King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

What can we learn from the total purchasing pilots about the management costs of Primary Care Groups?

A briefing paper for Health Authorities

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The Total Purchasing National Evaluation Team (TP-NET)

The national evaluation of total purchasing pilot projects in England and Scotland is a collective effort by a large consortium of health services researchers. The study is led by the King's Fund Policy Institute, but also involves the National Primary Care Research and Development Centre at Manchester, Salford and York Universities, together with researchers from the Universities of Bristol and Edinburgh, the Institute of Health Policy Studies at the University of Southampton, the Health Services Management Centre at the University of Birmingham and the London School of Hygiene and Tropical Medicine.

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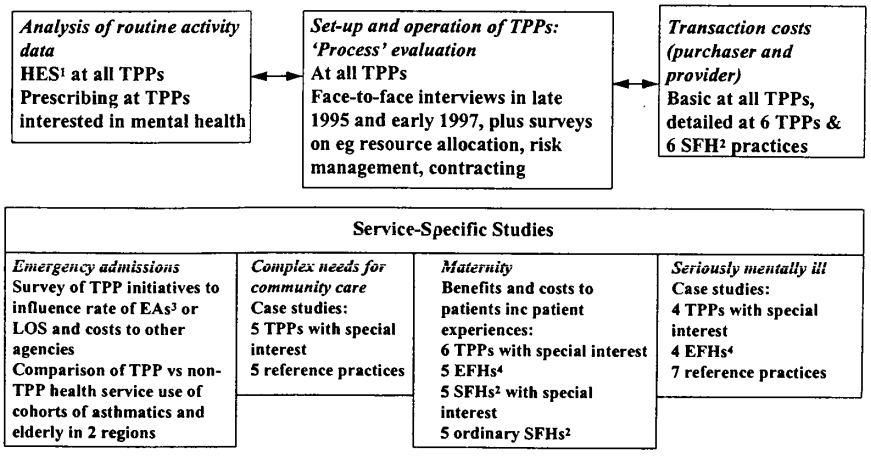
Contents

Preface: The National Evaluation of Total Purchasing Pilot Projects

Total Purchasing Pilot Projects allow for the purchasing of potentially all hospital and community health services by fundholding general practices which began their preparations for contracting in April 1995. Since 'total purchasing' (TP) represented an important extension of the already controversial fundholding scheme, the Department of Health decided to commission an assessment of the costs and benefits of this NHS Executive initiative. This working paper represents part of the interim reporting of the evaluation which began data collection in October 1995 (mid-way through the total purchasing pilots' (TPPs') preparatory year) and which is due to produce final reports in Autumn 1998, by which time the TPPs will have completed two full purchasing years. Other titles in this series of working papers are listed on page iii.

The evaluation amounts to a programme of inter-linked studies and is being undertaken by a large consortium of researchers from different universities led from the King's Fund. Full details of the participants are given on the back cover of this report. All 53 of the 'first wave' TPPs and the 35 'second wave' pilots which began a year later are being studied. The diagram below summarises the main elements of the research which has at its core an analysis of how TP was implemented at all projects and with what consequences, for example, in terms of hospital activity changes. These elements are linked to a series of studies at sub-samples of TPPs which attempt to compare the costs and benefits of TP with conventional health authority purchasing for specific services (emergency admissions, community care, maternity and mental health). In these parts of the evaluation, comparisons are also made between extended fundholding (EFH), where practices take on a new responsibility for purchasing in a single service area (e.g. maternity or mental health) and TP, where practices purchase more widely.

Main components of National Evaluation of First Wave Total Purchasing Pilot Projects



[1] HES = hospital episode statistics, [2] SFH = standard fundholding, [3] EAs = emergency admissions, [4] EFH = extended fundholding pilot

Further details about the evaluation design and methods are available in a leaflet available from the King's Fund and in the preliminary report of the evaluation which was published by the King's Fund early in 1997 and entitled *Total purchasing: a profile of national pilot projects*.

The evaluation would not have been possible without the co-operation and interest shown by all the staff involved in the TPPs. We are very grateful, principally for the time people have given up to be interviewed, whether in practices, health authorities, Trusts, social services departments or elsewhere in the health and social care system.

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January 1998

National Evaluation of Total Purchasing Pilot Projects
Main Reports and Working Papers

Title and Authors	*ISBN*
Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Working Papers	
The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:	
Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
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1 Introduction

The White Paper *The New NHS: Modern-Dependable* has set out the direction for the future development of local commissioning[1]. The vision in the *New NHS* is of a transformed local health system. Within this system the Health Authority (HA) will work in partnership with local government, primary care and local people to draw up and implement a Health Improvement Programme. Primary Care Groups (PCGs) will have a broad range of responsibilities to improve the health and health care of their patients and populations. They will take on responsibility for commissioning virtually all health care (except specialist services) on a staged basis. The most advanced PCGs at levels 3 and 4 will operate as free-standing Primary Care Trusts combining full commissioning responsibilities with provision of community services. In some cases, groups of GPs will merge with Community Trusts.

HAs and PCGs have to work within the management cost envelope set for each HA area. However, what will be the most appropriate and effective distribution of functions and deployment of this management resource to enable the new roles of HAs and PCGs to be developed and fulfilled? To help answer this question, this paper:

- defines how management costs are deployed within the current pattern of primary care commissioning;
- sets out some of the factors and issues relevant to setting up PCGs and their related management costs;
- considers how management costs might be deployed in the future within the HA management cost envelope.

There is at present no comprehensive information that allows appropriate levels of management costs to be determined. However, the experience of different GP commissioning models provides a source of guidance.

Total Purchasing comes closest to the approach envisaged by the White Paper. There are now 88 Total Purchasing Pilots (TPPs) nationally. The projects are at different stages of development, and have interpreted Total Purchasing in a range of ways. For many, Total Purchasing has stimulated the building of multi-practice organisations that are seeking to provide more integrated care, based on primary care development as well as commissioning secondary care.

This paper draws on the findings of three studies of the management costs of Total Purchasing (National Management Functions and Costs Study, and two studies undertaken as part of the National Evaluation of the Total Purchasing Pilots)[2,3,4,5] to shed some light on the management costs of PCGs.

2 What Are the Current Management Costs of Primary Care Commissioning?

Current primary care commissioning is pluralistic. Each district has a unique mix of commissioning models (including locality commissioning, GP commissioning, TPPs, GP consortia, multifunds and GP fundholding). These models vary in their scope and focus of commissioning responsibilities and, in particular, their degree of budgetary delegation. A recent survey has shown that the majority of districts had some form of sub-district level commissioning in 1997, but this functioned largely without delegated budgets (apart from the case of TPPs and fundholders)[6]. HAs were still commissioning for the majority of the population, while GP fundholders and Total Purchasers covering just over half the population were purchasing services in parallel on a selective basis.

An estimate of the level and distribution of management costs associated with this pluralist approach is shown in Table 1. It shows the direct management costs for HAs and GP purchasers (TPPs and Standard Fundholding (SFH) based on the National Functions and Cost Study)[2]. The average management cost of health authorities in 1996 was £9.40 per capita. This compares with the average management cost associated with SFH of approximately £5 per capita and the total management costs of TPPs of £6.63 per capita (based on a sample of 10 TPPs). The TPP national evaluation calculated the average incremental direct management costs of first wave TPPs (i.e. above SFH) as £2.83. The total management costs of TPPs, including their SFH costs, is, therefore, likely to be between £6 and £8 per capita. The total management costs of a pluralist pattern of commissioning in a district (including the costs of the HA) can, therefore, be in the order of £17-£18 per capita, and will be unaffordable in the long term. The PCG management cost allocation across all HAs will average about £3 per head of population[1]. Therefore, the future average total management cost envelope could be of the order of £13 per head. Given the government's commitment to reduce NHS management spending, £17-£18 is clearly not likely to be sustainable.

Table 1 also shows the distribution of the direct management costs by function[3]. Key features are as follows:

- HA core functions (headquarters, statutory, core finance and information functions, Family Health Services administration, accommodation and overheads) account for sixty percent of the costs of HAs. There is comparatively limited investment in 'general' policy and strategy development and in performance management. Ten percent of costs are spent on primary care strategy, development and support;
- GP fundholders and TPPs carry out about half of the functions for which HAs are responsible;

- Sixty percent of GP fundholding costs are spent on fund administration, fourteen percent on contracting and fourteen percent on strategy and policy development. There is some limited investment in public information and involvement and monitoring and performance management;
- About fifty percent of TPP management costs are spent on administration, but their investment in strategy is almost twice that of GP fundholders and at least equivalent to that of HAs on a per capita basis.

Table 1: Functions and Management Costs of Health Authorities and GP Purchasers, 1996

	HA*		Standard Fundholders**		Total Purchasing Pilots***	
Functions	£ per capita	%	£ per capita	%	£ per capita	%
Core Functions:						
Statutory/Essential	1.57	17	3.18	65	3.74	56
Finance & information	1.39	15				
FHS Administration	0.99	11				
Overheads	1.94	21				
Contracting	0.78	8	0.68	14	0.93	14
Strategy & Policy: General	1.22	13	0.71	14	1.38	21
Strategy & Development: Primary Care	0.50	5				
Primary Care-led Purchasing Support	0.48	5				
Public Information and Involvement	0.23	2	0.12	2	0.19	3
Monitoring and Management Performance	0.31	3	0.24	5	0.37	6
Total	**9.40**	**100**	**4.92**	**100**	**6.62**	**100**

Note: Totals may not equal column sum because of rounding.

*Based on sample of 77 health authorities.

**Based on sample of 40 standard fundholders.

***Based on sample of 10 Total Purchasing Pilots.

Source: Griffiths J. *Defining the essential: the functions, roles and costs of health authorities and GP purchasers 1996/97.* Final Project Report. Leeds: NHS Executive, forthcoming, 1998.

3 Issues and Factors Relevant to Setting Up PCGs and Their Related Management Costs

A range of issues and factors are relevant to establishing PCGs and estimating their likely management costs. These include:

- The link between management costs and the ability of primary care organisations to bring about benefits for patients and populations (i.e. performance).
- The range and type of services that it is appropriate to purchase at different sizes of population.
- The range of functions required to support the effective commissioning of services.
- The link between primary care development and commissioning.
- Organisational structural factors such as the size of PCGs and the complexity of their management arrangements.

3.1 The Potential Link between PCG Performance and Management Costs

Based on the experience of Total Purchasing, a complex range of factors appears to influence the performance of primary care organisations judged in terms of the extent to which they are able to achieve their commissioning objectives. These factors relate to 'internal' project characteristics (e.g. number of practices in the project, organisational complexity, previous experience of working together) and 'external' or contextual factors such as the nature of the relationship with the HA and providers. Analysis of the variation in level of performance between the first wave TPPs in their first year of purchasing (1996/97) has given an early indication of some of the most important factors.

While TPPs' achievements in their first live year of purchasing were generally modest in scale, TPPs which had taken on greater commissioning responsibilities, particularly budgetary responsibility, were more likely to report achieving their objectives[3,7]. Furthermore, those with higher management costs were more likely to do so. Higher management spending was associated with both a higher level of reported achievement in 1996/97 and a higher level of ambition for 1997/98. Also low spending on management was associated with low achievement. The higher costs of high performers were attributable in large part to funding of GPs' management contributions, suggesting that securing GP input is a vital element in bringing about service developments.

Table 2 shows the reported level of achievement of the first wave TPPs in 1996/97 within service areas newly included in total purchasing (i.e. mental health, continuing care of the

elderly, A&E and emergency admissions, and maternity services). It indicates that the highest achieving TPPs had considerably higher management costs than the lowest group.

Table 2: Direct management costs of first wave TPPs for 1996/97 by level of TPP Achievement in Total Purchasing Services Areas

TPP self-reported achievements against own objectives in total purchasing-related service areas	Average management costs per capita £
Low	2.65
Middle	3.14
High	3.68
All TPPs	2.82

The evidence suggests that devolving budgets enable some change to be brought about, but the extent of this will, in part, be dependent on investing in a management infrastructure that enables groups of GPs to operate as multi-practice organisations and actively engage individual GPs from all the participating practices.

3.2 Appropriate Population Levels for Commissioning Services

While improvements in certain services can be secured potentially through devolving responsibilities for commissioning services to PCGs, this will involve making decisions about which services are best commissioned at which population level. One classification of appropriate population levels for commissioning services could be based on the overall concept of 'subsidiarity'- that decisions should be taken at the lowest level at which they will not impact (adversely) on others. This involves assessing trade-offs between:

- the related issues of equity, coherent service and provider strategies, and financial and clinical risk-sharing;
- availability and economies of scale in management costs to ensure sufficient expertise in commissioning in the more complex service areas;
- the need to engage individual GP practices in the process of service development (and in assessing their resource consequences), if changes in their clinical behaviour and referral processes are involved.

Table 3, below, suggests one possible distribution of appropriate population levels for commissioning services based on this approach.

The experience of TPPs indicates that PCGs must have a choice with respect to the range of services they directly commission from providers and the pace at which they take on these responsibilities. A hierarchy of purchasing has emerged in the TPPs which reflects some of the trade-offs highlighted above. TPPs have tended to select services for direct purchasing in which they have a specific interest and concern. Certain services have been 'top-sliced' or 'blocked back' to the HA including highly specialised or low volume district-wide services (e.g. renal services, blood products, head/spinal injuries and health promotion). A range of services has been 'co-purchased', based on working in partnership with the HA, for which the projects have an indicative or shadow budget[8,9]. For those services directly purchased, TPPs report more success in some service areas than in others. For example, it has proved easier to develop community and primary care services in the mental health and maternity fields than to achieve changes in secondary care. The release and transfer of resources from secondary care has been highly problematic[7]. Consequently there is likely to be some limit, in practice, to effective PCG purchasing/commissioning.

Table 3: Appropriate Population Levels for Commissioning Services

Level of Commissioning	Example of service
Local level Primary Care Group 50,000-100,000 population	Community nursing Social care Continuing care of the elderly Maternity services Elective surgery
Mid-level Primary Care Groups working together within a HA 100,000-300,000 population	Emergency care Mental health
HA level 300,000-1 million population	Changes of provider/reconfiguration of acute and mental services ENT, ophthalmology Cancer care Cardiac care
Multi-HA/Regional level 500,000- 2 million population	Tertiary services: Intensive care, organ transplantation, neurosciences, secure units

While certain services may not be appropriately purchased at local level, it does not mean that such services should necessarily be purchased by the HA. Consortium arrangements between PCGs, or lead arrangements whereby PCGs take responsibility for different services and develop specialist experience and knowledge, are other options. Such collaborative arrangements could exert greater strategic influence and financial leverage to reshape provider services and bring about resource shifts, than PCGs working alone.

The issue of risk management should not necessarily limit the range of services that might be devolved to PCGs. Analysis has shown that rare costly referrals seem unlikely to bankrupt the typical TPP which is far smaller than the likely average PCG. Analysis indicates that a risk pool of at least 30,000 patients should be sufficient for most conditions. There are a number of ways of managing risk such as sharing risks between and within HA/PCGs, for example, managing budgets over a number of years[10].

The Audit Commission estimates that so called 'specialised' services typically account for 5%-7% of a total HA budget and states that HAs are best placed to commission these services (characterised by the need for specialist knowledge, small patient numbers, high cost per case, rapidly changing technologies and a focus on research, development and training activities)[11]. But HAs should consider joint commissioning with other HAs to ensure the most cost-effective use of specialist skills and experience in commissioning. The *New NHS* White Paper now gives the regional offices a lead role in ensuring that such specialised services are commissioned effectively[1].

The process of developing the district-wide Health Improvement Programme, involving all key stakeholders, will be critical in setting the parameters for the strategic development of services. Without a strong steer on the major reconfiguration of acute and mental health services by the HA, the devolution of commissioning responsibilities to free-standing PCGs could pose risks to equity, and to providers financial stability.

3.3 Agreeing the Respective Functions of HAs and PCGs

Section 2 indicated that the current 'pluralist' approach to commissioning is unaffordable given the Government's aim to reduce management spending appreciably. In the long term, the most effective deployment of management costs will depend on agreeing 'who does what'. As responsibilities for commissioning services are devolved to PCGs, certain operational commissioning functions should, in principle, transfer with a management budget from the HA to the PCG. Such functions include local public health (including population-based needs assessment) and strategy development, service specifications, definition of

clinical pathways, negotiation of service agreements, public involvement and information, quality assurance, development and local performance management.

However, the duplication of such functions within all PCGs (say four or five within a current district) is likely to be *more* expensive than current HA level arrangements, and also likely to fragment specialist expertise. Options that would ensure the most effective use of the management resource could include the use of service agreements that enable PCGs to access managerial skills from the HA, or collaborative arrangements between PCGs, whereby PCGs at levels 3 or 4 might provide certain functions on behalf of others.

There are a number of examples of TPPs already acting as a sort of informal development agency to support local commissioning functions elsewhere in the district. For example, a number of TPPs have undertaken district-wide reviews of certain services to define new service specifications. Protocols and care pathways developed by TPPs have set new standards and have been applied district-wide, and some TPPs have developed new information and contracting systems which will potentially provide the basis for future district-wide integrated information and IT systems and avoid the proliferation of separate systems by PCGs[12].

3.4 The Link Between Primary Care Development and Commissioning

The White Paper brings together commissioning and provider responsibilities within PCGs, recognising that the underlying principle of a primary care-led NHS is that a primary care organisation will 'do what it properly can, and buy in the rest'. Since most of the content of GPs' work relates to minor or chronic conditions with only a small proportion of patients requiring referral and access to secondary care[13], their purchasing objectives are largely shaped by this pattern of experience. The evidence from Total Purchasing has shown that while, technically, the focus of Total Purchasing was on purchasing of hospital and community services, in practice, Total Purchasing has proved an important vehicle for the development of primary care services and for shifting the boundary with secondary care[14].

In the service areas included in Total Purchasing, such as maternity, mental health, emergency admissions and continuing care, much effort has been devoted to defining patterns of care that extend and develop the role of primary care. For example, the appointment of practice-based nurse practitioners, development of GP-led minor injuries facilities and better patient education are being used to reduce emergency admissions and avoid inappropriate

admissions[14]. The development of mental health services has focused on extending Community Mental Health Teams, particularly through appointment of practice-based CPNs, counsellors and psychiatrists working on a sessional basis[15]. Implementation of *Changing Childbirth* has focused on the development of community midwifery, including the attachment of community midwives to practices and introduction of protocols that ensure low risk pregnancies are managed in the community[16].

The functional cost analysis of TPPs (Table 1, above) indicated that the development of primary care is integral to the extension of commissioning responsibilities. The relevant functions, therefore, will need to be identified and funded within PCGs, including medicines management, prescribing, evaluation and audit, management investment in primary care services development and the capacity to review GP's referrals and their referral decisions.

The development of networks between groups of practices to enable collective working is well recognised as a prerequisite for the development of primary care services. Findings clearly indicate that Total Purchasing has been an important mechanism for strengthening collective working, though this takes time and management resources to develop. A significant amount of the additional transaction costs of the TPPs are incurred co-ordinating Total Purchasing activities across practices (comprising twenty-six percent of the total transaction costs relating to Total Purchasing)[5].

These costs must be paid for. The building of a corporate infrastructure could in future provide a platform for further development of primary care, including audit and peer review and professional development. Such investment could pay for itself if such activity results in reduction of hospital use as well as improved standards of primary care.

3.5 How Should PCGs Be Organised?

The relationship between organisational structure, effectiveness and cost is complex. The size of the primary care organisation (number of practices), level of involvement of GPs and associated management arrangements are interrelated and linked to performance. In principle, economies of scale in the management function would be expected to lead to lower per capita costs in larger organisations (up to some point). However, the evidence from the first wave TPPs shows that such economies are offset by the costs of co-ordinating more GPs across practices[5].

The larger multi-practice TPPs have had to establish more 'complex' organisations and management systems, which include sub-group working, in order to involve their GPs, other clinicians and agencies in planning and service development. This has implications for

performance. The multi-practice TPPs that achieved most in 1996/97 had developed 'complex' organisations, employed a specific project manager, developed reasonable or good relations with their local health authority, developed a dialogue with local providers, invested in information technology and encouraged the involvement of non-lead general practices and a wide range of participation from other staff in the practices within the project.

Therefore, the experience of TPP suggests that relatively complex organisations compared with SFH may be required to enable PCGs to operate as corporate organisations engaging GPs in bringing about service developments and managing a collective budget.

4 Likely Future Management Costs of Primary Care Commissioning

The potential for the redeployment of management costs to support HAs and PCGs fulfil their new roles and functions is illustrated in Table 4. It shows a development towards a local health system based on PCGs, with fully devolved commissioning and providing responsibilities. It sets out assumptions about the features of the local health system at three stages of development and their management cost implications.

The 'pluralist' approach of the early (current) stage is characterised by a very uneven deployment of management investment and costs within districts and nationally. Currently (mid-1998), HA commissioning covers the majority of the population while GP fundholding and Total Purchasing operate a parallel system with some duplication of commissioning functions and costs. This phase is also characterised by significant expenditure on 'core' functions in these organisations (amounting to at least fifty percent of management costs). For HAs, these include statutory functions, core finance and information functions, Family Health Services administration, accommodation and overheads.

After April 1999, when PCGs officially begin, there is likely to be a transitional period since the pace of devolving commissioning to PCGs will vary greatly within and between districts and nationally, because of the varying levels of previous experience of SFH and Total Purchasing. HAs will accredit PCGs to undertake different levels of commissioning responsibility, according to their management and organisational competence, underpinned by an appropriate level of management costs. HAs and PCGs will be 'co-purchasing' many services for a number of years, since the majority of PCGs will only directly purchase a selective range of services for some time. They will not have developed the necessary commissioning expertise immediately.

During this transitional period, there is likely to be significant pressure on management costs, given the need to build both the management functions of all PCGs and strengthen the strategic functions of the HA. There could be some savings from rigorous internal review of HA costs through benchmarking (particularly, the Family Health Services and IT/IM functions). The abolition of GP fundholding will also release money and would enable PCGs to establish integrated management and accounting systems. In some cases, the management costs of Community Trusts will support the new Primary Care Trusts (Level 4 PCGs). However, this is unlikely to be sufficient, adequately to fund all PCGs wishing to operate at levels 3 and 4. The pace of investment in PCGs and devolution of commissioning responsibilities could, therefore, be highly constrained. This transitional period could well last for some years.

In the final phase of a fully decentralised local health system (say, in 3-5 years time, or longer in some districts), the HA will have reconfigured itself to operate as the strategic planner and local regulator of the system. Ideally, well established PCGs will be commissioning a full range of health care services and promoting the health of the populations they serve, working within the context of HA Health Improvement Programmes. There will be clarity and agreement between the HA and the PCGs on the distribution of functions to support new roles. The sharing of responsibilities and functions between PCGs through collaborative working will enable most operational commissioning functions to be devolved to primary care. HAs will share certain functions. In some districts, integration of planning and service development with Social Services will also lead to further sharing of management functions and reductions in costs. Core functions will be reduced and shared. These arrangements will allow effective and efficient deployment of management costs and duplication will be largely eliminated.

Table 4: Future Primary Care Commissioning: Developmental Pathway and Management Cost Implications

Development Stage	Role of HA	Role of PCGs	Assumptions	Management Cost Implications
Early Stage, 1998	Direct accountability for £ Primary care development agency Responsible for most functions	Advisory Indicative budgets Few functions	Current diverse mixture of different models of local commissioning HAs commissioning full range services with associated functions The majority of the population covered by some form of locality commissioning with GPs acting in an advisory role, with indicative budgets TPPs undertaking selective purchasing in areas beyond standard fundholding	Uneven deployment of management costs within districts and nationally, based on evolution of different local commissioning/ purchasing models. Unaffordable in long term within management cost envelope. Total approx. management costs £17-18 comprising: HA £9.40 TPP £2.80 (incremental)/ £6-8 (total) GPFH £4.90
Transitional stage	Co-commissioner Budgets delegated for specific services More functions shared or delegated	Selective delegated financial accountability Responsible for some services More functions	Establishment of PCGs, (each covering approx. 100,000 pop), and universal coverage (approx. 5 per district) HA acting as co-commissioner with PCGs, with extension of selective purchasing by PCGs Wide variation between PCGs in scope of commissioning responsibilities and development of functions/ management infrastructure within districts Majority of PCGs do not directly purchase; or purchase selectively	Significant pressure on management costs. Need to extend and invest in PCGs across the district. Need to strengthen HA strategic, developmental and performance management functions (including public health) as well as commission in partnerships with PCGs Release of costs with internal performance review/benchmarking, possible early savings from Family Health Services Providers reduce transaction costs with fewer purchasing units, but increased costs with greater direct purchasing by primary care organisations for greater range of services Potential rationalisation of costs (£6-8 per capita) through combining TPP/SFH and integration within PCGs Community Trusts' management costs supplement management costs of some PCGs at levels 3 and 4

Table 4 cont.: Future Primary Care Commissioning: Developmental Pathway and Management Cost Implications

Development stage	Role of HA	Role of PCG	Assumptions	Management Cost Implications
Decentralised/ Primary Care Commissioning	Strategic-regulator Devolved budgets for many services to PCGs Many functions devolved to PCGs	Delegated £ accountability for appropriate services Some budgets at practice level Many functions PCGs in consortium working together	HA has strengthened its functions of strategic overview, public health, best practice, support and development, standard setting, monitoring and performance management HA operational commissioning functions devolved to PCGs (local public health, service specifications, clinical pathways, negotiation and service agreements, public information and local performance management) All PCGs well established across a district. Possibly half would be at stage 3 & 4 operating as a free-standing organisation. Some primary care Trusts status (merged community Trust and GP grouping)	Agreed clear distribution of functions - 'who does what'- involving devolving and sharing of functions within local health system between HA, PCGs and Trusts to achieve effective deployment of management costs and elimination of duplication Consortium arrangements between PCGs or advanced PCGs, take lead responsibilities for different services Management costs relating to core functions significantly reduced, particularly Family Health Service costs and IT/IM (district-wide integrated information management system) Merging of small HAs to achieve management cost savings

5 Conclusions

The New NHS sets out a vision of a local health system with new roles and responsibilities for HAs, primary care and local government. Ultimately, commissioning will be decentralised and undertaken by PCGs. This paper has considered the management cost implications of moving towards this pattern of primary care commissioning. It suggests that, in setting up PCGs, it will be important to ensure that Groups have sufficient management and organisational capability to function as multi-practice organisations if they are to fulfil their responsibilities (particularly at Levels 3 and 4). The evidence suggests that those TPPs which undertook independent contracting with devolved budgets and had higher management costs were more likely to meet their objectives and bring about changes with potential benefits for their patients and populations than those which did not.

In devolving commissioning responsibilities to PCGs, it will be important that services are commissioned at levels appropriate to the population served (PCG itself, groups of PCGs, HA wide and beyond). This will involve some system-wide trade offs between local sensitivity and responsiveness and overall equity and efficiency of service delivery.

It is vital that agreement is reached about the respective functions of PCGs and HAs; who will be responsible for what and how the work will be carried out. In particular, new ways of fulfilling the tasks associated with operational commissioning will need to be tested to secure the most effective and efficient distribution of management costs.

PCGs (particularly those operating at Levels 3 & 4) will need to develop relatively complex organisational structures if GPs and other professionals are to be genuinely engaged in making decisions about their commissioning and service developments. This GP involvement will be key to achieving objectives.

It seems likely that the development of a decentralised primary care commissioning system will not be rapid. It appears likely that management cost pressures will be particularly acute during the transitional period which could last several years if the experience of the self-selected TPPs is any guide. During this period, PCGs will be at different stages of development and HAs will need to continue to commission for much of the population, while increasingly PCGs undertake commissioning on a selective basis (i.e. for a specific range of services).

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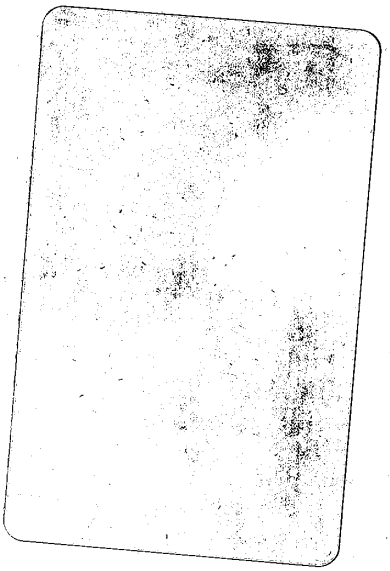

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