or emergency care is likely to be highly limited for reasons of lack of practical alternative suppliers and lack of available time to plan in advance.

Transaction costs of such a system may be high. In England, *Patient Choice* is requiring a substantial investment in information technology to enable direct booking of hospital services within primary care. There will also be a significant financial burden associated with the provision of sufficient information to enable patients to make meaningful choices. The impact of this commissioning approach on equity and health needs is more difficult to judge. In one regard, equity may be improved as all patients will have guaranteed rights. However, it is also possible that such entrenched inequities will be strengthened as advantaged groups make better use of new powers than disadvantaged groups.

The degree of financial risk will be dependent on the demand management structures that are put in place alongside such a commissioning approach (for example, budgetary constraints at GP practice level – see below). However, new risks may emerge if direct payments are pursued. If patients are delegated their own budgets for a ‘year of care’ in relation to a chronic disease, problematic outcomes may obtain if patient do not manage their own budget carefully (i.e. it is unlikely that patients will be left without care if the overspend their allotted budget early in the year).

The impact of this commissioning approach on clinical quality is difficult to judge as it will depend on the overarching structures that are in place. However, arguably such an approach may increase the likelihood that a patient perspective is brought to bear through greater patient empowerment.

Model 2: Single practice-based commissioning

Description

In single practice-based commissioning, a budget is allocated to an individual practice within, for instance, a PCT in England for the commissioning of services. The practice focuses on deciding what should be purchased and when, while the PCT deals with the formal contracting process. It is seen as a way of bringing GPs and practices back into the commissioning process and of encouraging them to take responsibility for part of the PCT budget. This model can be based on real budgets, indicative amounts or some mix of the two. There has been a gradual increase in the number of practices receiving some sort of budget from their PCT in England (e.g. Waltham Forest PCT, East Devon PCT, South Hams and West Devon PCT) and the approach is encouraged in recent policy guidance about developing practice-based commissioning (Department of Health, 2004a). Practices are usually allowed to keep part of any savings as an incentive to take part.

Evaluation

This approach to commissioning is founded on a high degree of primary care engagement in the commissioning process. Practice-based commissioning is likely to be most effective in relation to: first contact care, where new extended primary care services may be commissioned to substitute for secondary services (Regen et al, 2001; Wilkin et al, 2001); elective care, where evidence suggests referral rates may decline and practices may obtain relatively shorter waiting times (Propper et al, 2002; Dusheiko et al, 2003); and for 'referral sensitive' services such as chronic

care where financial incentives may encourage better management in primary care to avoid utilisation of specialist resources (Mays et al, 2001). Practice-based commissioning is unlikely to be significantly effective in shaping accident and emergency care (although it may reduce its utilisation), tertiary care or public health, as the catchment population for these services is far larger than the practice population, thereby necessitating a higher level commissioning organisation.

If practices assume budgets for first contact care, there is the potential for significant conflicts of interest, and hence there would be a need for strict criteria and standards of service attached to the devolution of the budget. Otherwise, practices may be able to purchase services from themselves with little oversight. As a response to the difficulty in practices holding budgets for first contact primary care, some PCTs have devised practice-level incentive schemes to reward practices for improvements in the quality and efficiency of their general medical services similar to the incentives in the national GP contract and which do encourage them to take responsibility for their patients' use of resources elsewhere in the health care system, such as in hospitals. A striking example of such an approach is that adopted by Bradford North PCT.

Practice-based commissioning is highly consistent with patient choice and responsiveness, and provider contestability. In this model, commissioners are able to develop individually tailored packages of care. Patients (and individual GPs as their advisers) have significant opportunities to express their preferences (of what care to receive and from which provider). Patients also may exercise choice of commissioner through their selection of general practice, although this choice may be more theoretical than real where there are workforce shortages or in rural areas.

North Bradford PCT practice-level budget holding and incentive scheme

The objectives of the North Bradford approach are to engage practitioners directly in helping the PCT improve its management of both primary care and hospital care resources while improving the quality of care. Rather than devolving budgets to practices to commission services on behalf of the PCT, North Bradford PCT has progressively devolved first indicative and later actual budgets to individual practices for the provision of general

medical and other services provided by the practices themselves, and for their patients' use of hospital services so that the practices themselves can act to manage demand. To enable them to do this, practices receive regular information on their patients' use of hospital services. This relies heavily on having developed a sophisticated information system that captures resource use at a practice level. Practices are incentivised in three ways to improve quality and efficiency: by specific payments for quality improvements in their general medical

services related to local priorities; by being able to retain a share of any 'savings' they are able to make against the indicative hospital budgets allocated to them, by developing better services in the community or improving what they themselves do (e.g. through admission avoidance schemes and better chronic disease management to reduce their patients' reliance on local hospital care); and, non-financially, by receiving comparative clinical information on their performance compared with their peers (profiling).

Experience of GP fundholding and total purchasing suggests that practices are able to manage financial budgets and risk but that transaction costs are likely to exceed those of other, more collective models of commissioning. Clinical engagement is likely to be high, where practice-based commissioning is working well and is appropriately supported, though it is not clear which comes first: the clinical engagement or practice-based commissioning. However, with salaried general practice options replacing independent contractor status at the margin, it is possible that not all clinicians will share in the financial and other incentives associated with practice-based commissioning and therefore engage with the process. This depends of course on how their salaries are structured.

The most contested area of practice-based commissioning is its impact on equity. Practice-based approaches may lead to allocative inequities (i.e. imperfect budget-setting leading to inappropriate resource allocation across practice populations) and outcome inequities (more effective commissioners may achieve better outcomes for their patients than less effective commissioners). There is little empirical evidence whether outcome inequities would be temporary or entrenched, as effective commissioning methodologies were disseminated. However, it is worth bearing in mind that there are differences in effectiveness between commissioning organisations already today (e.g. between PCTs).

Whether or not practice-based commissioning is likely to improve the governance of clinical quality is likely to be a function of the accountability framework within which it is located. As such, practice-based commissioning could perform badly or well against this criterion depending on local context.

Model 3: Multi-practice or locality commissioning

Description

In this approach, a group of practices within a PCT takes responsibility for a shared budget to commission services. This has some parallels with earlier fundholder multi-funds, GP commissioning groups and total purchasing pilots in which groups of practices of different sizes collaborated to take a collective commissioning role. It is also clearly similar to single practice-based commissioning in that it requires the PCT (or equivalent) to hold the practice groupings' commissioning decisions within an overall PCT strategic and accountability framework. Like single practice-based commissioning, it is not currently found in Wales, Scotland or Northern Ireland.

Multi-practice and locality commissioning tends to develop in order to try to reduce the number and frequency with which patients with chronic conditions are admitted to local hospitals in order to improve their quality of care and the

overall efficiency with which resources are used. Multi-practice and locality commissioning initiatives thus typically invest in extended primary and intermediate care. Such schemes can also include commissioning provision of what are normally hospital specialist services in the community, e.g. a wider range of diabetic services. For example, a group of practices in Smethwick and Oldbury PCT commissions specialist diabetic (and other) services in the community through a specialist PMS contract which brings together the primary care team, intermediate care and hospital services under a single agreement with the PCT. Bradford North PCT is exploring a similar arrangement for the commissioning of mental health services, again using specialist PMS contracts.

The goals and service responses in multi-practice and locality-based commissioning initiatives are very similar to those in single practice-based commissioning initiatives. Other examples of locality schemes are to be found in Mid-Devon PCT, North East Lincolnshire PCT and Dartford and Gravesham PCT, all of which were GP commissioning pilots schemes over the period 1997-1999, demonstrating the enduring interest in locality-based approaches in certain areas.

Evaluation

While this approach shares similarities with that of single-practice commissioning, some important differences also emerge. A collective approach is likely to trade off responsiveness and contestability against equity and risk. Locality/multi-practice approaches are likely to entail strategic alliances between practices and selected providers, designed to deliver pre-agreed outcomes and applicable to all patients within the area – indeed this is their strength, although one consequence may be less choice for individual patients. This approach may work particularly well where the services in question are complex or require substantial redesign, for example, where hospital reconfiguration is required without destabilising the local health economy.

It is also arguable that financial risk may be better managed through the creation of a larger population risk pool, however, this obviously depends on the nature of the services being commissioned by the locality or group of practices and the nature of the contracts they have with providers. Similarly, transaction costs at both practice and provider level may be reduced through collective action. Evidence from evaluations of locality commissioning and TPPs suggests that improvements in clinical quality may be a key priority of such collective commissioning approaches.

Model 4 – Joint or integrated commissioning

This approach is designed to ensure that services for patients/clients whose needs span the responsibilities of

health and social services are met in a co-ordinated way without cost shifting in either direction. Joint commissioning is normally based on defining a shared, jointly managed budget, for instance, for the full range of care of older people.

In Wales, LHBs have been designed with a particular emphasis on collaboration with the local authority both for service delivery and for public health improvement. In Scotland, integrated health and social care for older people has been promoted through requirements for joint working between NHS boards and local councils. Local partnerships in Scotland have been instructed to set up: systems to deliver single shared assessment; a joint equipment and adaptation service; intensive home support services; short breaks for carers; a rapid response service to keep older people out of hospital. Some partnerships have aligned high-level budgets between NHS boards or primary care trusts and local authorities. Others have set up separate partnership bodies that bring staff equipment, property and aligned budgets into one body that has more delegated responsibilities and decision making powers and single management structure, but the bodies cannot employ staff.

In England, the introduction of the Health Act 1999 provided health and social care organisations with new opportunities to integrate public services. The Act removed the legal obstacle to pooling health and social care budgets and promoted the notion of joint commissioning and integrated health and social care provision. This has facilitated new joint commissioning arrangements, specifically to help co-ordinate existing health and social care services by commissioning, for example, 'integrated' community health and social service teams or developing joint health and social care beds. The *NHS Plan* (Department of Health, 2000) went further by detailing a vision of care trusts, or new multi-purpose legal bodies to commission and be responsible for all local health and social care. By March 2001, the Department of Health detailed its emerging framework for care trusts. The document reneged on the original and radical proposal in *The NHS Plan* that care trusts should be a completely new statutory commissioning organisation to be responsible for all health and social care.

As a result, of the eight 'pilot' care trusts which developed between April 2002 and April 2003, only two involved the integration of commissioning functions (Northumberland and Witham, Braintree and Halstead).

Evaluation

This approach is likely to benefit people with complex needs for health and social care services, and to offer opportunities to support their continued care in home and local community settings, with the potential to reduce both unplanned use of hospital services and delayed discharge from hospitals. It can happen at any level, including patients registered with single practices, groups of practices or larger primary care organisations. The level of joint commissioning will offer trade offs in relation to clinical and professional engagement, administration and transaction costs. The extent to which it is able to offer choice of either institutional or community based providers of care will depend on the local health and social care market, including the availability of community hospitals beds, publicly and privately owned nursing and other residential care home facilities, as well as the availability of a workforce to deliver home-based care. In order to increase user choice, this approach may be used in tandem with a system of direct payments for service users (see model one).

Joint commissioning of integrated care services has the potential to be effective in managing budgets and financial risks, although there is anecdotal evidence of reluctance from local councils to share risk with NHS providers who are more threatened by, and face fewer sanctions for, overspends. This means that budgets are much more likely to be 'aligned' than 'pooled'. It has potential to improve quality of care through a range of performance measures.

Perhaps the biggest weaknesses of joint commissioning relate to the different objectives, funding sources and planning cycles of the local NHS and local authority social services. Relationships are also made more complex by a lack of coterminosity in many places between health and social services boundaries.

Northumberland Care Trust

The Northumberland Care Trust began in April 2002 and is an integrated health and social care agency across three PCTs and a county council. The care trust commissions all health and social care and also provides primary and community and adult social care services (except mental health) based

across four localities. The care trust employs a similar model of governance to that of a PCT with a board and a professional executive committee. In 2002/3, the care trust controlled a budget of £375m of which £87m had been transferred from the County Council previously used for care management. The care trust's locality

structure provides a strong basis for local needs assessment and prioritisation. Localities lead on commissioning primary, community and intermediate health and social care for the own area, working together with provider organisations. Secondary, tertiary and specialised services are commissioned on a county-wide basis.

Model 5: Primary care organisation/PCT commissioning

Description

This approach is currently represented in the UK by PCT commissioning in England and LHB commissioning in Wales. Under this approach, the organisation responsible for ensuring the provision of primary health care and community health services also takes commissioning responsibility for all or most of the other health services used by the population for which it is responsible.

Evaluation

As the main commissioning body in the English NHS, PCTs and their predecessor PCGs have been extensively studied and their performance monitored. The overall assessment seems to be that performance is patchy (Roche, 2004). Given the size of PCTs with populations ranging from around 55,000 to 330,000 people with the vast majority over 100,000 patients, in principle, they can commission potentially all but the most specialised services if the principal criterion is simply their ability to manage the related financial risk. PCTs are also reasonably well placed to develop joint or integrated commissioning activities with their corresponding local authorities (see model 4, above). Yet there is a consensus that, like their predecessors, they have struggled to exercise influence over their acute hospital providers, in part because the risk of destabilising the pattern of acute services is perceived to be much greater at the level of a PCT than of smaller commissioners such as single practice commissioners and thus the constraints imposed much greater. On the other hand, the Audit Commission reports that some PCTs are able to reshape services and are offering quicker access to treatment and more services closer to home and outside hospitals by extending ambulatory and intermediate care (Audit Commission, 2004).

There will be differences of view as to whether a PCT or similar body is an appropriate entity to commission primary health care, depending on whether one regards a PCT as fundamentally a primary care-driven organisation or simply one which is influenced by primary care professionals. If the former, then it may not be appropriate for the PCT or equivalent to commission primary care to avoid blatant conflicts of interest. The more closely primary care professionals are involved in the PCT's governance, strategy and commissioning, the more difficult it is to sustain the argument that the PCT should be the commissioner of primary care in a system built on a separation between commissioner and provider. On the other hand, some entity has to determine what, at a minimum, local general medical practices should be providing, helping them develop the quality of their services and holding them accountable for their performance. This remains a key role for English PCTs and Welsh LHBs.

In principle, there is no reason why PCTs and similar organisations as commissioners cannot offer a choice of provider for those services where choice is desirable and feasible (see above). Clearly, as a relatively macro-, population-focused commissioner, the PCT or LHB is not in a position to respond directly to individuals' particular demands, but it should have the capacity to undertake needs assessment and reviews of patient experience to inform its future commissioning. So while the PCT is inevitably less responsive at the individual level than practice-based or individually based approaches, it has the ability to commission services that relate in broad terms to population preferences.

It is clear that PCTs, at least as constituted in England, find it difficult to sustain the level of clinical engagement and enthusiasm to be found in some of the smaller scale, practice-based forms of commissioning (see models 2 and 3 above). This is likely to be partly a function of size, but more importantly a function of the governance and management arrangements, and the external requirements placed on PCTs by central government. There is an obvious trade-off between a larger organisation which has the potential to spread its management and transactions costs across a larger population and build commissioning expertise, with a smaller organisation with which clinicians, particularly GPs can identify more closely. A response to this trade-off is for the PCT or equivalent to pass some of its commissioning responsibilities and resources to lower levels.

In addition to the challenge of sustaining clinical engagement, one of the main limitations on commissioning services at PCT level relates to developing sufficient commissioning expertise across a wide range of services (which may drive PCTs to collaborate (see approach 6, below). As a result, the PCT is only likely to undertake a part of the commissioning role. Its principal functions in future are likely to be to receive and parcel out the total NHS budget for its population between the different sub-commissioning groups in the area and the more macro-commissioning arrangements it chooses to participate in for more specialised services, since there needs to be an organisation to whom a fair total resource for a defined population can be allocated in the NHS. As a result, its role is likely to be increasingly to lead the process of identifying the most appropriate mix of commissioning approaches in its area for its population, coordinate the activities of the different organisations and groups involved in commissioning on its behalf, support their activities with relevant information, expertise, etc. and hold them to account for their use of resources.

Model 6: 'Lead' PCT/LHB/HB commissioning

Description

Under this approach, PCTs or their equivalent in Wales,

Scotland and Northern Ireland, come together to commission services, either when they lack suitable expertise at PCT level, or when a number of commissioners are dependent on a single supplier and wish to avoid being played off against one another. In these circumstances, it may be important for commissioners to co-ordinate their intentions and timing by formally collaborating. These higher level forms of commissioning can be ad hoc or can have more permanence and are generally regarded as suitable for highly specialised (high cost, low volume) services and for health protection (public health) services.

Most PCTs in England are involved in some form of collaborative commissioning for specialised services, and in Wales 'secondary care commissioning groups' are typically used for secondary care commissioning. In Scotland, the requirement for NHS boards to form regional planning groups for tertiary services is enshrined in the NHS (Scotland) Act 2003.

Evaluation

This model of commissioning is likely to be utilised as an addition to other approaches, not a substitute. This approach lends itself most readily to more highly specialised services than the previous model: the bringing together of commissioners to enjoy exclusive power to purchase from a given provider. However, lead commissioner arrangements may also be effective where complex strategic change is required, such as a major service reconfiguration, or where technical efficiencies may be made through collaborative action, such as the collective commissioning of independent sector 'patient choice' options in Sussex, or the commissioning of out-of-hours services in the North of Scotland.

The ability to engineer complex service change, and to shift the purchasing power balance between commissioners and providers in non-contestable markets, would suggest that this approach offers advantages over more local commissioning for specific services. Lead commissioning would be relatively effective in managing often volatile budgets and financial risk, while reducing transaction costs. The resulting increase in commissioning power may mean that 'lead' commissioners can extract greater responsiveness to patient needs, for example, through the agreement of policies relating to care management processes, and higher efficiency than would be achieved by micro-purchasers. However, this approach would score poorly in its ability to offer patients choice or contestability of services. Indeed, its purpose is to do the precise opposite.

The impact of this commissioning approach on equity is ambiguous. On the one hand, pooling budgets and agreeing access criteria to specialist services across a wide area may serve to increase equity of access. On the other

hand, large scale commissioning could serve to conceal, rather than reveal, inequitable access to scarce services, although this could be mitigated by having good information on who is using which services, by small area.

Clinical engagement is likely to be weak in this commissioning approach as the 'distance' between primary care and the commissioning process will be great. On the other hand, it may be possible to engage a small number of clinicians directly as advisers as well as setting up consultative mechanisms with a larger number to get clinical buy-in for decisions. It is clear that once commissioning decisions have been taken at this level, it becomes crucial to encourage and maintain GP compliance (i.e. in referring their patients in line with agreed contracts).

Model 7: National commissioning

Description

In Wales and Scotland there is some national level commissioning of infrastructure and highly specialised services. For example, the Welsh Health Commission (see box below) commissions cardiac, specialised cancer, blood and ambulance services for the whole of Wales. In smaller systems such as Wales and Scotland, it is understandable why more services might be commissioned at national level to reduce the costs of commissioning which is spread across small populations.

Evaluation

National commissioning models share a number of the advantages and disadvantages of both lead PCT/LHB and professionally driven network commissioning models and national commissioning may in fact play a particular role in facilitating the commissioning of clinical networks. National commissioning may appear particularly relevant to Wales, Scotland and Northern Ireland as clearly defined, yet relatively small nations, with less apparent relevance on an all-England basis. However, the lessons learnt from national commissioning can equally be applied to any proposed regional/SHA arrangements in England. National commissioning has tended to focus on high cost/low volume services and as such is only ever likely to be a complementary approach to other forms of commissioning. It may, however, also have a particular place in leveraging complex service reconfiguration on a national or regional basis although this is likely to be both time and context specific. In common with lead PCT/LHB commissioning it is particularly appropriate where technical expertise is scarce and monopsony purchaser leverage is required.

National commissioning is relatively effective in reducing transaction costs and managing budgets. It is also likely to be effective in minimising the financial risks to smaller organisations of commissioning high cost/low volume

Health Commission Wales

Health Commission Wales (HCW) is a Welsh Assembly Government Agency which is responsible for commissioning specialised health services. HCW was established in 2003 replacing the Specialised Health Services Commission for Wales and drawing its powers and budget into the National Assembly for Wales. HCW commissions

specialised services such as cardiac services, specialised cancer services, the ambulance service and the Welsh Blood Service.

- No one waiting over 10 months for cardiac surgery
- Waiting times for angiography reduced to no more than 6 months
- Long waits for cochlea implants for all priority groups virtually eliminated

- Extra £2m invested in renal services and major increase in renal transplants funded
- No child waiting more than 12 months for surgery
- Major increase in funding for patients with haemophilia
- Implementation of £1.5m investment plan in Welsh Genetics Service

services. The approach would deliver little in terms of patient choice or contestability although this may not be of particular significance outside England. Responsiveness is also likely to be diminished although this may be dependent on mechanisms introduced by national commissioners to engage a range of stakeholders. Clinical engagement of primary care practitioners is likely to be weak although other clinicians providing specialist services may be more engaged, much will again depend on the mechanisms adopted by the commissioner.

The impact of national commissioning on improving and ensuring clinical quality is ambiguous. It may be effective through the setting of national standards of care although its wide remit may mask problems with quality and stifle innovation in service delivery. National commissioning may also have an equally ambiguous impact on equity and inequalities. As with PCT/LHB lead models national commissioners can employ financial, standard setting and access advantages to promote equity and reductions in inequality and may have a particular place in commissioning for public health. At the same time they lose both a patient and local focus and may conceal both inequities and inequalities.

Evaluating models of commissioning – summary

It is clear that each of the seven commissioning models has both strengths and weakness (see tables 4 and 5, below), and that they are not mutually exclusive. The key question, therefore, is what attributes are particularly desirable for different service combinations, in different circumstances and in different environments. Tables 4 and 5 set out a broad classification of the performance of each commissioning approach against the selected criteria for assessment. Each has been assessed as either effective, not effective or ambiguous/context-specific.

The overall strength of the approach cannot be judged simply by counting the numbers of pluses and minuses. The 'strength' with which the commissioning model is considered effective must always remain a context-specific

judgement. Such a judgement will in part be based on a 'technical' appraisal, but it may also be informed by political values. For example, a clear distinction has emerged between English and Welsh health services over the value that should be attached to providing patients with 'voice' or 'choice'.

What this suggests is that each health economy should consider a series of assessments in order to determine the most effective combination of approaches to commissioning for its local area. The steps to be taken might be as follows:

- 1 Analysis of the service(s) to be commissioned – is the service simple or complex; are commissioners likely to be well or poorly informed about its content and effectiveness; is the service potentially contestable or not?
- 2 Analysis of the context and environment – is there already a choice of providers of this service or not; are patients likely to be willing and able to travel is local providers are not suitable?
- 3 Analysis of the proposed commissioning model in relation to the assessment criteria.

Models of service integration

Interviews and stakeholder workshops carried out for this project revealed an increasing interest on the part of commissioners in using models of service integration (that are not in themselves commissioning models) as part of the overall process of organizing care commissioning in a local health economy. For example, there was a view that new managed care approaches to the delivery of chronic disease management, and care pathways were methods of service integration that were closely related to the activity of commissioning. Many of these models of service integration, for example Californian chronic disease management organisations, and care pathway health plans in Arizona are more developed in countries other than England. A brief summary of these other approaches that might be considered by PCTs/LHBs/health boards for use as part of the overall commissioning activity is set out below.

Table 4: Relative effectiveness of commissioning approaches – different services

	<i>Patient choice</i>	<i>Single practice-based</i>	<i>Multi-practice-based</i>	<i>Joint or horizontally integrated</i>	<i>PCO/PCT</i>	<i>Lead PCT/LHB/HB</i>	<i>National</i>
<i>First contact care</i>	Effective	Effective	Effective	Effective	Effective	Ineffective	Ineffective
<i>Primary care</i>	Ambiguous	Effective	Effective	Effective	Effective	Ineffective	Ineffective
<i>Elective surgery</i>	Effective	Effective	Effective	Ineffective	Effective	Ambiguous	Ambiguous
<i>Accident & emergency</i>	Ineffective	Ineffective	Ambiguous	Ambiguous	Ambiguous	Effective	Ambiguous
<i>Acute care</i>	Ambiguous	Ambiguous	Effective	Ambiguous	Effective	Effective	Ambiguous
<i>Tertiary/specialised care</i>	Ineffective	Ineffective	Ineffective	Ineffective	Ineffective	Effective	Effective
<i>Public health</i>	Ineffective	Ineffective	Ineffective	Ambiguous	Ambiguous	Effective	Effective

Table 5: Relative effectiveness of commissioning approaches – assessment criteria

	<i>Patient choice</i>	<i>Single practice-based</i>	<i>Multi-practice-based</i>	<i>Joint or horizontally integrated</i>	<i>PCO/PCT</i>	<i>Lead PCT/LHB/HB</i>	<i>National</i>
<i>Choice, contestability, responsiveness</i>	Effective	Effective	Ambiguous	Ambiguous	Ambiguous	Ineffective	Ineffective
<i>Budgets and financial risk</i>	Ineffective	Effective	Effective	Ambiguous	Effective	Effective	Effective
<i>Transaction costs</i>	Ineffective	Ineffective	Ambiguous	Ambiguous	Ambiguous	Effective	Effective
<i>Clinical engagement</i>	Ambiguous	Effective	Effective	Ambiguous	Ineffective	Ineffective	Ineffective
<i>Needs & inequalities</i>	Ambiguous	Ambiguous	Ambiguous	Effective	Effective	Ambiguous	Ambiguous
<i>Clinical quality</i>	Ambiguous	Ambiguous	Effective	Effective	Ambiguous	Ambiguous	Ambiguous

KEY: = effective = ineffective = ambiguous or context-specific

Approach 1: care pathway commissioning

These are disease- or client group-specific case management initiatives involving vertical or horizontal integration or co-ordination of providers. Although care pathways are often described as a form of primary care-led/based commissioning, they are probably better seen as the output of local commissioning decisions; i.e. as an approach to service redesign compatible with a range of different organisational approaches to commissioning, including locality-based, vertically integrated and

horizontally integrated forms. Where there is an emphasis on horizontal integration, this approach is very similar to joint or integrated commissioning, though normally narrower in scope. Where the emphasis is on vertical integration between hospital and ambulatory/primary care, the approach has some similarities to US ‘carve outs’ of services for particular conditions in which the budget and services for a specific disease are separately managed by a specialised agency on behalf of the payer.

A managed clinical network for cardiac services in Dumfries and Galloway

Dumfries and Galloway is a predominantly rural area in South West Scotland. It covers a population of 145,800, with thirty-six general practices organised in four local health care co-operatives, with one district general hospital. The MCN began as a pilot phase in May 2000 and was formally launched in July 2001. Its broad aims were to provide patients with better access to services, more effective services, improved co-ordination between services, consistent advice and better care and prevention.

The MCN received £50,000 from the Scottish Executive over two years and employed a part-time GP as its clinical lead, together with a network co-ordinator and part-time administrative support. It was set up independently of existing institutional and professional structures. Great efforts were made to bring together representatives from all sectors involved in cardiac care, including patients and carers from local self-help groups. Five overlapping working groups used the concept of the 'typical patient journey' to map existing services and to develop quality assurance systems. They developed protocols for chest pain and acute

myocardial infarction, applied successfully for funds for specialist heart failure nurses and developed a protocol for care of people with heart failure. After an initial period of scepticism, the MCN was successful in bringing together clinicians, patients and managers to redesign services. Patient involvement was perceived by clinicians and by the representatives themselves as successful and the initiative was eventually well received by the public and by clinicians. Of sixteen clinical care indicators, three improved significantly and nine showed non-significant improvement, and there was no difference in resource use.

Vertically, the approach is typically used to facilitate chronic disease management for common chronic conditions across the primary-secondary divide to improve quality of care and reduce dependence on more costly and inappropriate hospital care by agreeing protocols of care between primary and secondary clinicians. Examples include the *Evercare* pilots in England, which are based on a public-private partnership between PCTs and United Health Care, a US managed care provider, but there are a number of other similar schemes developed by PCTs within the NHS.

Care pathways have been used as a commissioning approach by some county councils in Sweden through an initiative called 'Chains of Care'. The purpose of the approach is to develop costed care pathways that incentivise providers to work collectively to promote integrated care. Chain of Care contracts, it is argued, may help overcome the competitive and isolate tendencies associated with creating competition between providers to improve choice. Lessons from Sweden suggest the 'Chains of Care' pilots have yet to make any significant changes to clinical services due to weak overall incentives and a resistance from the medical profession (Ahgren, 2003).

Approach 2: professionally-driven networks

This approach emphasises vertical and horizontal co-ordination of provision for a range of patient groups. It is driven by the interests and concerns of clinicians to improve the quality of care as well as to use resources effectively and efficiently. These approaches have developed in Scotland as part of that country's rejection of the purchaser-provider split. Scottish managed clinical networks are based on groups of providers, with active

public and patient involvement. An example is set out in the box below:

These networks depend on being able to establish a clear consensus between all providers in an area as to how services and quality standards should develop. One way to do this is for all providers to agree to establish a collective, clinically governed body with decision rights over service development and reconfiguration. If some providers believed that they were in competition with others to retain their place in the system, it would be difficult to set up such a collective organisation.

Approach 3: total commissioner-provider integration

Like the managed clinical network, this approach to commissioning effectively abolishes the distinction between purchaser and provider functions in the health care system, but on a far larger scale across all services. The approach consists of an entity taking responsibility for a budget to provide a comprehensive range of health (and, under some models, related social care) services to promote the health and respond to the health care needs of a defined population. Generally, such approaches are designed to try to encourage efficiency in the use of a fixed budget, remove the incentives to shift costs to other parts of the system, and encourage active management of individual patients to ensure that good quality care can be provided without overspending. Scottish NHS boards can be seen as integrated health systems with smaller populations. If an English PCT, Welsh LHB or Scottish CHP were to take direct responsibility for all NHS providers in its area (e.g. owning and managing the hospitals and perhaps buying or contracting all the general practices), this would result in a totally integrated commissioning-providing organisation.

A number of health maintenance organisations (HMOs) in the US are organised as comprehensive, fully integrated organisations in which the insurer, commissioner and provider functions on behalf of an enrolled population are all undertaken within the same entity. Kaiser Permanente is the best known. There is no separation of primary and secondary care in that specialists, for instance, are not affiliated with specific hospitals. Instead, they work to a defined patient population. Kaiser, and others like it, have been intensively studied by the NHS recently because of their pro-active approach to disease management and disease prevention.

Potential future approaches to commissioning and service integration

In interviews and discussions with stakeholders and within the research team, together with a review of overseas experience, a number of potential future approaches to commissioning and/or service development at sub-national or local level in the UK NHS have emerged. Briefly, they represent either new owners for commissioning organisations or more ambitious forms of service integration, as follows:

- 1 Professionally owned and run primary care based commissioning organisations providing primary care services:** the New Zealand independent practitioner associations (IPAs) might be the inspiration for this sort of approach. IPAs are mainly GP owned and controlled organisations hold public budgets for a range of elective and directly referred services, including pharmaceuticals and have also developed admission avoidance schemes based on rapid response and alternatives to hospital admission.
- 2 Community owned and run commissioning organisations with or without direct provider responsibilities:** the third sector primary care organisations in New Zealand might be the model for this approach. These are bulk-funded organisations providing primary care mainly to low income and minority ethnic populations. Most are constituted as community trusts or other non-profit forms. They are governed by boards which are representative of the local community or the ethnic associations responsible for setting them up. They could have a place in commissioning services in the UK in places where there are large concentrations of people from ethnic minorities, for example.
- 3 Commercially owned and run commissioning organisations with or without provider responsibilities for primary care:** it is widely predicted that the new GMS contract will encourage private sector entrepreneurs to enter the GMS market on behalf of the NHS in areas where the NHS cannot sustain conventional general practices through its customary funding routes. These new entrants might be on a

sufficient scale to become involved in commissioning services for the same populations.

- 4 Vertically integrated NHS primary-secondary commissioning and providing organisations:** these would be organisations such as large multi-specialty group practices, in which primary and secondary clinicians come together to provide services for a geographic or enrolled population. They would integrate service provision, but might see advantages in not owning or running hospitals. Instead, they could negotiate contracts to use hospitals, as needed.
- 5 Vertically integrated, professionally owned and run commissioning and providing organisations providing primary and secondary care:** these would be like comprehensive versions of the managed clinical networks in Scotland, owned and run by clinicians themselves outside the NHS. Some US HMOs are based on physician groups that own or part-own the organisation.
- 6 Vertically integrated, commercially owned and run commissioning and providing organisations providing primary and secondary care:** these would be similar to commercially owned US HMOs.

While none of these approaches currently exists in the UK, some of the developments described in this chapter are not very dissimilar. For example, no.4 in the list immediately above (the vertically integrated multi-specialty group practice owned and run by its clinicians) is a possible evolution from the professionally driven clinical networks already in place. All of the six approaches have radical implications, particularly for accountability and regulation to ensure that such organisations would operate consistently to fulfil the goals of the NHS. Collectively, they represent the sorts of organisations that might be invited to take over all or part of the commissioning and/or provision role in the NHS under a franchising regime in which the NHS contracts with the agent best placed to ensure the provision of high quality, efficient and equitable services to NHS patients within budget. They are perhaps most likely to enter the NHS as a response to major, irremediable performance failures stemming from management, governance or both levels in PCTs, LHBs and the like. The UK should follow events in New Zealand in the next few years very closely as PCOs outside the state sector are taking responsibility for public capitation budgets to provide access to primary health care and related services for an enrolled population. This should provide valuable learning as to the pros and cons of involving non-NHS organisations in commissioning of important services for populations.

Summary

It is clear from the description and analysis of the different approaches to commissioning organisations that many of the options are complementary since none can

satisfactorily meet all the desirable attributes of a commissioning approach. They also depend on the existence of a body such as a LHB, PCT or health board to receive the total NHS budget, since they are likely to be appropriate to a specific sub-set of the complete range of services likely to be commissioned in the NHS. There are three key strategic decisions to be taken by these overarching bodies, PCTs, LHBs or health boards:

- How should the choice of commissioning approaches be made, and on what basis?
- To what extent should organisational forms that integrate commissioning and provision be developed as part of the overall commissioning/planning process?
- What is the appropriate blend of commissioning approaches for the local health economy?

6 Implications for policy, development and research

KEY POINTS

There is little evidence to show that any primary care-led (or other) commissioning approach has made a significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers.

Primary care-led commissioning has been shown to be effective in the area of primary and intermediate care and in encouraging greater responsiveness in elective hospital services. There is significant potential to build on this experience of service development and innovation, this time within a stronger framework of public accountability and national health priorities.

Primary care-led commissioning may be effective as part of a continuum of commissioning models, and particularly appropriate for 'simple' and community-based chronic disease management and primary care services. Other models of commissioning are required for more specialised and complex services, including the development of more integrated forms of service provision based on managed care techniques and approaches together with care pathways. The challenge for funding organisations is rigorously to select an appropriate blend of approaches and to be clear about how and for what reasons that selection has been made.

There is a need for more systematic assessment of the impact of models of health commissioning, including the an examination of their ability to achieve specific service and patient quality objectives which can be monitored in a rigorous manner.

To achieve this, commissioning organisations need a degree of organisational stability. Providers have had relative stability for some 15 years whereas commissioners have been subject to numerous major imposed reorganisations.

Commissioners need new and more advanced forms of support, in particular in developing a range of new skills and competences such as the stratification of

patient risk, commissioner-led advanced case management, predictive modeling of high user patients, handling and analysis of routine data, and more refined assessment of service quality and outcomes.

Policy makers need to ensure that commissioning organisations have sufficient headroom and freedom to develop and implement local as well as national commissioning priorities. This is vital if local clinicians are to feel engaged with commissioning and service development activities.

Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all points along the commissioning continuum, and in particular within those approaches closest to the patient.

The legitimacy and accountability of commissioning organisations needs to be made clear within whatever blend of models is applied within a health economy, and needs to be balanced with the necessary engagement of clinicians.

In this report, we have explored health services commissioning and its alternatives in each of the four countries of the UK, examined the published evidence and findings from informant interviews regarding the effectiveness of primary care-led commissioning, identified the range of commissioning approaches and alternatives currently in place, and evaluated these against criteria deduced from our review of the evidence. In this final section, we set out the implications of our study for health policy, development and research. A set of messages for policy makers and managers is distilled and specific challenges to the health systems in each of the four countries of the UK are made. The report concludes with a suggested agenda for development and evaluation in the UK.

Messages from this research

1. There is little evidence to show that any primary care-led (or other) commissioning approach has made

a significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers.

There is little research evidence to show that any commissioning approach has made a significant impact across an important range of performance measures, with the exception of the progress made by primary care commissioners in bringing about important changes to primary and intermediate care, and (in the case of fundholding) the impact made on waiting times and prescribing (see Chapter 3 on impact). This raises three questions. Firstly, can commissioning, in whatever form, achieve significant change or are the incentives always going to be too weak and the constraints too strong in the NHS for this to work (Le Grand et al, 1998)? Secondly, are the transaction costs involved in a system based on commissioning and provision worth the gains made in terms of service development? And thirdly, can the enduring problem of provider (hospital) capture of planning and resource allocation within health be addressed via a process of commissioning?

Our assessment of the research evidence and analysis of the views of a set of stakeholders points to a response to the first two questions that reads: 'Yes, primary care led commissioning can work and is likely to be more effective than PCO commissioning for elective secondary care commissioning and for primary/intermediate care/chronic disease management service areas'. To the third question, the response from this review would be: 'No, not unless the system has, as part of its spectrum of commissioning, strong purchasers at a lead PCO, SHA or similar level (model 6) who have the political support to make difficult decisions about secondary care services, along with the possibility of moving or closing services'.

There are of course other levers for change in the NHS, such as redesign, collaboratives, effective regulation, the use of national targets, and legislative pressures to reduce the working time of doctors, and these have to be worked into the overall commissioning process at national and local level – the trick being to use these as part of the overall shaping of local services in line with strategic objectives. One characteristic of the rise in programmatic service improvement activity is that it has been largely separate from the commissioning agenda. In future, following the current changes in the English Modernisation Agency, and the further maturing of PCTs, SHAs and their PCTs will have greater influence over the use of funds made available for service improvement. This will provide an opportunity for PCT commissioners to take a greater role in integrating service improvement activity with commissioning objectives.

PCT commissioning has the potential to hold the ring: facilitating external dialogue with secondary care providers and SHAs to manage the 'local' response to the range of national imperatives; and, internally, providing a locality-based infrastructure in which information, clinical peer support, and practice-based incentives can be effectively co-ordinated in order to build on the efforts of enthusiasts. In the words of Ham et al (2003a, p435) 'the balance between a top-down and bottom-up approach [to quality improvement] is precarious'. PCT commissioners have an opportunity to manage this balance within the constraints of local contexts.

2. Primary care-led commissioning has been shown to be effective in the area of primary and intermediate care and in encouraging greater responsiveness in elective hospital services. There is significant potential to build on this experience of service development and innovation, this time within a stronger framework of public accountability and national health priorities.

A major lesson from this review is the strength of the evidence concerning the achievements made by primary care commissioners in bringing about changes to primary and intermediate care. There are numerous examples in the research evidence of service developments such as: new community-based care for chronic disease (e.g. diabetes in Harrow East and Kingsbury PCG, community mental health team in Central Southampton PCG); the use of community hospitals, intensive home support and nursing homes as alternatives to acute hospital care (Bromsgrove TPP, Carlisle Community Support Team, fast stream reablement in Mid-Devon PCG); the development of case management of individual patients with complex needs (Evercare pilots, Arizona health plans); and the development of new specialised primary care services (second tier GP referral services in the Birmingham Multifund, referral guidelines project in North East Lincolnshire PCT).

There are three key challenges for PCTs and their equivalents elsewhere in the UK as regards the use of primary care-led commissioning to bring about change in primary and intermediate care. Firstly, there is a need to find ways of continuing and extending such developments where they already exist, stretching those who have already innovated, enabling them to be ever more creative in how they review, redesign and commission local services. Secondly, there is an important challenge to commissioners in relation to how to spread such innovations beyond the practices and localities that have been in the vanguard of making primary care commissioning innovations. The third challenge relates to the previous one, namely the need for PCTs to work out ways of managing primary care-led commissioning within an overall strategic and accountability framework. The tension of local engagement and

innovation, and the need for a PCT (or equivalent) to assure equity and adherence to national priorities and objectives, will be much more heightened within the move towards a greater degree of practice-based commissioning in England.

3. Primary care-led commissioning may be effective as part of a continuum of commissioning models, and particularly appropriate for 'simple' and community-based chronic disease management and primary care services. Other models of commissioning are required for more specialised and complex services, including the use of integrated forms of service provision such as managed care and care pathways. The challenge is rigorously to select an appropriate blend of approaches and to be clear about how and for what reasons that selection has been made.

Commissioning and service change/development is a complex business, evidenced by difficulties in defining its remit and assessing its effectiveness. The process of ensuring that health planning, resource allocation and service development occurs in an appropriate manner calls for a sophisticated management solution that recognises this complexity. Consequently, there are many approaches currently in operation within the NHS in the UK. This review demonstrates that no one model is appropriate for all contexts, services and client groups – each model has inevitable strengths and limitations.

This does not, however, mean that the solution is one of 'horses for courses' where anything goes, or that policy makers and senior managers can leave PCTs/LHBs/health boards to their own devices. Nor is it a recipe for further structural reorganisation at a formal level in any of the four countries. On the contrary, what is called for are tools and techniques that enable managers and clinicians rigorously to select a blend of approaches appropriate to the local population and its needs. The making of such a selection is not in itself sufficient. It will be important for PCTs/LHBs/health boards to make explicit the basis for their decisions about how they plan to carry out commissioning, setting out the rationale for their choice of approaches, and what they are expecting to be achieved within each commissioning model. This will be of particular relevance in England in early 2005, as PCTs decide what services and resources to devolve to practice-based commissioners. PCTs will be required to defend these decisions, both to the clinicians seeking devolved responsibility, and more importantly to PCT boards and local communities seeking assurance that any new arrangements are robust and in the best interests of patients.

There is also a set of new and emergent models of commissioning and service integration, largely drawn from international experience, that could also be considered by

NHS commissioners when designing an appropriate mix of approaches to service design, planning, and development (see the end of Chapter 5). Further analytical work and investigation into how these approaches work elsewhere is needed before they could be advanced in the UK, along with political commitment to managing the consequences of moving towards options such as franchising of commissioners and/or patient choice of commissioner. The latter presents many risks in a system predicated on trying to secure equity of access to services.

Much will depend on context – specific concerns associated with different models of commissioning will be relevant to certain ideological, political, cultural, professional, service and geographical contexts. For example, in an area with well-developed primary care provision and intermediate care, local practice-based commissioning combined with care pathway commissioning, and lead commissioning for more complex services, may be an appropriate set of approaches. On the other hand, where primary care is less well developed and choice of providers is low, it may make sense to look towards an NHS or third/private sector integrated commissioner-provider body to assume responsibility for primary care and at least the general elements of secondary care. The touchstone has to be selecting the kinds of organisations and people leading them who are most likely to be equipped and motivated to drive service improvement.

Although the decision as to the appropriate combination of approaches to commissioning, including more integrated forms of service development such as care pathways should be taken within each health economy in light of local circumstances, there will always be wider issues to take into account. One such with potential implications for the evolution of health services commissioning in the UK is EU competition law. The extent and manner to which EU law impinges on domestic health care systems is unclear and complex (McKee et al, 2002). While the manner in which each EU country organises its health care system is not within the competence of the EU, aspects of the health care system could be construed as falling within the jurisdiction of EU law. Thus health services can, under certain circumstances, be treated like any other service in relation to the single market and thence be subject to EU law. The more a service is procured and provided in a commercial manner, the more it could be subject to competition rules. Thus the more commissioners seek to use private and non-government providers, the greater the likelihood that they will have to ensure fair competition for contracts between all possible providers. For instance, it may not be straightforward to restrict competition to a particular type or group of potential providers. The implication for commissioners is that they may have to

be increasingly careful in future to make sure that invitations to tender for clinical services as well as other services are posted in the EU Gazette. Publicly provided services would most likely fall outside the scope of EU competition law. Thus if a single NHS organisation both commissions and provides services with only a service agreement between its provision and 'purchase' arms (e.g. community health services within a PCT), or if a commissioner were to develop a clinical network within the NHS, the services would most likely be regarded as 'social' in character and exempt.

A second area where EU law may impinge on health services commissioners is in relation to *Patient Choice*. It is now clearly established that all EU citizens have a right to receive 'ambulatory' or 'extramural' care in any country of the EU. Their country of citizenship then has to pay for this treatment. This does not apply to inpatient care. The implication for NHS commissioners is that they have to keep an eye on this risk, but it will presumably not increase as NHS capacity rises over the next few years, though they would be well advised to keep their GPs aware of the fact that overseas treatment will eventually have to be paid for by the PCT or equivalent in other parts of the UK. Presumably, overseas treatment will mainly relate to people on holiday who need immediate care.

For each health system, the overarching challenge is then to have a set of indicators that enable the monitoring of the overall effectiveness and outcomes of the commissioning process, and to be able to question local commissioning organisations about their approaches to commissioning and the relative effectiveness thereof. This calls for the health departments in each part of the UK to allow appropriate diversity to develop, and provide a better framework for evaluation and learning than has been demonstrably the case in the past.

4. There is a need to develop much more systematic assessment of the impact of models of health commissioning, including the setting of specific service and patient quality objectives which can be monitored in a rigorous manner.

This study has revealed an important gap in the research evidence in relation to the assessment of the impact of primary care led (and other) commissioning models. The rapidity of policy and organisational change in the NHS over the past fifteen years has mitigated against prospective studies focused on assessing health and service outcomes associated with specific models of commissioning, in contrast to the more common short-term process-orientated evaluations. Even where longer-term retrospective studies have been undertaken, for example in relation to waiting times or prescribing, there has been little attempt to compare the performance of different approaches to commissioning. What

the recent studies of GP fundholding and waiting times, and of GP commissioning and prescribing do show however is that sustained research effort can bring forth important insights into the impact of commissioning on health services.

There is a natural experiment under way in the UK, one that is going largely unevaluated, namely the trying out of markedly different approaches to commissioning and service development in each of the four countries of the UK, including wholesale rejection of the commissioner-provider split in Scotland. A key question arising from this research is how one can tell when any single commissioning or service development approach or combination of approaches (in whichever health system) is effective. To do this, there is a need for a set of indicators that enable progress to be measured in respect of aspects such as addressing inequalities in health, improving access to health care, and increasing patient satisfaction with services. Gains from commissioning, in whatever approach, take time to realise. What is needed is for policy makers to provide a degree of stability in terms of organisational context, and targeted support and development to the clinicians and managers charged with making commissioning decisions.

5. To achieve this, commissioning organisations need to be given a degree of organisational stability and a chance to prove themselves. Providers have had relative stability for some 15 years whereas commissioners have been subject to numerous major imposed reorganisations.

As noted in the previous section, one of the main reasons for the limited availability of research evidence about the effectiveness of commissioning is the regularity with which NHS commissioning bodies have been subject to structural reorganisation. There is however extensive support to support the need for NHS (and other) organisations to have structural stability if they are to be able to deliver on longer term strategic objectives and avoid the inevitable distraction, loss of momentum and morale, and costs associated with reorganisation (Smith et al, 2001, Fulop et al, 2002). Although many NHS trusts have been through mergers and internal reorganisations in recent years, nationally imposed reorganisations (particularly in England) have tended to focus on commissioning bodies. Given the time that is required to achieve change and demonstrate impact within commissioning, commissioners have therefore been in something of a vicious circle – damned for not achieving adequate change in secondary care services, yet destabilised by reorganisations that undermine local relationships, result in the loss of valuable expertise and skills, and detract from the hard business of exerting service improvements and change from providers.

6. Commissioners need new and more advanced forms of support, in particular in developing a range of new skills and competences such as stratification of risk for patients, commissioner-led advanced case management, predictive modelling of high user patients, handling and analysis of routine data, and more refined assessment of service quality and outcomes.

This review has clearly demonstrated the link between adequate levels of management and analytical expertise and the achievement of commissioning objectives (see chapter 4). In chapter 5, the emergence of a range of new approaches to service integration were highlighted as potential tools for commissioners to use when selecting the appropriate local blend of commissioning models. What is clear both from the analysis of the NHS commissioning continuum and a consideration of the emerging approaches to service integration is that commissioners are going to require many new skills and competences. Managed care techniques from the USA are gaining currency in the UK, in particular for the commissioning and delivery of chronic disease care. Evidence from the USA experience of such approaches suggests that information/analytical skills such as the stratification of patient risk, predictive modelling of likely high users of services and the impact on local service provision, detailed analysis of patient use of existing services, and assessment of patient outcomes will all become increasingly important. In addition, we know from experience such as the Arizona Health Care Cost Containment System that a robust system of patient-focused commissioning calls for highly developed case management led by the commissioners, not providers, and operating at a very detailed level (see chapter 4).

7. Policy makers need to ensure that commissioning organisations have sufficient headroom and freedom to develop and implement local as well as national commissioning priorities. This is vital if local clinicians are to feel engaged with commissioning and service development activities.

This study has revealed that none of the four countries of the UK, with the possible exception of Wales, currently have much headroom for genuinely local commissioning to take place, particularly in respect of determining objectives and priorities that differ from those set at national level. Central ‘must do’s’ dominate much of the commissioning and planning agenda for health boards, PCTs, and LHBs – the ‘what’ and the ‘how’. Innovative commissioning and service development activity typically takes place at the margins, as indeed it did earlier when GP fundholding, total purchasing and GP commissioning were operating. The challenge for the UK NHS is to make real the talk of

devolution and responsiveness to local communities, and to give commissioning organisations the permission and space to set at least part of the agenda themselves. To do this, local agencies must be seen as both legitimate and appropriately accountable for their actions. This again points to the need for robust methods of assessing the overall effectiveness and outcomes of services and hence of making decisions about the relative merits of different approaches and proposed local solutions.

8. Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all stages of the commissioning continuum, and in particular within those approaches closest to the patient.

Evidence from this review underlines the importance of effective engagement of ‘frontline’ clinicians, rather than having clinicians as ‘advisers’, within any commissioning or service development approach. In the interviews carried out for this study, this factor more than any other was thought to be associated with effective commissioning and service development. Without such engagement and the accompanying ability to align clinical decision making with desired service change and development, any commissioning approach or combination of approaches is doomed to failure. Effectively harnessing the experience and enthusiasm of clinical colleagues, without losing the sense of challenge and constructive criticism brought about by the purchaser-provider separation when it works well, is perhaps the most difficult and yet important task facing health care managers and commissioners. To do this, there is a need to be aware of what motivates individuals and organisations within particular contexts and services, and to align rewards and sanctions in such a way that specific service objectives can be achieved. It should be noted that whilst there are advantages to engaging primary and secondary care clinicians in commissioning and service development, there is a risk of the relationship becoming too ‘cosy’ and lacking necessary contestability. Hence, the argument for a mix of approaches based on both close collaboration between commissioners and providers, and more market-like relations.

9. The legitimacy and accountability of commissioning organisations needs to be made clear within whatever blend of models is applied within a health economy, and needs to be balanced with the necessary engagement of clinicians.

There is a fundamental question to be posed of all models, particularly those based on a separate commissioning organisation; on what basis can they be considered ‘legitimate’ in respect of taking decisions about needs, service design and purchasing/use of resources on behalf of populations, particularly if these are at variance with

national guidance or imperatives? Primary care-led commissioning is predicated on the view that primary care professionals, and GPs in particular, are better placed than bureaucracies like strategic health authorities or patients themselves to make decisions about health planning and service development. This view could be challenged, particularly in relation to the evidence of weak involvement of, and participation by, patients and the public in these areas in the primary care-led commissioning models examined in this report.

Furthermore, all current commissioning and planning organisations in the UK include some provider interests within their governance structures, and hence face potential conflicts of interest (e.g. PCTs provide community services and have GPs and other practitioners on their executive committees, LHBs have GPs and other primary care professionals as board members, CHPs have clinical members). At a time when accountability to local communities is being emphasised in national policy in each of the four countries, this research points to the need for the development of greater clarity about how accountability is built into commissioning processes and decision-making on service development. For example, since English foundation trusts now have local people as trust members and governors, is there not a need for commissioning bodies to have at least as much, if not more, local input and direction?

Policy futures for commissioning in the NHS

What then does this analysis of the research evidence about effective commissioning and service development have to offer the health systems of the four UK countries? This study has, as far as we are aware, been unique in its focus on the four countries of the UK and its attempt to assess the effectiveness of primary care led (and other) approaches to commissioning as well as alternatives to the commissioner-provider split across all four UK nations. It is therefore appropriate that in setting out challenges to the NHS based on this research, we do this for each of the four countries in the form of a series of specific questions. All four systems appear to be trying to steer the best, balanced course, given the context, between competitive markets that can often fail in health care and integrated, monopoly provision that can be resistant to change and unresponsive to patients' needs by exploring collaborative and networked forms of decision making and provision. Each country needs to look critically at the balance and coherence of the blend of market, network and hierarchy approaches it has developed since the mid-1990s.

Challenges for the English NHS

The English NHS is striking in its continuing commitment to the purchaser-provider split and hence to a commissioning function based largely on contracts or service agreements, though with the development of a range of network and

collaborative ventures and a new commitment to devolving power and responsibility to clinicians (Department of Health, 2004a). It has also been characterised by a strong centrally-driven performance culture where national targets backed up by external regulation are used as a key driver for securing specific national health service objectives. However, recent policy interest in developing and extending practice-based commissioning in the NHS signals an intention to move towards a much more locally and clinically led system of commissioning. Our challenges to the English NHS are in areas such as the need to make real the plans about practice-based commissioning and enable space for local commissioning priorities to be developed and implemented, what methods and incentives will be used to draw clinicians back into commissioning decisions and processes, the public health and inequalities agenda, the integration of the modernisation agenda with commissioning, and the proper and full involvement of local people. Challenges to the English NHS can be articulated as follows:

- **Can PCTs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?**
- **Can space be created for the implementation of local commissioning models and priorities when PCTs are faced with an extensive set of national targets and performance indicators? Is the NHS prepared to tolerate the local variation that will result from this 'letting go'?**
- **How will clinicians be re-engaged and incentivised in the commissioning process, given the evidence that this has been largely lost over the past few years? What if local practitioners do not want to take up practice-based commissioning? How will this process of development be resourced?**
- **Is there real interest in commissioning to reduce health inequalities and to achieve public health outcomes? If so, is the current set of approaches to commissioning adequate to this part of the commissioning task?**
- **How will the experience and learning from service redesign and modernisation activity be integrated fully into the commissioning process?**
- **How can local people be properly involved either as citizens or consumers in commissioning and have a true voice in determining health priorities?**

Challenges for the Northern Ireland NHS

The Northern Ireland NHS has proved to be the most problematic for this research study in terms of making judgements about the effectiveness of commissioning, given the ongoing uncertainty about the political process in that country and the consequent difficulty for its health administration in developing alternative planning and

commissioning approaches that engage those clinicians previously active in fundholding and its alternatives in the 1990s. Along with a relative lack of policy development in this area, there is little published research about current and recent approaches to commissioning, so conclusions are therefore hard to draw. Nevertheless, it seems relevant to pose some general questions to policy makers in Northern Ireland, based on our overall analysis of commissioning in the UK:

- **Are local health and social care groups (LHSCGs) feasible as a method of commissioning, given the current political context in Northern Ireland?**
- **Can LHSCGs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?**
- **To what degree is it possible (or desirable) to have a system based on a purchaser-provider split in a health system which is tightly integrated and geographically coherent?**
- **Can space be created for the development of local commissioning models and priorities when LHSCGs and boards are faced with an extensive set of national targets and performance indicators?**
- **How will GPs be re-engaged with the commissioning and service planning process?**

Challenges for NHS Scotland

NHS Scotland has been the most definite of the four UK nations in its decision to move away from the NHS internal market and a system of purchaser/provider distinction and in developing an alternative approach based clearly on partnership and integration. As such, what is typically understood by 'commissioning' has been replaced by a system of planning and partnership driven by a set of centrally determined targets and based on a set of professional incentives and external inspections. Even relational contracting appears to have disappeared. Structural change across primary, community and secondary care has underpinned this approach, as has the development of single integrated (planning and provision) health bodies for each administrative area of Scotland. Our research reveals a number of questions for those developing health policy in Scotland:

- **Is the right set of incentives in place to achieve the changes required through community health partnerships (CHPs)?**
- **How will primary care based and secondary care clinicians be engaged in planning processes for CHPs? What are the incentives for them to engage?**
- **Is there a 'right size' for CHPs? Is there potential to consider lessons from the development of other primary care organisations on the right size for planning and delivering different services?**

- **Is there no scope for contestability of provision of any services in Scotland? Where does patient choice enter the system?**
- **Why not enable a greater range of incentives and levers within the health system through delegating budgetary control to a range of subsidiary organisations rather than simply to acute and primary care operating divisions?**
- **For example, why not allow NHS boards to experiment with different approaches to commissioning based on CHPs such as practice-based, care pathway and commissioner-provider commissioning at CHP level (devolving the entire capitated budget to CHPs in some areas), or to managed care networks?**

Challenges for NHS Wales

Since devolution, Wales has retained the purchaser-provider split, and the commissioning function is largely focused on local health boards (LHBs). In parallel, health care providers have been drawn together into a smaller number of larger integrated community and secondary care organisations, arguably reducing the potential for contestability in many areas of the country. Welsh health objectives at a national level are very strongly associated with public health and the reduction of health inequalities, and with seeking to engage local communities in developing partnership arrangements and other solutions appropriate to meeting this broad health and regeneration agenda. It should however be noted that external assessments of the Welsh health system have been critical of key elements of service delivery in areas such as waiting times for treatment. This said, our questions to policy makers in Wales are as follows:

- **In the context of an overall policy of community engagement and partnership working with local government as the key levers for addressing health inequalities, how will the health service delivery agenda be tackled?**
- **What will be the response to public concern about waiting times for treatment? Is there scope for increasing contestability of provision of acute elective services in Wales? Where does patient choice enter the system?**
- **Is there scope for a broader range of commissioning models, including the use of practice-based commissioning to engage clinicians and the development of national targets for key service delivery areas?**
- **Which commissioning models will be used to reconfigure health services when there is no evidence to date that a public health commissioning approach is likely to achieve this?**

The development and research agenda for commissioning

This review of the evidence concerning primary care-led commissioning and alternatives has been used to distil a set of research-based messages for health policy makers related to commissioning and service development, and to identify specific challenges to the national health systems of the four UK countries. Running through this analysis is an assumption that there are key organisational development issues facing the NHS in the UK, and also that there are important gaps in the research evidence. We set out what we believe to be the key elements for a development and research strategy in the UK.

We already know a lot about what makes primary care-led commissioning effective in terms of process and organisation

It is clear from this review that a great deal is known about what facilitates or inhibits effective primary care-led commissioning organisations. Indeed, this knowledge is likely to apply equally to other forms of commissioning – it just happens that what is termed ‘primary care-led commissioning’ has been extensively evaluated, whilst many other approaches to commissioning have not, to date, received the same degree of analytical attention. Within health policy and management, it can be tempting for managers and policy makers alike to claim that there is no evidence base for new initiatives, including models of commissioning. However, what this study has shown is that much is known about the contextual, processual and organisational factors that facilitate or inhibit effective commissioning. Our assertion is that these lessons apply to all models of commissioning. Where the evidence is less strong is in relation to the impact of commissioning, largely due to frequent organisational change in the NHS that makes longer term evaluation of outcomes difficult.

Support for commissioners

Those managers and clinicians charged with carrying out commissioning, planning and service redesign face some of the most difficult challenges within health care management. Given that the research evidence points to the relative lack of success for all commissioning agencies in terms of bringing about significant strategic change in secondary care provision, those now tasked with this objective face what may seem like an insurmountable challenge. This calls for programmes of targeted development and support of commissioners themselves, including: the managed care techniques referred to in message 6 above; skills such as assessing and selecting models of commissioning and service development that are fit for specific purposes; detailed analysis of routine data; skills in developing robust partnership working within clinical networks as well as managing more contestable and competitive arrangements for securing services;

approaches to enhancing greater clinical engagement; and methods of working with local communities in developing and enacting commissioning priorities.

Demonstration sites of new and emergent models of commissioning and service development

The review of primary care-led commissioning undertaken on behalf of The Health Foundation documented how a number of approaches to securing health services had evolved in the UK. Examination of these different commissioning models showed that there was no evidence to suggest any significant or measurable impact or change, particularly to secondary care provision. More importantly, the lack of a sound evidence base did not provide any grounds upon which to make a judgement call as to what might be described as ‘best practice’ in commissioning. Indeed, most ‘exemplars’ cited in the literature were not approaches that had been evaluated in terms of their impact or effectiveness, but were most often case studies publicizing new commissioning innovations or ideas.

The lack of awareness and understanding of the relative merits and effectiveness of different commissioning models remains a significant gap in our knowledge. For health funders and planners seeking to find appropriate commissioning models that can demonstrate effective practice and outcomes, this lack of knowledge and understanding of what makes for effective commissioning presents significant challenges. Developmental projects are needed which investigate, support, and compare the various emergent models of commissioning in order to provide an understanding of how commissioning occurs, to establish sites of best practice, and to support innovators in developing and disseminating their approaches.

Developing longer term comparative study across the UK nations

Perhaps the most striking aspect of this study, for the research team, has been the richness and diversity of the comparisons across the four UK nations and the degree to which these comparisons have enabled new understanding, different challenges to each country’s health system, and a clear sense that there are very different ways of doing things in systems that were much more similar just a few years previously. Equally striking has been the minimal nature of analysis of commissioning and health management across the four countries and the apparent lack of clear rationale for choosing the very different approaches in each country.

That such an impression has been gained by the research team underlines the lack of current comparative study of health policy across the UK and the need for long-term study of the effectiveness of commissioning and service development across the four countries of the UK, based on

a set of core indicators. This is not suggesting that the countries should move towards some common approach to planning or commissioning. It is instead a plea for evaluation of the natural policy experiment that is taking place, and a chance for each health system to compare itself with its neighbours and learn from the best of what is taking place in each country, as appropriate to local policy and management objectives. This would enable each health system to find out whether it has a justifiable blend of commissioning approaches and if it is sufficiently critical of those in which it has placed its faith.

Examining the impact of commissioning

A core finding of this study is the lack of evidence about the impact of primary care led, and other, commissioning. While much is already known about process factors and organisational features associated with effective commissioning, few studies have explored outcomes, in part due to the relatively short lifespan of NHS commissioning organisations to date and also because of the difficulty of attributing change to commissioning per se, as opposed to other changes in the management and policy environment. A consideration of these confounding factors must be built into any future policy development and evaluation.

Studies need to be developed of the impact of commissioning and planning approaches in relation to specific patient/client groups and services whose needs are a high priority in all four UK countries. A set of core performance indicators for NHS commissioning are a prerequisite to such studies, but would seem to be crucial if the transaction costs of models of commissioning are to be tested for their ability (or otherwise) to effect strategic change within the NHS. Without the development of such indicators backed up with robust and independent study as to their implementation in the UK countries, it is hard to see how health commissioning can actually prove its worth, both in terms of the management costs it consumes, and most crucially, the impact it has on the level and quality of patient care and the health of the population.

Conclusion

This study has used the evidence concerning the effectiveness of primary care-led commissioning as the basis for distilling key policy messages regarding the future development of commissioning and service development more widely. In so doing, the challenges facing each of the four countries of the UK have been set out, as have suggestions about the future research and development necessary to provide an adequate evidence base to underpin future decisions concerning which commissioning and planning models might be appropriate in different countries, health communities and localities. What is clear is that there is a wealth of experience of commissioning and

planning across the UK, some of which has been evaluated to quite a significant extent, but mainly in terms of process and organisation rather than impact and outcomes. As each health system contemplates its next stage of development, the greatest challenge in respect of commissioning and service improvement is how a choice of approaches is made in a robust and critical manner, and how that choice is then assessed using core indicators of performance that enable careful monitoring of health outcomes and user satisfaction. Comparisons within this study of commissioning and service development across the UK have revealed that each country is largely pursuing its own policy and management agenda with little reference to its neighbours' experience. If ever there were a natural experiment in health policy that offered important potential for comparative learning for policy makers, clinicians and managers alike, then this is it.

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Appendix A

Literature review search strategy

HMIC and HELMIS search

This search was based on descriptors. The results are shown in tables a and b.

Table A: HMIC and HELMIS search descriptors*

<i>Search based on</i>	<i>Number of references</i>
primary care	11,308
commissioning	1,244
purchasing	3,322
contracting	3,169
fundholding	1,770
budget	1,496

* The descriptor terms used in the search are noted below

Table B: HMIC and HELMIS search combinations and results

<i>Combinations of search results used</i>	<i>Number of references</i>
primary care and commissioning	252
primary care and purchasing	306
primary care and contracting	133
primary care and fundholding	227
primary care and budget	109
TOTAL	1,027

Descriptors for 'primary care'

PRIMARY-CARE
 PRIMARY-CARE-GROUPS
 PRIMARY-CARE-INVESTMENT-PLANS
 PRIMARY-CARE-ORGANISATIONS
 PRIMARY-CARE-PARTNERSHIPS
 PRIMARY-CARE-TEAMS
 PRIMARY-CARE-TRUSTS
 PRIMARY-HEALTH-CARE
 PRIMARY-HEALTH-CARE-SERVICES
 PRIMARY-HEALTH-CARE-TEAM
 PRIMARY-HEALTH-CARE-TEAMS

PRIMARY-HEALTH-SERVICES

Descriptors for 'commissioning'

COMMISSIONING
 COMMISSIONING-
 COMMISSIONING-AGENCIES
 COMMISSIONING-STUDIES

Descriptors for 'purchasing'

PURCHASING
 PURCHASING-
 PURCHASING-ARRANGEMENTS
 PURCHASING-AUTHORITIES
 PURCHASING-INTELLIGENCE
 PURCHASING-OFFICERS
 PURCHASING-PLANS
 PURCHASING-POLICIES
 PURCHASING-POLICY
 PURCHASING-ROLE

Descriptors for 'contracting'

CONTRACTING
 CONTRACTING-
 CONTRACTING-CONSORTIA
 CONTRACTING-OUT
 CONTRACTING-PROCESS
 CONTRACTS
 CONTRACTS-
 CONTRACTS-MANAGEMENT
 CONTRACTUAL
 CONTRACTUAL-ARRANGEMENT
 CONTRACTUAL-ARRANGEMENTS

Descriptors for 'fundholding'

FUNDHOLDERS
 FUNDHOLDERS-
 FUNDHOLDING
 FUNDHOLDING-PRACTICES
 FUNDING
 FUNDING-

Descriptors for 'budget'

BUDGET
 BUDGET-COST-STATEMENTS
 BUDGET-CUTS
 BUDGET-DEFICITS

BUDGET-INCREASES
 BUDGET-PERFORMANCE
 BUDGET-REPORTING-SYSTEMS
 BUDGET-SETTING
 BUDGET-SYSTEMS
 BUDGETARY
 BUDGETARY-CONTROL
 BUDGETARY-CONTROL-CHILDREN
 BUDGETARY-CONTROL-SYSTEMS
 BUDGETARY-SYSTEMS
 BUDGETING
 BUDGETING-
 BUDGETING-PILOT-SCHEMES
 BUDGETS
 BUDGETS-

Medline search

This search was based on the descriptor 'Primary Health Care' and keywords for the other terms. The results are shown in tables c and d.

Table C: Medline search descriptors* and keywords**

<i>Search based on</i>	<i>Number of references</i>
primary health care*	26,244
commissioning**	523
purchasing**	3,061
contracting**	7,069
fundholding**	293
budget**	5,772

Table D: Medline search combinations and results

<i>Combinations of search results used</i>	<i>Number of references</i>
primary health care and commissioning	69
primary health care and purchasing	37
primary health care and contracting	43
primary health care and fundholding	37
primary health care and budget	92
Total	278

Embase search

This search was based on the descriptor 'Primary Health Care' and keywords for the other terms. The results are shown in tables e and f.

Table E: Embase search descriptors* and keywords**

<i>Search based on</i>	<i>Number of references</i>
primary medical care*	15,731
commissioning**	574
purchasing*	1,127
contract*	1,443
Budget/financial management**	15,777

Table F: Embase search combinations and results

<i>Combinations of search results used</i>	<i>Number of references</i>
primary medical care and commissioning	62
primary medical care and purchasing	26
primary medical care and contracting	94
primary medical care and budget/FM	470
Total	652

Appendix B

'Key' references on primary care-led commissioning identified by the research team

- 1 Audit Commission (1996) *What the Doctor Ordered, a study of GP fundholders in England and Wales* London, HMSO
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Appendix C

Interviewees

Richard Armstrong
Head of PCTs and Commissioning Branch,
Department of Health

Ian Ayres
Chief Executive, Merton & Sutton PCT

Anne Baines
Director of Commissioning, South Birmingham PCT

Doug Black
Commissioning Lead, Nottingham City PCT

Sir Ian Carruthers
Chief Executive, Dorset and Somerset SHA

David Colin-Thome
GP and National Director of Primary Care, Department
of Health

Sheena Cumiskey
Chief Executive, Wrightington, Wigan & Leigh PCT

Phillip Davies
Head of Performance, Improvement And Planning,
SE Wales Regional Office, NHS Wales

Mike Dixon
GP and Chair, NHS Alliance

Mike Farrar
Chief Executive, Trent SHA

Debbie Freake
Director of Service Design, North of Tyne
Commissioning Consortium

Chris Ham
Director, Department of Health Strategy Unit

Martin Hill
Director of Modernisation, NHS Lanarkshire

David J Hunter
Professor of Health Policy & Mgt, University of Durham

Chris James
GP Southampton City PCT and Vice Chair, NHS Alliance

Sir Alan Langlands
Principal and Vice-Chancellor, University of Durham

John McGrath
LHSCG Manager, Mid-Ulster Health & Social Care Group

Andy McKeon
Managing Director (Health), Audit Commission

Peter Mitford
Former Director of Primary Care, Northumberland Care Trust

Rhidian Morris
GP and President , National Association Of Primary Care

Chaand Nagpaul
GP and PEC member, Harrow PCT

Alastair Noble
GP, Nairn, NHS Highland

Katie Norton
Chief Executive, Neath & Port Talbot Local Health Board

John Oldham
GP and Head of National Primary Care Development Team,
Department of Health

Judith Paget
Chief Executive, Caerphilly Local Health Board

Gordon Peterkin
Associate Medical Director, NHS Grampian

Mike Ponton
Director, Welsh NHS Confederation

Iain Rutter
GP and Chief Executive, Bradford North PCT

Peter Smith
GP, and Chair, National Association of Primary Care

Chris Town
Chief Executive, Peterborough PCTs

David Wilkin
Professor and Director, National Tracker Study of PCG/Ts,
University of Manchester

Andy Williams
Chief Executive, Powys Local Health Board

Lynn Young
Primary Care Advisor, Royal College of Nursing

And one other civil servant who asked to remain
anonymous

Appendix D

Stakeholder workshop participants

June and July 2004

Richard Armstrong
Head of Primary Care Trusts and Commissioning Branch,
Department of Health

Ian Ayres
Chief Executive, Sutton and Merton Primary Care Trust

Ann Blight
Deputy Director of Commissioning, South Birmingham
Primary Care Trust

Edward Coyle
Director, Wales Centre for Health

Pieter Degeling
Director of the Centre of Clinical Management
Development, University of Durham

Tom Easterling
Policy Advisor, North Central London Strategic
Health Authority

Nigel Edwards
Policy Director, NHS Confederation

Eric Gatling
Head of Service Improvement, Dorset and Somerset
Strategic Health Authority

Nick Gould
Senior Research Fellow, Welsh Institute for Health and
Social Care

Karen Hayton
Project Officer, Huntingdonshire Primary Care Trust

Julie Higgins
Director of Public Health /Deputy Chief Executive,
Salford Primary Care Trust

John Howie
Emeritus Professor of General Practice,
University of Edinburgh

Vicky Irons
Project Manager, Care Division, Scottish Executive
Health Department

Peter Johns
Director Designate, Association of Community Health
Councils in Wales

Eddie Kinsella
Consultant, NHS Clinical Government Support Team

Linda Marks
Senior Research Fellow, School for Health,
University of Durham

Martin McShane
PEC Chair, North East Derbyshire Primary Care Trust

Mini Mishra
Senior Medical Officer, Scottish Executive
Health Department

Alistair Noble
GP, Nairn Health Centre

Gordon Peterkin
Associate Medical Director, NHS Grampian

Janet Pomroy
Head of Commissioning and Contracting, Heart of
Birmingham Primary Care Trust

Chris Riley
Strategy Advisor for Health and Social Care Department,
Welsh Assembly

Eleanor Sanders
Performance Manager, South East Wales Regional Office

Ian Trimble
GP, Nottingham City Primary Care Trust

Elizabeth Wade
Commissioning Manager, Hounslow Primary Care Trust

Caroline Watts
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Collaborative Director – Primary Care Contracting
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