King's Fund

Purchaser Plurality in UK Health Care

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Nicholas Mays & Jennifer Dixon

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Summary

This book describes the trend towards more diverse and devolved forms of purchasing and combinations of purchaser organisations within the boundaries of health authorities in the UK National Health Service (NHS) since the NHS quasi-market changes introduced in 1991. Variability in the configuration and availability of services on the supply side of the quasi-market – a long-standing characteristic of the NHS before 1991 – is increasingly echoed by heterogeneity on the demand side, as the NHS tries to relate purchasing decisions more closely to the views of GPs as informed agents for patients.

The book presents a multi-dimensional profile of each of the current models of purchaser organisation (health authority purchasing, locality commissioning, GP commissioning, standard fundholding, community fundholding, GP multifunds, fundholding consortia, extended standard fundholding and GP total purchasing), along dimensions such as population size, scope of services purchased, degree of budgetary control, management structure and degree of autonomy. All in their different ways attempt to decentralise purchasing, or the main influences on purchasing (commissioning), to groups embracing smaller populations than a typical health authority. All rely heavily on the judgement and skills of general practitioners (GPs), but with little knowledge as to whether and, if so, how this is appropriate.

Policy statements by both the Liberal Democrats and the Labour Party and action by the Government in the form of the emergence of the national GP total purchasing pilot sites in early 1995 and the October 1996 primary care White Paper, suggest that the diversity on the ground may conceal a growing consensus among the main political parties that health care purchasing should be managed in future by organisations which attempt to embody selected features of 'bottom-up', demand-led purchasing as exemplified by standard fundholding and of 'top-down', needs-based purchasing for a population as exemplified by health authority purchasing. The nature of the discussion has thus been fundamentally altered by GP fundholding. The parties differ in the extent to which they favour giving actual delegated budgets to general practice-based purchaser organisations.

However, a convergence of view does not necessarily produce an adequate model of NHS purchasing. Current trends and policy developments are discussed in relation to the likelihood that they will give rise to purchaser organisations which are *sustainable, accountable, have the right mix of skills and minimise conflicts of interest* and which can successfully undertake the main tasks of NHS purchasing, namely, *assessing patient needs, obtaining adequate information about services, influencing providers, securing patient involvement and choice, setting appropriate priorities, monitoring and maintaining equity, minimising transaction costs and managing financial risk.*

A large number of questions are thrown up by an examination of current trends, few of which can be answered with the evidence available:

- which sorts of purchaser organisations are most appropriate in which circumstances?
- which services are most appropriately purchased by which forms of purchaser, given the different skills, time, knowledge and level of financial risk inherent in each?
- does the effective devolution of responsibility for shaping future purchasing depend on allocating real budgets to these purchasers or can influence be generated in other ways?
- what are the implications for purchasing of giving increasing purchasing responsibility to primary care *providers*?
- are general practices as currently configured an appropriate, sustainable building block for NHS purchaser organisations in terms of their degree of organisational development and level of access to information on cost and quality of services?
- what are the peer and public accountability and governance implications of the new models of purchasing?
- what role, if any, can individual patients play in these emergent forms of purchasing?

Each of the current models of NHS purchasing organisation exhibits a different combination of merits and drawbacks such that it appears unlikely that a single, optimal model is waiting to be found. Three particular weaknesses of current developments are worthy of attention if devolved forms of purchasing are to form the basis of NHS purchasing in the foreseeable future. The first is the risk of increasing conflicts of interest

faced by GPs because of their dual roles as health care purchasers on behalf of the NHS and as contracted service providers dependent for their incomes on what they can offer to the NHS, if models of purchasing are pursued which further increase their influence over resource deployment. The second are the relatively underdeveloped structures of accountability and governance in place in devolved forms of purchasing organisation to limit the first weakness. The third weakness is the lack of attention so far to ways of increasing patient involvement and choice in the new forms of purchasing.

For example, the ability of patients to choose which kind of purchaser they wish to have acting on their behalf has been relatively ignored hitherto. This contrasts with the experience of GPs who have been offered an increasing range of choice as to whether and, if so, how they can become involved in shaping hospital and community health services in their areas.

A range of potential future options is discussed, each of which attempts in different ways to respond to the limitations in current models of purchasing. Each option is assessed in relation to the requirements for NHS purchasing set out above. No single option instantly recommends itself on all counts. The less radical options which largely accept the location of the current purchaser-provider split in the NHS, the separation of the general medical services' and hospital and community health services' funding streams and the current means whereby patients enrol with a general practice, do relatively little directly to address the three particular weaknesses of current arrangements – potential perverse incentives, weak accountability and absence of patient choice. The more radical options, including a more competitive 'mixed economy' of NHS purchasing, have the *potential* to mitigate the three particular weaknesses in current arrangements set out above in that each would bring a greater degree of demand-side patient choice into the NHS quasi-market. However, it is likely that each would necessitate strong external regulation, especially to ensure that purchasers recruited patients equitably, kept transactions costs to a minimum, avoided financial conflicts of interest and operated within national policy goals. Such developments, some of which were suggested for piloting in the October 1996 White Paper on primary care, should be assessed critically in relation to the fundamental aims of the NHS and the requirements of effective purchasing of health services.

Chapter 1

The evolution of purchaser plurality

Models of purchasing in the *Working for Patients* reforms

The NHS White Paper of 1989, *Working for Patients*,[1] introduced a purchaser-provider split into UK publicly funded health care based on two seemingly incompatible models. In one model, health authorities were to be transformed into purchasing organisations responsible for assessing the health care needs of the large populations within their boundaries, setting priorities between care groups and types of care and securing the maximum amount of health care possible within their budgets in order to improve the health of their populations. Typically, district health authorities in England were responsible for purchasing rather than providing *all* the hospital and community health services (HCHS) for populations in excess of 250,000 people. In the other model, GP fundholding was introduced, in which GP practices volunteered to hold a budget withdrawn from the overall budget of their local health authority to enable them to manage a budget for their prescribing and to purchase a selected range of mainly *elective* health services for the patients on their practice lists. The fundholders' budgets were set initially on the basis of the costs of their past activity and are still largely historical, whereas the health authorities' budgets were to be set through a system of weighted capitation. Fundholders were allowed to make and keep a negotiated share of any savings which they were able to accrue through more resource-conscious decision-making. Particularly in the first few years of the two models, the fundholders were permitted far greater freedom to commit their resources as they saw fit and to shift work between providers. The health authorities with far larger budgets could have destabilised local providers and so were restricted in the extent of changes which they were allowed to make.

The standard fundholding (SFH) budget includes most elective surgery, most outpatients, community health services (CHS), tests and investigations, direct access services such as physiotherapy, GP-prescribed drugs and non-medical practice staff (e.g. practice nurses). In total, this amounts to about 20 per cent of fundholding patients' health care in cash terms.

Initially, fundholding was only open to larger practices with over 9,000 patients, but it nonetheless represented a far more disaggregated form of purchasing than health authority purchasing.

The idea behind GP fundholding was that the newly resource-conscious GPs with their direct knowledge of individual patients and of the health care which they typically received from local providers would be in a good position to act as their agents in securing for them the most appropriate form of care at reasonable cost. For example, the fundholders would make referrals in the knowledge that since each was a charge on the practice's budget, they would want to secure a good quality of health care at reasonable cost in order to maintain their enlisted patient numbers. The GP has been described as being '... close to the pains and preferences of patients' and, therefore, responsive to their demands while having to be resource-conscious for the first time when prescribing and making referrals to secondary care. Practices which were able to make 'savings' from their budgets were given the incentive not available to non-fundholders of being able to use a share of these resources either to buy more HCHS for their patients or to invest in their own practice facilities. Fundholding was to be an essentially 'bottom-up' style of purchasing built up from the clinical experience of many practices and their interaction with many patients. In this sense, it was more consistent with a market-type system than health authority purchasing. By contrast, the health authority model stressed an epidemiological, strategic approach which had much in common with past models of 'top-down' NHS planning. In the early period of the NHS reforms following *Working for Patients*, the two models were frequently viewed by both analysts and those implementing the NHS reforms as in competition with one another. In retrospect this seems unhelpful since the two models are in crucial respects not comparable (see above). However, it is true to say that the two models of purchasing are still regarded as *independent* of one another and operate largely separately.

It is perhaps typical of the paradoxical nature of recent changes in the NHS since 1991 that while both GP fundholding and health authority purchasing have led to more diverse and decentralised forms of purchaser organisation, at the same time, the NHS has become more managerially centralised than ever with an even stronger chain of command stretching between the NHS Executive at the centre and the health authorities, via

the new regional offices of the Executive.[2] The ever-stronger thrust of policy from the centre has been to encourage more devolved forms of purchasing based on the fundholding model! In practice, as the contrasting fundholding and health authority models have come face-to-face with the pervasive problems of purchasing health care, particularly the difficulty facing large purchasers of understanding the needs of individual patients and the difficulty for small purchasers of influencing providers' behaviour, this has led to the development of a wide range of approaches to purchasing below the level of the health authority area. Whereas before 1991 the principal source of organisational variation in the NHS lay on the supply side, increasingly this is echoed by local heterogeneity on the demand side, as the NHS tries to relate purchasing decisions more closely to the needs of patients by taking into account the views of GPs and sometimes others, as agents for the patient.

Trends in health authority purchasing

Two trends have been apparent in health authority purchasing organisation in the period 1991–96: first, amalgamations of health authorities to form larger entities and, latterly, mergers with their corresponding family health services authorities (FHSAs), which administered the family practitioner services provided by independent medical, dental and other practitioners, have occurred to form integrated health authorities; and, second, initiatives and organisations *below* health authority level have proliferated, aimed at increasing the involvement of GPs directly, and of local people indirectly, in decisions affecting health authority purchasing.

Amalgamations and mergers of authorities

The rationale behind purchasing on a bigger scale was that some districts were regarded as too small to be viable because of diseconomies of scale or a shortage of skilled staff (e.g. in public health) or because they lacked sufficient financial leverage over local providers. For example, some authorities merged in order to have a choice of more than one major acute provider within their boundaries, thus increasing the theoretical possibility of moving business between them. In other cases, mergers enabled health authorities to relate more easily to local authorities thus facilitating integrated purchasing across primary, secondary and community care sectors. However, as purchasing decisions began to be taken further away

from the local level, typically at the level of populations of 500,000 people, there was a concern that they might become insensitive to local and individual needs and circumstances. Thus as health authorities came to cover larger populations and as the work of GP fundholders in securing improvements in health care for their patients became more widely known, so health authorities themselves experimented with ways of reconciling the advantages of big population purchasing with local sensitivity to needs. As a result, almost all health authorities have developed various forms of GP consultation as the most modest form of GP involvement.

Unlike GP fundholding which was the product of a national policy initiative embodied in legislation, health authorities working with local general practices have generated a range of locally defined schemes which are variously known by terms such as *locality purchasing, practice-sensitive purchasing* or *GP commissioning*. These schemes have taken a wide variety of forms depending on the size of the population covered, the degree of decision-making autonomy and budgetary devolution from the health authority enjoyed by the scheme, the extent to which they are organised around geographic communities or amalgams of practices, and the ways in which local GPs are involved. [3, 4, 5, 6]

Sometimes localities have simply been constructed from adjacent electoral wards, sometimes from small towns or neighbourhoods and sometimes by reference to social services 'patches'. As a result, their population sizes have varied widely from about 10,000 people to as many as 100,000. Localities constructed from groups of general practices have tended to be smaller, in the range between 30,000 and 60,000 people. In some schemes, the decentralisation of the purchasing function consists in as little as purchasing managers having locality responsibilities which are taken into account when formulating district purchasing plans. In others it extends as far as locality teams or groups of GPs with their own budgets to use to purchase services directly. More often than not, the budgets are notional but are set on the same basis for all practices in the health authority area to ensure equity. In general, the greater the degree of purchasing autonomy enjoyed by a locality scheme, the more restricted the range of services which can be purchased through the locality structure. Many schemes focus exclusively on services which are delivered on a local, geographic

basis (e.g. community nursing), while others include community and acute services. The two main types of scheme (locality commissioning and GP or practice-based commissioning) are discussed below.

Although health authorities had worked with local communities before in order to understand better the needs of sub-groups in the population for planning purposes,[7] this type of activity was greatly stimulated by the example of GP fundholding, as it became increasingly apparent that GPs had a potentially key role in informing the purchasing process from their own clinical experience in ways which health authorities could not. Thus, increasingly, locality schemes have focused not so much on the locality as the GPs within it. In some cases, the health authority was motivated by a desire to show that sensitive and innovative purchasing could be achieved by an organisation with a large population without having to resort to handing a portion of the health authority's budget over to GP fundholders (i.e. fundholding created an incentive for health authorities to do better). In other cases, practices which were either too small to be eligible for the original form of fundholding or which were ideologically opposed to the idea of holding their own budgets, but which, nonetheless, wished to influence the heath authority's intentions took the initiative to set up schemes. In still further cases, practices wished to avoid the time and cost of managing their own budgets. Typical objectives include developing services which are more flexible and community-based than their predecessors and which can be targeted on needy groups in the local population. Unlike fundholding, locality and practice-based schemes allow GPs and others to influence a wider range of services but with a notional budget set on the same basis as all the other practices in the area. In all cases, the resources which may be identified as relating to one of these sub-health authority schemes remain the legal responsibility of the health authority, unlike in GP fundholding. The GPs are attempting to influence the health authority on behalf of their patients but without holding their own budgets.

Although it is hazardous to draw hard-and-fast distinctions between the wide diversity of sub-health authority purchasing initiatives, it is possible to distinguish schemes by the extent to which the purchasing function has been devolved directly to some local body, whether actual or notional budgets have been allocated to the local body and the extent to which the

scheme is driven by the health authority or by local GPs. The terms 'purchasing' and 'commissioning' have tended to be used in a specific way in the NHS, although not always consistently, so that on occasions they are used interchangeably. However, in general, most participants would argue that 'purchasing' refers to *buying* a specific service through a contracting process, using resources which are directly controlled by the purchaser. 'Commissioning' tends to be used to describe a broader process which may include some direct purchasing, but in which the commissioner attempts to exercise a strategic influence over a range of services and agencies not all of which the commissioner has direct control over or, indeed, a budget for.

In general, the range of alternatives to fundholding tend towards commissioning rather than purchasing and thus have the potential disadvantage for participants of becoming merely advisory. In addition, the practices in a locality have no shared legal responsibility or accountability for their decisions and may leave a scheme at any time.

Locality commissioning

Locality commissioning usually involves a group of general practices within an area collaborating in order to make purchasing recommendations about a range of secondary care for the population of a defined locality. Many health authorities are now organised into localities for the purchasing of certain services which are provided on a geographic basis. Localities are typically populations of about 50,000 people. They normally have a health authority paid co-ordinator to orchestrate the views of the GPs and produce a locality strategy and purchasing intentions. Locality schemes do *not* usually involve any formal budgetary devolution to the locality organisation from the health authority. Purchasing decisions and contracts are still generally made centrally. An example of this kind of commissioning structure is Bromley, where locality commissioning has led to the development of a clinical commissioning board at district level consisting of clinical commissioning directors, who are GPs appointed from the established localities in the district through a process of competition and who are accorded equal status with the executive directors of the health authority.[8] According to the health authority, the Clinical Commissioning Board is the main body through which Bromley commissions HCHS. Interestingly, it includes fundholders and non-fundholders.

In general, it would appear that locality commissioning groups are dependent on their local health authority's willingness to respond to their suggestions for change. They are also dependent on the health authority for the resources to organise and support a group.

Practice-sensitive commissioning or GP commissioning

These schemes are mechanisms for giving groups of independent general practices a say in health authority purchasing decisions without holding their own budgets. Generally, they are regarded as giving GPs more influence than locality commissioning, which tends to be orchestrated more directly by the health authority. Most GP commissioning groups were initiated 'bottom-up' by GPs themselves and have a strong emphasis on internal democracy and equitable commissioning. Administrative costs are met by the health authority. The GPs propose purchasing strategies and contracts which the health authority implements on their behalf. Sometimes, the GP commissioning group is given a notional or indicative capitation budget covering a wide range of the HCHS previously purchased on the GPs' behalf by the health authority, against which past activity and costs can be compared. The aim is progressively to move recent past resource shares towards those indicated by capitation. There are well-known schemes in Bath, North Derbyshire and Northampton. Perhaps the best known GP commissioning group is in Nottingham where the group has had such success in influencing the local health authority that fundholding has attracted a very much smaller proportion of local GPs.[9] There are currently said to be about 60 GP commissioning groups in England, with 11 million patients and involving 5,000 GPs. A National Association of Commissioning GPs has been formed.[9] GP commissioning served approximately half as many patients as fundholding in 1995.

There is a suggestion that practice-sensitive schemes may be more costly to implement than locality purchasing but may produce greater benefits. Unfortunately, the merits of the many different variant forms of GP commissioning and other locality purchasing schemes have not so far been the subject of any proper comparative evaluation. Similarly, there have not been any explicit comparisons between these forms of purchasing devolution and standard GP fundholding. However, the Nottingham non-fundholding group has estimated that its management costs are approximately half as great as those of fundholders and has claimed that the

benefits are as great as for standard fundholding but without disadvantaging other practices.[10] The Nottingham group consists of 79 practices and a population of 380,000, but does not even have a shadow budget. Its influence derives from its size, its democratic structure, the information it can rapidly collate from 79 practices and the advice it makes available to the health authority, which it channels through a committee of 14 GP members elected annually by the 200 GPs in the group. The committee works in such a way that the other GPs are relatively free to concentrate on their clinical roles as before. The group has a contract with Nottingham Health Authority to advise the authority on purchasing. Despite their title, the Nottingham non-fundholders include fundholders in their group who can continue to negotiate their contracts directly with local providers. The group prides itself on including *all* GPs who wish to take part in the commissioning of services.

Trends in GP fundholding

By comparison with the models of devolved purchasing sketched out above, GP fundholding has been based from the outset on a legal entitlement for eligible practices which have been accepted into the scheme to manage their own budgets directly and independently. With strong support from the Government and the provision of a fundholding management allowance plus investment in practice computing to support the information and accounting requirements of the scheme, the proportion of the population covered by fundholding practices has risen rapidly since 1991/92 (see Table 1). It is estimated that in 1996/97 about 50 per cent of the population of England and Wales was served by fundholding practices which controlled over 10 per cent of the total spending on HCHS normally routed through health authorities.

Fundholding has been especially popular among larger practices with better facilities, such as purpose-built surgeries and more attached staff, and among practices serving less deprived populations. For example, fundholding is relatively far less common in inner cities than in suburban areas and market towns in the leafier shire counties.[11] Anecdotally, it seems to be the case that the early waves of SFH practices tended to include many of the best organised and most innovative practices in each area, which may go some way to explain certain of the relative successes of the scheme.

Table 1 Trends in GP fundholding in England and Wales

Year	*% population covered*	*No. of funds*	*% of health authority HCHS budget controlled*
1991/92	7	303	?
1992/93	13	590	?
1993/94	24	1,248	?
1994/95	34	1,836	8
1995/96	41 (range 4–85 at district level)	2,221	9
1996/97	≅ 50	?	≅ 11

Source: Audit Commission (1995), *Briefing on GP Fundholding*, London: Audit Commission; and data from NHSE, 1996.

A comparison of the characteristics of the 18 first-, second- and third-wave SFHs in Lincolnshire with the 81 non-fundholding practices during the same period indicated that the SFHs were more likely to meet a number of quality criteria established officially after the introduction of the 1990 GP contract, particularly their ability to control their prescribing costs, which appeared to predate their SFH status.[12]

Since the original single-practice model of GP fundholding was introduced in 1991/92, four main trends have occurred in official policy on fundholding and more informally through its implementation. First, the SFH model has been adapted to allow smaller and smaller practices to take part; second, the range of services which can be purchased under SFH has expanded; third, arrangements in which fundholding practices work more closely together either in consortia or GP multifunds have become more common; and, fourth, experimental extended SFH and 'total purchasing' pilot projects have been developed. Thus SFH was initially restricted to practices with 9,000 patients before the limit was reduced to 7,000. From April 1996 practices with lists of 5,000 or more patients were eligible to join the SFH scheme and a new form of 'community' fundholding was introduced in which practices with 3,000 to 5,000 patients are if they so wish to purchase all the non-hospital services contained in the SFH envelope.[13] From April 1996, SFHs can purchase specialist nursing care (e.g. stoma care nursing and diabetic nursing), in addition to the previous range of services.

While these two changes enable more practices to take part and a few more services to be purchased by GPs, they are ultimately administrative adjustments to the original SFH scheme. However, the two other developments are likely to have greater long-term impact: namely, the development of GP consortia and multifunds and the extensions of the fundholding concept to include a far wider range of services than previously in the form of the extended fundholding and total purchasing pilots.

Fundholding multifunds and consortia

The idea behind GP fundholders forming multifunds was to reduce the perceived disadvantages associated with single practice fundholding (e.g. the administrative time commitments) without losing the benefits of holding a budget. Multifunds were not part of the original official conception of fundholding, but have grown up in response to local circumstances and preferences as part of the plurality of NHS purchasing. In essence, multifunds are organisations constructed by fundholders who agree to pool varying proportions of their SFH management allowances in order to pay to employ their own managers whose job it is to support the purchasing activity at practice level. The secretariat of the multifund deals with all the administrative work of fundholding (e.g. associated with raising invoices) for all the practices and assists the individual practices to co-ordinate their purchasing activities. However, each practice is still technically responsible for its own budget and must account for its expenditure separately at the end of each year to the regional tier of the NHS. In this sense, the multifund only handles the pooled management allowances of the practices, not their purchasing budgets.

The multifund has an executive group of leading GPs who are usually elected and ceded authority to act on behalf of the constituent practices. In England, there are at least 16 multifunds covering around 2 million people in over 350 practices.[11] In the UK as a whole, there are now over 50 multifunds with over 3 million patients in all and an Association of Independent Multifunds (AIM).[14] They vary widely in size in that some multifunds have fewer than ten practices, while others include between 30 and 50 practices. Most cover 50–80,000 patients, but the largest has over 300,000. Since multifunds are aggregations of practices, not localities, they do not necessarily include all practices within a defined area and frequently stand-alone SFHs and non-fundholding practices are also present in the same localities.

Although specific research comparing their performance against SFH has not been undertaken, multifunds appear to have the potential to reduce the management overhead compared with SFH, since it is plausibly cheaper to manage a larger entity.[15] They are particularly attractive to small practices which are either anxious about the additional work involved in SFH or too small to reach the minimum list size to enter SFH and which must, therefore, join with others to pool risks. This may be the main advantage of multifunds. Another general attraction to the GP participants may lie at least partly in the fact that the organisation is controlled directly by the GPs who occupy executive positions and employ their own managers. This contrasts with many health authority-inspired schemes, such as locality commissioning, in which the managerial support is generally provided directly by the health authority. In some cases, multifunds were established to overcome the perceived inequity between SFHs and non-fundholding practices and to develop a more co-operative, less self-seeking form of purchasing than single-practice SFH.[14]

The amount of systematic information on the functioning of multifunds is very limited. However, they suffer from a number of potential weaknesses. For example, they may not be particularly stable organisations since they depend on the willingness of separate, autonomous practices to work together voluntarily. Difficulties have been reported in arriving at agreed decisions across practices and in maintaining consensus, despite the fact that all have some sort of system for obtaining the views of the constituent practices and for communicating decisions back to them from an executive group of GPs.[16] There is a fine balance to be struck by the multifund managers and leading GPs between centralised and decentralised ways of working, since previously independent practices may want to offload the clerical burden of SFH without at the same time giving up their purchasing freedom. Some multifunds also appear to be excessively dependent on the vision and commitment of a few of the GPs, which makes them vulnerable in the longer term. Finally, critics have pointed to the relatively weak formal accountability of the multifunds to their registered populations in the absence of any formal requirements to do so other than those set out in the SFH regulations. On the other hand, the GPs involved can point to the fact that they tend to practise in an area for many years, whereas health authority managers are constantly changing.

GP fundholding consortia are generally more informal alignments of SFH practices in which the practices agree to co-ordinate their purchasing intentions in specific areas in order to exert greater leverage over providers.

Extending the fundholding model

Fundholding has been held up by the Government as one of the unequivocal success stories of the *Working for Patients* reforms. Although the formal research evidence about the pros and cons of fundholding is far more ambiguous, suggesting a complex balance of costs and benefits[17, 18, 19, 20] with not all fundholders capable of grasping the opportunities presented by having their own budgets,[21] the NHSE announced two sets of pilot extensions of the SFH scheme in October 1994 as part of an initiative aimed *Towards a Primary Care-Led NHS* (EL (94)79):[13] first, extended SFH pilots in which selected fundholders opt to purchase in a single additional service area as if it were a part of their normal fund; and second, total purchasing pilots (TPPs) in which groups of SFHs join together in order to purchase potentially *all* HCHS for their patients on behalf of the local health authority. The NHSE indicated in *Towards a Primary Care-Led NHS* that the eventual role of the health authority would be to concentrate on developing a broad health strategy, including primary care, while monitoring and regulating the purchasing process which would be undertaken by groups of GP practices. Both extensions to fundholding were introduced as 'pilots' on the grounds that the resources which the practices were to use were still the responsibility of the health authority. Legislation would have been required to modify the SFH scheme to allow the fundholders to hold extended budgets in their own right. Nonetheless, it was clear that the two pilot schemes were regarded by the NHSE as part of the broadening and deepening of a fundholding model of GP influence over HCHS purchasing rather than as a development of the alternatives such as locality schemes and GP commissioning. In contrast to the rapid and contentious introduction of SFH, both sets of pilot projects are currently the subject of external research evaluation.[22, 23]

The extended SFH pilots cover services such as maternity, palliative care, services for seriously mentally ill people and complementary therapies, such as osteopathy. Purchasing in each service area is being implemented in six SFHs and compared with the experience of comparable SFH and

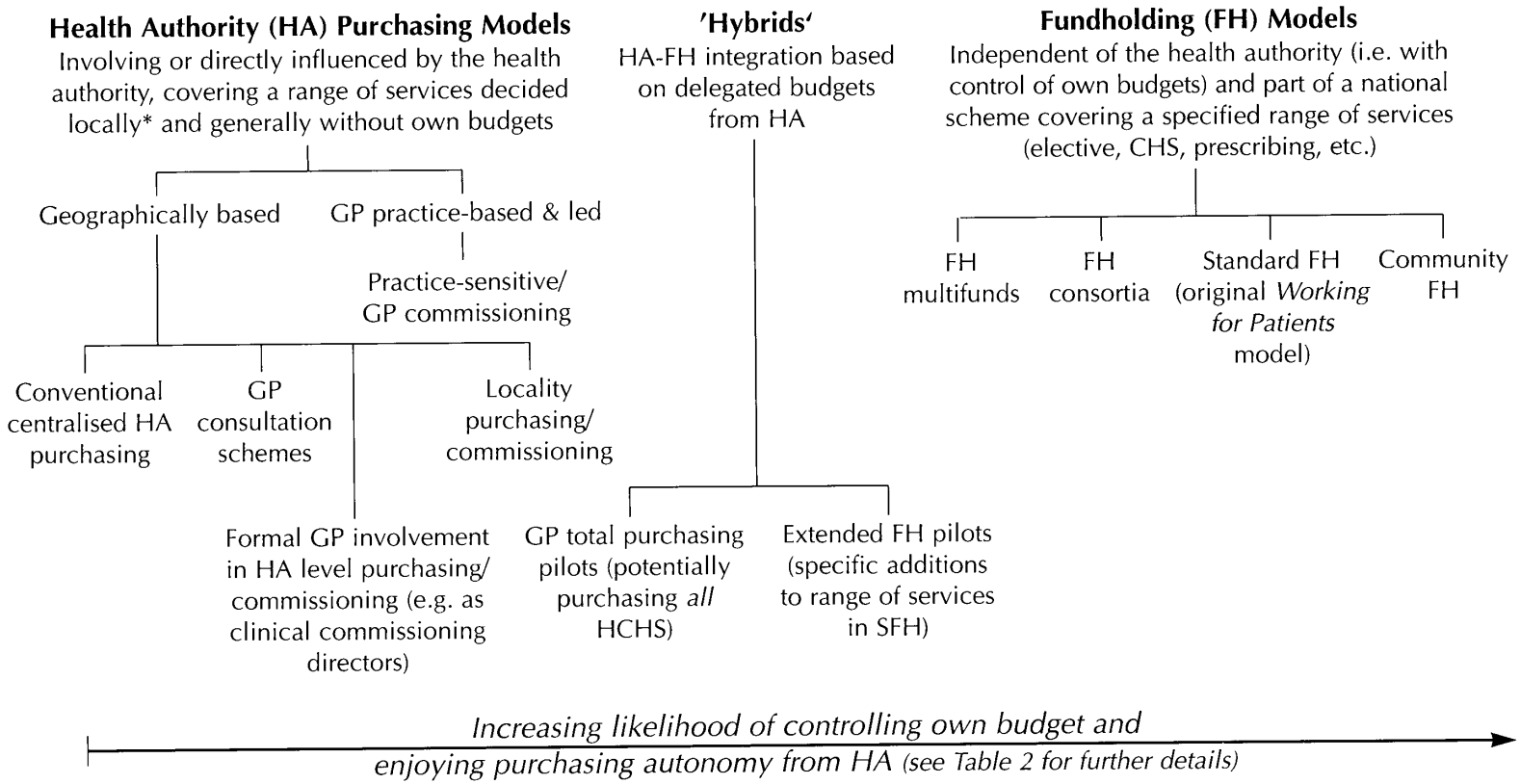
non-FH practices whose services are still purchased by their local health authority. Total purchasing is being piloted on a far greater scale and started with four pioneer projects which began purchasing potentially all HCHS for their patients in April 1994 ahead of the announcement of the national pilot scheme. These projects were followed by 53 national TPP projects in England and Scotland, which began their preparations for total purchasing in April 1995, with a view to active purchasing in 1996/97. They were joined by a second wave of projects in April 1996.[24] In addition to the national TPPs, there are locally inspired total purchasing experiments. Total purchasing is normally based on groups of practices rather than single SFHs in order to spread the financial risks inherent in managing a budget which potentially includes *all* health care, including emergencies over a larger population. However, there are single-practice sites. The populations covered range in size from 13,000 to around 80,000 people.

Unlike SFH, which by now has some degree of consistency of application across the UK and detailed rules and regulations, total purchasing will be defined and developed through its local implementation in the context of the interaction between the local health authority, which is obliged to support any local sites, the practices and the providers. For example, the TPPs can choose which services they wish to concentrate their purchasing efforts on and opt to follow the contracts of the health authority for the remainder. Apart from a nominal, introductory management allowance of £20,000 payable on entry to the scheme, all the management and support costs of the sites have to be found either from the resources of the practices or from the health authority. Since the resources going into the TPP budgets are still legally the responsibility of the health authority, unlike the situation in SFH, most of the projects are constituted as formal sub-committees of their local health authority. There is an expectation on the part of the health authorities that the TPPs will be subject to the same forms of accountability and performance review as health authorities. Ahead of any legislation altering the informal status of total purchasing, the activity purchased by the TPP with its share of the health authority budget will count towards the authority's overall Purchaser Efficiency Index. In all these ways, total purchasing may be seen, at least provisionally, as a form of *delegation* by the health authority for part of its purchasing to a relatively autonomous group of GPs. It is too soon to say what effects the TPPs will produce.

Purchaser plurality: towards a classification of purchasing organisations in the NHS

Having begun in 1991/92 with two contrasting models of how best to secure cost-effective health care sensitive to people's needs, the demand side of the NHS now boasts a plurality of different models. Each district now has its near-unique blend of purchasing carried out by the health authority at district level, by SFHs and community fundholders, by multifunds and other constellations of fundholding practices, through locality commissioning organisations and GP commissioning below the district level on behalf of non-fundholding and sometimes SFH patients and, now, increasingly through the pilot extensions of SFH and the total purchasing initiative, which is expanding rapidly both through the national scheme organised by the NHSE, and through a number of local experiments. In each district, the number of schemes, their share of the population and range of services purchased vary and, so too, do the levels of transaction costs generated for the health authorities and providers. Figure 1 attempts to summarise the range of models which may be present within the boundaries of health authorities. Compared with the situation at the beginning of the period of the so called 'NHS reforms', there is far more emphasis today on forms of purchasing involving all types of GP practices and health authorities working together.

The principal variables which could potentially distinguish the different models of purchaser organisation discussed above are numerous and are summarised in Box 1. Table 2 characterises the main variants of health authority purchasing and GP fundholding using the main variables from Box 1. It starts from the left with centralised health authority purchasing and the two main alternatives to fundholding which have emerged and is completed by SFH and its newer variants. From the features of the schemes it may be observed that the GP total purchasing pilots amount potentially to a hybrid of SFH and health authority approaches to purchasing. In practice, the differences between GP commissioning and GP total purchasing may turn out to be more in terms of their ideological origins and terminology than the way in which they operate. GP commissioning has largely emerged spontaneously among practices opposed to fundholding, whereas the national total purchasing pilot projects are aligned far more with the Government's policy of extending the SFH model and are dominated by SFH practices.



*Some FH practice involvement in some schemes, but generally involving non-FH practices

Figure 1 A Typology of Current Purchasing Organisations in the NHS

Box 1 Variables distinguishing different models of purchaser organisation

- The size of the population covered
- Whether the organisation is based on GP practices or geographically defined populations such as localities or 'natural communities'
- Whether the organisation was initiated by bottom-up (e.g. by the GPs themselves) or top-down (e.g. by the health authority) action or whether it represents some mixture of the two
- Whether practices are in the scheme simply by virtue of their location or whether they have to elect to take part with others of their own choosing
- The nature of the commitment which membership of the scheme places on participant practices
- The degree of budgetary control exercised by the scheme (e.g. whether an actual budget is allocated to the scheme or an indicative sum identified) and whether those taking part take independent purchasing decisions or simply advise others on how to put their views into practice
- Whether the practices involved have any direct financial incentive to take part (e.g. whether GPs are paid for their time, whether management costs are paid for or whether it is possible to make 'savings' from a purchasing sum which may be invested at practice level)
- How the resource base for the scheme, whether it is an actual or indicative sum, is calculated and its relative generosity *vis-à-vis* other local purchasers
- Whether the scheme is restricted to fundholders only or whether all types of practices can take part
- The range of services over which the scheme aims to exert some sort of influence or actually negotiate contracts, and whether the scheme can select on which services it wishes to concentrate its purchasing effort
- The organisational complexity and cost of running the scheme
- The nature of the external accountability and managerial relationships between the scheme and the wider NHS (e.g. the contrast between the relative freedoms afforded to SFHs as against the requirements for upward accountability placed on health authorities)

Table 2 Profiles of current purchasing models in the NHS, 1996/97

	Conventional HA purchasing	*Locality commissioning*	*Practice-sensitive commissioning/ GP commissioning*	*GP total purchasing pilots*	*Extended FH pilots*
Population size	**250,000 plus**	**40–60,000**	**Average 180,000**	**13–80,000**	**6–15,000 (as for SFH)**
Practice or locality/ geographically based	Geographical boundaries	Usually geographic though sometimes practice-based (volunteer)	Usually (volunteer) practice-based; based on groups of practices	Practice-based (volunteer); usually groups of SFHs	Practice-based (volunteer)
Involvement of FHs	Not directly	Primarily non-FHs but FHs involved sometimes	Primarily but not exclusively non-FHs	Exclusively SFHs	SFHs only
Degree of budgetary control over funds to purchase services	Own capitation-based budget	Not generally any devolved budgets (i.e. commissioning rather than purchasing)	Sometimes indicative or devolved budgets from HA (mixed capitation/ activity basis)	Delegated budget from HA	Delegated budget for extensions of SFH
Payments to participants for management	Professional managers paid by HA	Often paid co-ordinator/locality manager (paid by HA)	Sometimes GP sessional fees from HA to take part in purchasing	Variety of management fees/support from HA and regions	Variety of management fees/support from HA and regions
Range of services purchased/ commissioned	All HCHS (minus that of SFHs)	Varies, emphasis on needs assessment/locality profiles	Varies, can be wider than locality schemes	Potentially *all* HCHS but normally a sub-set in practice	As for SFH, plus one of a range of specified services (e.g. maternity, mental health, etc.)
Management structure/organisation	Bureaucratic hierarchy with GP advice on purchasing	Locality groups/GP fora and GP representatives	Sometimes paid GP committee to advise HA purchasing	Usually formal sub-committee of HA with specific powers	As for SFH – practice-based
Degree of autonomy from health authority/ influence over health authority	n/a	Modest – usually orchestrated by HA	Greater than locality schemes – usually GP-initiated	Similar to SFH but HA input to decisions	Similar to SFH

cont.

Table 2 *(cont.)*

	FH multifunds	*Standard fundholding*	*Community fundholding*
Typical size	**50,000–250,000**	**5,000–15,000**	**3,000–5,000**
Practice or locality/ geographically based	Practice-based (volunteer)	Individual practices (volunteer)	Individual practices (volunteer)
Involvement of FHs	SFHs and CFHs only	SFHs only	CFHs only
Degree of budgetary control over funds to purchase services	Own budget top-sliced from HA (capitation with activity element)	Own budget top-sliced from HA (capitation with activity element)	Own budget top-sliced from HA (capitation with activity element)
Payments to participants for management	Variety of management fees, support from HA and regions	Variety of management fees, support from HA and regions	Variety of management fees, support from HA and regions
Range of services purchased/commissioned	As for SFH. Specified elective inpatient care, most outpatients, CHS, diagnostic tests, direct access, drugs, practice staff	Specified elective inpatient care, most outpatients, CHS, diagnostic tests, direct access, drugs, practice staff	Most CHS, drugs, diagnostic tests and practice staff
Management structure/ organisation	Practice-based and joint managers appointed across all practices in the multifund. GP representation on board of multifund	Practice-based through FH manager	Practice-based through FH manager
Degree of autonomy from health authority/influence over health authority	Large degree of autonomy and some influence over HA	Large degree of autonomy, some influence over HA but less than multifund	Large degree of autonomy. Relatively little influence over HA

Chapter 2

Is there a convergence of thinking on the future of NHS purchasing of hospital and community health services?

In an earlier part of this book, we discussed the Conservative Government's latest thinking in the form of the Executive Letter and accompanying booklet *Towards a Primary Care-Led NHS*.[13] In summary, it appeared to be advocating general practice-led purchasing of HCHS (possibly with some involvement yet to be determined by other primary care providers), with the health authority gradually withdrawing from the direct purchasing of services in favour of a monitoring and regulatory role, combined with an unspecified responsibility for developing and implementing a local health (as against health *services*) strategy in collaboration with other public agencies such as the local authority. Similar statements have been made both by Labour and the Liberal Democrats, which indicates the force and appeal of the thinking underlying the original SFH concept. These will be briefly discussed in order to reach a view about whether a convergence of view is occurring.

Labour's proposals for reforming the internal market

In the summer of 1995, the Labour Party published a wide-ranging discussion paper on health policy which, although not amounting to manifesto commitments, nonetheless gave an indication of the direction of thinking in the party.[25] The document stated that an incoming Labour government would abolish single-practice SFH within about two years of coming to power on the grounds that it is too costly to administer and too inequitable in its current form. New fundholders would not be permitted to join the fundholding scheme during the phasing-out period. Beyond this, Labour would not indulge in any major upheaval in the organisation of the NHS. The emphasis would be on a pragmatic adjustment.

The purchaser-provider distinction at the heart of *Working for Patients* would be retained along with the Conservative Government's assumption that health authority purchasing is generally insufficiently responsive to the needs and views of local communities. In its place and in place of fundholding, a system of *GP commissioning* would be developed in consultation with GPs, in which groups of general practices would work in partnership with their local health authority to purchase health services. All practices would be able to participate. Bureaucracy would be minimised by abolishing costly billing processes, and all patients would have equal access to treatment.

The term 'commissioning' was used instead of 'purchasing' to indicate that the practices involved would not be buying services from their own budgets, but rather they would be located within a structure in which their views were influential with the health authority as resource allocator on their behalf. The lead GPs in the commissioning groups would be paid for their time spent on planning and purchasing services using some of the money saved by abolishing SFH with its assumed higher transaction costs. The GP commissioning groups would be allocated a shadow budget with which to make planning recommendations which would be implemented by the health authority on their behalf. Health authorities would be obliged to ensure that their plans reflected the views of their local GPs. At the same time, it looks from Labour's subsequent thinking that GPs would be guaranteed freedom to refer their patients wherever they liked, thus ending the system of health authority contracts with specific providers. It was not stated how this might be achieved within a purchaser-provider system with cash limits. Neither the 1995 document nor a subsequent statement in July 1996 [26] includes much detail of how the scheme might work, including no indication as to the range of services which the GP commissioning groups might influence. The document and more recent statements by the then Shadow Health Secretary were both imprecise as to whether the GP commissioners' views could prevail if the health authority opposed them.

Explicit reference is, however, made in the document to the example of the Nottingham GP commissioning scheme and to the work of the National Association of Commissioning GPs. The Nottingham scheme has been widely reported and is said to share many of the strengths of

fundholding without the additional costs of the bureaucracy required when practices have their own budgets and providers have to negotiate separately with each SFH. It is claimed that the GP commissioning group has been able to secure service improvements and that the key to influence, rather than having a budget, is collaboration within a local NHS culture which recognises the value of a primary care perspective on purchasing (see above).

Liberal Democrat proposals for the reform of the internal market

In the autumn of 1995, the Liberal Democrats outlined their views on the development of the purchasing function in the internal market.[27] Like the Labour Party, the Liberal Democrats were concerned at the 'two-tier' Health Service which they saw SFH institutionalising, but coupled this with a stronger belief in the importance, for securing change in services through the purchaser-provider split, of general practices being given an actual allocation of money rather than an indicative sum. They proposed that *all* practices in each health authority area should be allocated a fair budget by the health authority in order to circumvent the built-in inequity of fundholders and non-fundholders. Then the practices could choose either to purchase independently very much as the current SFHs, but within a stricter framework of accreditation and regulation (e.g. fundholders would be permitted to spend their savings only in ways agreed in advance with the health authority), or opt to purchase services as part of a local GP consortium, or, finally, to allow the health authority to manage their funds on their behalf. The health authority would also be required to formulate a local health plan and to agree it with all the local practices so that it became the framework within which all the local purchasers operated.

The Liberal Democrat outline said little about the range of services which each type of purchaser would be able to purchase, focusing instead on the advantage of allowing *all* practices to hold a budget. Aside from a stronger system of external controls over fundholders' actions and a stronger system of accreditation of purchasers to assess their fitness to take on the task, the Liberal Democrat proposals appeared to be very close to the Conservative Government's position.

Convergence?

Despite the paucity of evidence on the comparative merits of the different approaches to securing more and better services with the same volume of resources (essentially the same advantages are claimed for schemes such as GP commissioning as for SFH), there would appear to be a growing convergence of thinking from the three main political parties as to the broad features which should be adopted in NHS health care purchasing in the future. For example, the Conservative Secretary of State for Health, Stephen Dorrell, agreed in March 1996 to consider the possibility that GP commissioning might be put on a similar footing to GP fundholding (i.e. to reimburse GPs for time devoted to commissioning in the same way as in fundholding) and stated that, 'there is no single blueprint and the Government has never suggested there should be'.[28] Similarly, the Labour Party appeared to be softening its antipathy to fundholding by hinting at about the same time that it might accept some form of fundholding as long as it was undertaken by groups of practices representing all GPs and patients in a locality and as long as the practices were made to be properly accountable for the decisions they took.[29]

As a result of such thinking, it is possible to extract a large number of shared beliefs between the main parties (see Box 2). The principal *disagreement* between the parties, and perhaps more broadly in the NHS, concerns the importance of holding a budget in the process of influencing the pattern of services purchased. Here there is a clear and potentially crucial distinction between Labour, which favours shadow or indicative budgets, and the other two main parties, which favour genuine budgetary delegation to practices. The principal difference of *emphasis* between the parties concerns the degree and nature of external scrutiny and regulation which should affect the actions of general practice-based purchasers, where Labour and the Liberal Democrats both appear to favour a greater degree of control over the freedom of action of fundholders and others than the Government. Another possible difference in emphasis concerns the weight which each party would place on a system of purchasing on behalf of a voluntarily enrolled population (the GP's list) and a system based on purchasing for an administratively defined population. In principle, this distinction should have significant consequences for the organisation and focus of NHS purchasing. However, there is no evidence on which to base an argument.

Box 2 Assumptions about the future organisation of NHS purchasing shared by the main political parties

- GPs should be centrally involved in shaping local health strategies and in purchasing health services, but this should include, if possible, all GPs, not just the current SFHs
- The purchaser-provider distinction is a worthwhile innovation and should be retained
- General practices making purchasing decisions must be accountable to the wider NHS for these decisions and must take national policies into account
- The future of purchasing lies not in reinforcing a dichotomy between health authority and SFH approaches, but in new ways of combining the insights generated by the fundholding experience with the virtues of planning services to meet the needs of populations
- All purchasers should be funded on the basis of a fair system of capitation
- The leading professional group in purchasing at this stage should be the general practitioners rather than any of their colleagues in primary care
- GP purchasers' incomes should not be directly affected by their purchasing decisions.

Chapter 3

Do the convergent views offer an adequate model for the future?

Although there appears to have recently been a considerable convergence of views in the UK on the future configuration of the commissioning and purchasing function, this does not automatically equate to a solution to all the problems which the NHS reforms have been attempting to solve on the demand side of the health care internal market. Indeed, the current largely unscrutinised trend towards greater heterogeneity in forms of purchasing relationship raises at least as many issues as it solves, suggesting that the current plurality of organisations (see Figure 1) is likely to give way to further change in the not-too-distant future.

To discover which aspects of the theoretical and actual models of purchasing discussed earlier in this report are likely to produce improvements in the quality, efficiency and relevance to need of HCHS, at least cost, a better understanding is required of the potential consequences of the current models. The recent trend has been to decentralise purchasing to agencies serving smaller populations which rely increasingly heavily on the judgement and skills of GPs, but with little knowledge as to whether this is appropriate. It is unlikely to be helpful, if it ever was, to try to prove that one model is 'better' than the rest;[30] rather, the key questions which policy-makers need to ask are, 'what are the goals we want to achieve in purchasing' and 'which sorts of purchaser organisation may be most appropriate to achieve these goals'? In this chapter these key questions are discussed. Since there is strikingly little evidence available to assist the development of policy on purchaser development, much of the discussion has to be hypothetical.

Which goals do we want to achieve?

One could choose a number of aims for purchasing, although there may be difficulty prioritising them. The ultimate aim might be to achieve the delivery of high quality, effective, acceptable and equitable health care at

minimum cost. For this to happen, it is likely that the *purchasing process* should include: assessing the needs of the population for care; having adequate information about services to be purchased; having the ability to influence providers regarding the efficiency and quality of services; involving patients and offering them choice in decisions affecting their care; setting appropriate priorities; monitoring and maintaining equity; managing financial risk adequately; and minimising transaction costs.

Additional goals might relate to the *qualities of purchaser organisations* themselves rather than the purchasing process. Organisations should be sustainable, accountable, have an appropriate mix of skills, and there should be minimal or no conflict of interests operating.

To what extent are the current models of purchasing likely to achieve these goals?

Processes required to help meet the goals of purchasing

Assessing patient needs

Since the patients who demand care do not always need it, and vice versa, rational and efficient purchasing requires at least an acknowledgement of the importance of assessing need. In health authorities, assessing the health care needs of the population is generally carried out by public health staff, who are able to influence the purchasing process to varying degrees. In fundholding practices, this activity is rare, and purchasing, and indeed the process by which the purchasing budget is set, are almost entirely driven by demand and the clinical experience of the GPs. The obviously low priority of needs assessment on the current agenda in general practice (and even in some health authorities) partly stems from the already large agenda of change that general practice has had to deal with since the late 1980s, partly because of the failure of public health professionals to articulate, in terms meaningful to GPs and health authority managers, the rationale for assessing need (as opposed to meeting demand), how practically to carry it out, and how to use the results to benefit the population. Conducting a needs assessment also requires time and specialist skills, for example in epidemiology, which generally GPs do not have and may not be interested in acquiring.

While there are examples where public health professionals have been seconded to work with fundholding practices and locality purchasing groups to assess need, the results and benefits have not been clearly demonstrated – partly because of the difficulty in doing so. Without a clear impact as a result of effort, it is unlikely to take root in general practice – fundholding or not. As a result, assessing the needs of populations remains almost entirely an activity carried out in health authorities.

Another dimension to consider here is the fact that the practice-based population is essentially an enrolled population, whereas a health authority or locality population is based on geography. Where it is important to take into consideration geographical factors or variables collected on a geographical basis (such as the 1991 Census, deprivation, or mortality data) when assessing needs, this will be more problematic at practice level, as has been shown in a recent study.[31]

One might, therefore, argue that the most appropriate arrangement would be a joint effort, with public health staff in health authorities taking the lead to assess needs and working with general practices or localities. But as the purchasing responsibilities of health authorities are curtailed because of greater numbers of fundholders, and with the current level of ambivalence in general practice, needs assessment is unlikely to be higher on the agenda outside health authorities without further action.

Obtaining adequate information about services

The policy of devolving budgets for services to practice or locality level makes assumptions about the knowledge and information available to, and usable by, the practice or locality staff involved in purchasing (mainly the GPs) which is appropriate for purchasing. But can it be assumed that GPs either have adequate information to purchase a range of services or have the capacity and willingness to use it? Obviously, GPs have a good deal of day-to-day knowledge of the more common services to be purchased, such as elective surgery. But what about services for which GPs have less experience, such as specialist tertiary services? What is the relative importance of formal sources of information as against personal experience in making effective purchasing decisions?

It may be helpful to make the distinction between two broad types of information. The first might be called 'descriptive' information about local services, such as the type of care offered, by whom it is offered, the availability of that care, and the experience of patients using it. The second is 'evaluative' information, for example on the effectiveness or cost-effectiveness of a treatment or broader service. This type of information or 'evidence' may not be available on local services, but instead may have to be derived from an amalgam of findings from published studies such as the NHS *Effective Health Care* bulletins[32] or the Clinical Standards Advisory Group's guidelines (e.g. on management of low back pain).[33]

GPs are likely to have descriptive information mostly about services for common, straightforward conditions. The fundholding scheme originally allowed GPs a budget to purchase care for these types of conditions – mostly elective surgery and outpatient care. These are services for which demand is predictable, treatments are elective and generally straightforward, and which are provided by the majority of acute hospitals – giving GPs both a choice of provider and an adequate knowledge with which to make an informed choice.

GPs may have little or no recent descriptive knowledge of specialist services, such as paediatric cardiology, organ transplantation, neurosurgical and specialist cancer care, clinical genetics and forensic psychiatry, and to keep up with recent developments is likely to be too time-consuming to be feasible.

For both common and rarer treatments, GPs are much less likely to have or use 'evaluative information' than health authorities. Such information is often in short supply and, even when available, may be too time-consuming to read, and its practical use in decision-making may be far from clear. As a result, busy GPs are unlikely to use 'evaluative' information and even health authorities (where there are designated public health staff to interpret the information) show few signs of using it. This may change with the policy push towards 'evidence-based medicine'.[34]

The theoretical benefits of giving GPs a budget and allowing a choice of provider are to improve the quality and cost of local services through GPs articulating their and their patients' needs and demands more accurately

through the contracting mechanism, and for providers to compete for those contracts. But these theoretical benefits will only occur if GPs have adequate 'descriptive' and 'evaluative' information to be able to articulate the requirements for a good quality service, if there is enough information for GPs to make a judgement about the quality of local services, if there are enough providers to compete for care, if the GPs are interested in changing providers, and if competition actually results in improved quality and cost.

Some of these preconditions may hold for the basket of services purchased in SFH, but may not hold for more specialist services, such as paediatric cardiology, organ transplantation, neurosurgical and specialist cancer care, clinical genetics and forensic psychiatry. As argued above, GPs are likely to have limited knowledge and information available to purchase such services appropriately. In any case, there may only be one provider to choose from, and competition may result in duplicated facilities and, therefore, be undesirable. In these circumstances, one could argue that it is inappropriate for GPs or small purchasers to have the main responsibility to purchase care for these services. For similar reasons, it may not even be appropriate for health authorities to purchase these specialist services. Indeed, a key question is whether the purchaser-provider split itself is an appropriate mechanism to ensure that patients needing these services can access them: some type of centrally planned and resourced system may be optimal.

There are other less specialised, but still uncommon services, for example palliative care or otolaryngology, for which GPs may have some knowledge and experience, but not to any great extent. In these circumstances, there is a role for purchasing organisations covering larger populations (health authorities), which are likely to have more descriptive knowledge, to take the lead in purchasing, but perhaps influenced by the collective experience of GPs – as in the case of forms of locality purchasing and models like that of Bromley referred to above.[8]

Therefore, if one were to develop a hierarchy of purchasing organisations based on the criteria of GP knowledge about services and the potential for and desirability of competition, it might be more appropriate to have three levels of purchasing for different sorts of services:

- very specialised services could be funded and planned through a central system and outside the internal market, for large populations;
- very common, elective treatments could be funded through practice budgets or possibly, as discussed below, via patients directly (see option 8, page 60), for populations which are the size of a large practice;
- the rest could be purchased through an organisation covering a population at least the size of a current health authority.

Influencing providers

What are the features of purchasing or purchasing organisations which most influence providers? Does holding a budget make a difference or can influence be generated in other ways? Are purchasers who pursue what Hirschman[35] calls a 'voice' strategy (i.e. exerting influence over public services through representation and involvement in decision making) more or less effective than those who pursue or threaten to pursue an 'exit' strategy (i.e. exerting influence by moving their business between providers or threatening to do so)? How important is the size of the purchasing organisation: are smaller purchasers (who are also providers, i.e. GPs) likely to command more influence with acute providers than larger purchasers (such as health authorities), possibly because of their more detailed knowledge about local services?

To date there has been no systematic research to compare the effectiveness of various models of purchasing, including their influence on providers of secondary care. However, there are published studies of single models which document their actual or perceived impact. For example, Glennerster *et al.*[36] followed the experiences of fundholding practices in three regions and found that fundholders reported a marked change in power relationships as a result of holding a budget, which enabled them to make changes in secondary services. Glennerster *et al.* concluded that SFHs represented a successful example of an 'exit' strategy in which holding a budget significantly sharpened the response from providers to their wishes. Several questionnaire surveys of fundholding GPs have reported improvements in the process of care, such as prompter receipt of discharge letters and results for diagnostic tests, which fundholders generally attribute to holding a budget.[11, 37, 38] Anecdotally, the vast majority of fundholders are convinced that holding the purse strings directly has been

a powerful lever to making change and that other forms of commissioning are, by definition, less effective.

The small amount of research on the effectiveness of purchasing by health authorities alone or through locality purchasing or GP commissioning groups has largely been conducted using case studies. Results again show improvements, largely to the process of care, such as improved communication with trusts and positive effects on quality of service and waiting times.[39, 40, 41] GP non-fundholders who were organised into locality commissioning groups in Nottingham report bringing about major changes, but without the costs of fundholding.[10] It appears that the influence of the Nottingham group stems from its size and the detailed information on services derived from the GPs involved, which enables the health authority to purchase with greater confidence (a 'voice' strategy, in Hirschman's terms [35]). By contrast, there are anecdotal reports of GP fundholders who are involved in locality commissioning of services outside the scope of the SFH scheme who compare the locality schemes unfavourably with fundholding because of the lack of direct purchasing power by GPs when the health authority retains the budget.

While these reports provide useful description of how *structures* (such as organisational changes) and *processes* (such as culture) may have changed as a result of different models of purchasing, what we can conclude from them about *outcomes* is limited, except to note that proponents of each model are convinced of its effectiveness and efficiency. While there has been a relatively little analysis of the impact of fundholding on clinical care, patient satisfaction or choice, equity or efficiency (and the results available are inconclusive [17, 18, 20]), next to none has been carried out on the alternative models. However, such research is difficult to undertake because the effect of holding a budget or not is frequently confounded by the personal characteristics of the purchaser and the influence of the local environment and managerial culture on the ability to bring about improvements in services (details of which sorts of purchaser have developed in different settings and why are given below). In a very obvious way, the leverage which any form of purchasing organisation can exert will depend on the configuration of accessible providers of health care and the scope for choice which this offers. If, for example, supply-side policy in the NHS were to lead to more decentralised forms of provision (e.g. the revival of

small community hospitals), then it is possible to envisage an increase in the choice available to purchasers.[42] This, in turn, might allow smaller purchasers to operate more effectively than would otherwise have been the case.

In the absence of evidence from the UK, experience from other countries suggests that direct purchasing by GP-based agencies has attracted considerable support.[43] There is some evidence to suggest that where GPs hold their own budgets, the probability that they will be able to make worthwhile changes to health care is increased.[43] But how far this is due to actually holding a budget or having more detailed local knowledge of services, or a greater capacity or willingness to point out perceived deficiencies in local health services and use the tools of the market to improve them is unclear. One might argue that each of these is likely to influence providers, especially in areas for which GPs have good and relatively uncontentious information about local services, such as the quality of discharge letters, waiting times, and speed of receipt of results of diagnostic tests, rather than specific aspects of clinical care. It may be that those who argue that holding a budget is irrelevant to making changes in services and those who argue that it is essential are both correct in that they are referring to bringing about different sorts of changes. Holding a budget may enable an individual practice to bring about different changes from schemes which involve participation by large numbers of GPs in influencing health authority purchasing. The former is likely to focus on small-scale improvements in provider efficiency and the latter on altering health authority and provider strategic thinking over a longer period of time.

Increasing patient involvement and choice

The thrust of policy in recent years has been to encourage consumers of health care to become more informed about health services. For example, *The Patient's Charter*[44] aimed to provide consumers with more information about NHS services. As a result, many trusts and practices produced leaflets and other material describing the services that consumers could expect. Coupled with changes which made it easier for patients to change practices, this initiative aimed to promote the idea of patients 'shopping around' for both primary and secondary care. The aim of these policies was to increase the 'empowerment' of patients and as a result, so the logic ran, providers

and purchasers would be more responsive to patients, thereby improving the quality and appropriateness of services.

If greater patient influence is desirable, which purchasing models are appropriate to achieve this aim? Three elements of patient influence in purchasing are potentially relevant here:

- giving patients the power to purchase NHS care directly;
- giving patients greater opportunity to choose an appropriate purchaser;
- increasing patient involvement in setting priorities for the use of the purchasing budget thereby improving accountability (this is discussed below in the section on accountability on page 46).

Giving patients the power to purchase care

One of the reasons for introducing fundholding was to encourage providers to be more responsive to GPs and, through them, to their patients. The experience of fundholding indicates that, for a variety of reasons, providers have been more responsive to GP fundholders than to health authorities.[36] Yet a criticism of fundholding remains that it is more about GP choice than patient choice. The mechanism whereby patients could exert influence over their fundholding GP is unclear. Are there some services which it is more appropriate for patients themselves to purchase directly using NHS funds, for example, through a voucher system?

Currently, there are two main ways in which patients can purchase care directly: through direct out-of-pocket payments for care provided by the NHS or the private sector, for example *in vitro* fertilisation; and through private health insurance (mostly for outpatient care, elective surgery and diagnostic tests). But is this level of purchasing appropriate? There are very well-rehearsed reasons why a free market in health care with patients as consumers is not desirable; for example, the information imbalance between patients and doctors. But does this hold true for all types of care, or are there some services for which there may be enough information for patients to make an informed choice of whether or not to have treatment and where to receive it?

One could argue that uncomplicated elective treatments, similar to those covered by the standard fundholding scheme, might be one such area.

Disregarding for a moment the significant likely problems of allocating resources directly to patients, the perverse incentives which might follow, and the implications for priority setting if a patient is advised by their GP about their (uncomplicated) condition, the treatment and the quality of the local providers, is there any reason to believe that a patient would not make appropriate choices about their own care?

Giving the patient purchasing power rather than their GP for these types of conditions may have advantages, for example patients' criteria for choosing a particular provider may be different to that of their GP. Also GPs would have to take into account patient wishes when choosing a secondary care provider; and patients would be encouraged to be more informed and exercise 'voice'.[35]

But there are likely to be disadvantages which would have to be anticipated and guarded against. For example: moral hazard may be a problem; the GP may need incentives to be fully informed to advise patients; setting an appropriate value for the voucher is likely to be difficult; patients who need more care than is covered in a voucher may be a problem; and ensuring that less demanding and less knowledgeable patients receive appropriate care will be a challenge. These may be too difficult and costly to overcome and should be balanced against the potential benefits, which could include a greater responsiveness of services to patients.

Giving patients more power to choose an appropriate purchaser

Along with the emergence of different types of purchasing organisations since 1991, it is notable how much emphasis has been placed on the role of the GP as the *agent of the patient* and how little emphasis has been placed on the ability of patients to judge the success of their agents and act accordingly.

Yet with the current trend towards giving GPs greater influence in purchasing, it may become increasingly important to find ways for patients to have the information and opportunity to exercise a choice not just between providers but also, where budgets are devolved, between primary care-based purchasers. With health authority purchasing, patients have had no choice of purchaser for most of their care and very little information to make a judgement on the competence of the purchaser. But patients

currently also have very little information about the extent of involvement of their practice (or others locally) in purchasing, the portfolio of services bought, whether the practice actually has its own budget, or the special interests or competence of the practice as a purchaser. Where GPs are taking on the responsibility for purchasing a significant range of extra services (such as in the new total purchasing pilot projects), there are no extra structures in place to give patients more information or a greater opportunity to exercise choice over their purchaser.

Two total purchasing pilot projects have provisionally announced their intention of expanding to take in all the practices within their local district and to undertake *all* the purchasing of HCHS,[45] thereby relegating the health authority to a monitoring and regulatory role. In these circumstances, there is little chance of patients being able either to choose between practices based on the type of purchasing they are involved in, or on the grounds of their abilities as purchasers. There is also little opportunity for patients to influence the practices' purchasing preferences.

A discussion of patients 'shopping around' for the best purchaser may seem fanciful in the light of statistics which show that most people enrol with the practice most accessible to their home and evidence that most patients are interested to receive information about their condition, their prognosis and the course of their treatment, but far fewer are interested in information to choose their purchaser or their provider.[46] Nonetheless, there is some evidence that certain types of patient *do* seek out particular sorts of general practice for very specific reasons already, and this idea could, therefore, be developed in the future. For example, some patients from minority ethnic communities may choose a GP from a similar background. GPs who are skilled in managing the health care needs of substance abusers, or who are paid by the health authority so to do, tend to find that patients with drug problems are attracted to living close to their surgeries. Patients with major chronic diseases such as diabetes may be influenced to join practices with a particular expertise and/or clinics for the disease and/or links with a specific hospital clinical team. It will become more relevant for patients to have information on purchasing preferences and abilities as well as services provided when GPs or localities, rather than the health authority, have the direct responsibility for purchasing, because interests, skills and priorities are likely to vary widely among smaller purchasers. Policy-makers

could take steps to make it easier for patients to find out about local purchasers and act on this information.

Setting appropriate priorities

What size and type of purchasing organisation is most appropriate for setting priorities? Currently, health authorities set priorities in broadly two dimensions. The first is between broad service groups: for example, emergency and elective care, or between specialties. At this level priority setting is informed, to a greater or lesser degree, by knowledge of past use of services, the effectiveness of treatments, local and national political pressures, national policies and public preferences. The second is between individual patients: for example, patients who are referred by their GP to a provider with whom the health authority has no contract (as extra-contractual referrals (ECRs)). ECRs are approved on an individual basis, typically by a public health physician working in the health authority.

Devolving budgets to GPs has implications for the setting of priorities in both dimensions. First, while GPs generally have knowledge of the level of services used by their patients when drawing up their purchasing intentions, the extent to which GPs have or use information on the effectiveness of treatments, local or national policies or public preferences, is unclear, and it is doubtful that the information is used at all. While this may also be the case for other models of purchasing where a health authority has overall responsibility (such as locality purchasing), the health authority is at least held to account for its purchasing priorities by regions through the corporate contract. This structure of accountability is currently weak or non-existent for GP fundholders despite recent efforts to strengthen it.[47] (See below for more on this theme.)

Second, GPs may be better placed to judge the merits of each ECR: unlike health authorities, GPs know the individual patients concerned, are technically available 24 hours a day and, therefore, may be able to give providers a quicker response than health authorities. On the other hand, GPs are not in a position to judge the priority of *their* patients for an ECR relative to patients from another practice – and, therefore, may not be fully aware of the opportunity costs of ECRs. While the health authority is arguably better placed to set priorities between competing ECRs across practices, in reality, requests for ECRs are not likely to be made in a neat

order, for example, ranked by ability to benefit, during the financial year. Requests are more likely to be random and each case considered on its own merits.

There is, therefore, a role for both GPs to judge and argue the merit of an individual case for an ECR, and the health authority to provide guidance both to help GPs decide when a case may be high priority, to make an overall decision, and to monitor the consistency and equity of the decisions taken. Linked or integrated budgets would give both purchasers an incentive to heed each other's advice. (See discussion of *financial risk* in this section and Chapter 4, option 2, on page 55). The newer 'hybrid' forms of purchasing organisations, such as the national total purchasing pilot projects and the recent extensions of fundholding in which GP practices purchase on behalf of the health authority using part of its budget, may evolve in such a way as to address some of these issues of inter-related budgets.

Monitoring and maintaining equity

While providing equity of access for equal need is a basic principle of the NHS, in recent years far more attention has been paid in health authorities to other priorities such as efficiency. Part of this may reflect the central policy imperative to improve efficiency, and partly because assessing equity is not straightforward. First, it is necessary to decide upon the definition of equity to use (such as equity of access, or equity of use); second, to decide how best to measure access or use of services given the quality of the available data; and third, to decide what the differences observed are likely to mean. Health authorities have access to routine data across a large population on, for example, use of hospital care and patients on waiting lists, and are more likely to have the skills, capacity and time to analyse this information. While GPs, especially fundholders, may also have this information and other data, for example on consultations and referrals, they are unlikely to have the time or skills and computing capacity required. One might also argue that having lots of small purchasers monitoring equity for their (relatively small) registered populations is less valuable and more time-consuming than analysing equity across larger populations, particularly for services which are provided relatively rarely, such as tertiary services.

There are similar issues in relation to purchasing in order to maintain equity. Having more purchasers covering smaller populations of patients and with different contracts and priorities with providers may lead to a more uneven pattern of services than having a single purchaser purchasing for a large population. However, if maintaining and monitoring equity are a goal for purchasing, there needs to be more of an incentive for all the current forms of purchasing organisations to treat the issue as a priority.

Minimising transaction costs

Having a greater number and type of purchasing organisations is likely to increase the volume of contracting and therefore all the activity which goes with it, for example drawing up purchasing intentions, negotiating contracts, monitoring activity and finance, invoicing and payment. In this sense the existence of more organisations having direct responsibility for holding a budget must lead to higher transaction costs – indeed, the National Association of Commissioning GPs has pointed out that transaction costs of practices involved in commissioning are lower than those involved in purchasing through SFH.[10]

The type of contract is likely to be relevant too, since more sophisticated cost-per-case contracts are more expensive to administer than simple block contracts – witness the high costs of ECRs. A greater number of smaller purchasers is likely to mean increasingly sophisticated contracts, as is evident in SFH compared to health authority purchasing. But over time health authorities, if they remain as purchasers, are themselves likely to demand an increasing amount of information from general practice (for example on referrals to hospital), to understand more the nature of demands on their budget. Indeed, the current GP commissioning model also has appreciable costs which will increase if it becomes more common among non-fundholding practices:[48] for example, set-up costs, including information technology and management training, and continuing costs such as downloading and monitoring information on activity and finance for management from the health authority minimum dataset will be required.

Similarly, models which encourage greater patient involvement in purchasing or which allow more freedom for patients to choose among a range of purchasers may face greater demands for information, less perhaps

on activity and cost, but more on the quality standards specified in contracts and how providers live up to them.

Also transaction costs are not the only costs to consider here. The costs of regulating and monitoring various models of purchasing will also add to administrative costs. The greater independence and potential conflicts of interest inherent in each model (see below for more on this theme), the more information will be required to monitor them.

However, over time increasingly sophisticated information systems are likely to result in easier routine monitoring and contracting which may reduce transaction costs in future. Similarly, as staff become increasingly familiar with contracting, monitoring and regulation, if contracts are allowed to run for longer than one year, or if the level of detail of quality specifications in contracts reaches a plateau, then these may also act to stem the rise in costs in future.

Therefore an NHS with a diverse range of purchasing models, a lot of small purchasers, more sophisticated cost-per-case contracts and greater freedoms for purchasers is likely to face higher transaction and monitoring costs compared to models where health authority purchasing and GP commissioning predominate.

Managing financial risk

It is obvious that organisations purchasing care for large populations are likely to be less vulnerable to random fluctuations in the demand for, and therefore cost of, care than organisations covering smaller populations. But how large must the population covered by a purchaser be to manage financial risk comfortably, and for which range of services? Taking advantage of the range of purchasing models which are developing (see Table 2) and the services they are already purchasing, the following theoretical division of responsibilities is worth putting forward to stimulate debate:

- a population base of at least 250,000 (the approximate size of a smaller health authority) for purchasing expensive and unpredictable treatments where the financial risk needs to be spread over a relatively large population. For example, organ transplantation services, neonatal care, neurosurgical services, secure beds, ITU, major trauma care, and

screening programmes where investment in expensive equipment is required (e.g. the breast cancer screening programme) would come into this category;

- a population base of at least 50,000 (the approximate median size of a locality or a total purchasing pilot project) for purchasing more 'routine' emergency care;
- a population base of at least 10,000–50,000 (the size of a large practice or group of practices) for purchasing elective treatments, mental health care and care for people with learning difficulties;
- a population size of at least 3,000–10,000 (the size of a small practice) for purchasing community health services and perhaps, in future, social care.

The suggestions made above flow from the existing trends of purchasing rather than from empirical research – of which there is next to none. The suggestions are also made on the assumption that the purchasing organisation itself bears the financial risk rather than pooling risk with another organisation, for example, a larger NHS purchaser or a private insurance company.

But it may not be feasible for each to manage a separate budget and financial risk for their own range of services, as much of the recent evolution presumes. If the budgets for each purchaser are not integrated, then the larger purchasers (buying more expensive treatments for which demand is relatively more unpredictable) will not have access to the elective budget (managed by smaller purchasers) in order to cushion the financial risk when necessary. Without this ability, services bought by the larger purchaser may be prohibitively expensive to insure on the private market. Instead it may be preferable for the larger purchasers bearing the greater financial risk to have the ability to influence the volume of purchasing in the smaller purchasing organisations; for example, through the ability to slow down referrals to hospital for elective treatments in certain circumstances.

Therefore, if purchasing is to be carried out at different levels for different services then it may be best for purchasing organisations to have *integrated* or *linked* budgets with consent from the smaller purchasers for the larger ones to access their budgets in a limited range of situations. This could be organised either by a system of representation in which each of the smaller

purchasers plays a part in the decision-making of the larger, or through a formal delegation of purchasing power to the smaller purchasers in which spending beyond a negotiated ceiling by the larger would trigger a reallocation of resources from the smaller in certain circumstances. This would be an attempt to reintroduce into the current system of separate budgets some of the flexibility which was available to health authorities before 1991. At present, the existence of ring-fenced elective care budgets in the form of fundholders' allocations considerably reduces the room for manoeuvre of health authorities when they have to pay for emergency care towards the end of the financial year.

Integrated budgets across larger and smaller purchasers, with the smaller purchasers involved in the management of the larger entity, also have relevance when considering possible overspending by the smaller purchaser. At present, any overspends by fundholding practices are met ultimately by the health authority. Yet up to now, health authorities have had little say in how fundholders manage their budgets. Having linked budgets would lead to much greater scrutiny of each level of purchaser by the others.

However, it may be argued that this may be no different, in practice, from the hierarchical budgetary structures found in many large vertically integrated organisations; in which case, the smaller purchasers may simply be swallowed up by the larger ones. Therefore, if smaller purchasers are valued, there must be safeguards to ensure that their purchasing power is protected while giving purchasers of emergency care some flexibility.

Qualities required of purchasing organisations

Sustainability

One approach to considering the question of which models of purchasing are likely to be sustainable is to try to understand whether, and, if so, why some forms of purchasing have become more prevalent in certain types of areas. This may give some hint as to where the different models are most suitable and sustainable, and may provide clues about their generalisability.

Many have noted that practices which joined the fundholding scheme tended to be large, well organised, and located in relatively affluent areas, whereas those that did not, particularly in the early waves, tended to be

located in relatively deprived inner city or rural areas.[11] This could be because GPs who joined the scheme were already working to improve services locally, for example, through links with the local health authority, providers and other professional groups. Joining was a logical extension of this effort.

GPs may have been involved in this way because of personal or environmental factors. For example, the GPs joining fundholding, particularly in the early stages, appear to have been the innovators who wanted to be at the forefront of *any* new developments.[49] Environmental factors relate more to the demands of the local population and the extent to which they allow GPs to be involved in 'extra-curricular' activities. For example, fundholding practices are more likely to be located in affluent areas where residents are more likely to have private health insurance, be healthier and, therefore, make fewer demands upon the NHS.[11] In these areas, the practice population is relatively stable and because the location of the practice is desirable, it is easier to attract staff and, having trained them, to keep them. Under these circumstances, the GPs may be less stressed, patient demand may be more predictable and the practices may have a stable body of staff and a well-developed infrastructure (such as information systems).[50] As a result, the GPs may be more able to cope with the extra demands on their time required for purchasing. Another key factor may have been the GPs' relationships with local consultants. There is some evidence that early fundholders had particularly close relationships with their consultant counterparts.[51]

The converse is likely to be true for GPs serving deprived areas. Here there are greater demands on the GPs' time such that they may be too preoccupied with other more immediate tasks (such as meeting the demand for primary care and fulfilling the GP contract) to become involved in purchasing or commissioning of any sort. In cities, for example, GPs tend to be older and work in single-handed practices – severely limiting their capacity (their time and their ability to nurture the professional networks required) to be involved directly in purchasing. All this suggests that a range of purchasing organisations will need to be available in different areas of the NHS irrespective of the overall merits of particular approaches.

However, whatever the details of the local environment, a key factor to consider in relation to sustainability of involvement of all GPs in

purchasing or commissioning is the effect these activities have on the practice and GPs as providers. Many GPs are naturally resistant to taking on the managerial role required for purchasing especially if this creates extra workload or a detrimental impact on the primary care provided in general practice. Adequate support will be required to ensure that the standard of primary care provided is maintained.

Similarly, for involvement by practices in purchasing to be sustainable, effective allegiances will be required between GPs and other staff within the practice and, in the case of localities and multifunds, across practices (see section on skills below). This requires leadership and managerial skills which have not yet been a feature of training in general practice.

The second set of reasons why fundholders tended to come from particular areas may relate to the fact that the fundholding scheme was a highly politicised and contentious policy. Whether a practice joined or not was likely to have been influenced, at least in the early days, by the ideological persuasion of the GPs. GPs in more affluent Conservative-voting areas were more likely to join.

Other reasons why practices became fundholders or were more involved in locality purchasing/commissioning schemes might have included those listed in Box 3.

A combination of all these factors is likely to have led to a greater prevalence of some models of purchasing over others in different locations. Policy-makers seeking to extend the involvement of GPs in purchasing or commissioning will need to consider whether policies offering incentives to individual GPs (such as a management allowance in the case of GP fundholding, or possibly time off for training) will be more fruitful in future than policies which make the environment more conducive to the participation of willing GPs who are currently prevented from being more involved in purchasing. Of particular value here would be greater scrutiny of practices and locations where the GPs are not actively involved in any form of purchasing. Without appropriate help these practices may be left behind in terms of gaining expertise and influence in purchasing to the ultimate disadvantage of their patients, and potential of loss of equity of access to care.

Box 3 Possible reasons why general practices became involved in fundholding or alternative forms of GP involvement in purchasing

- The perceived or actual effectiveness of the health authority as a purchaser (e.g. cosy relations between the health authority and the local providers may have resulted in a slower pace of change than that desired by local GPs)
- The relationship of the GPs or practice to the health authority
- The ideology or effectiveness of the health authority in its role to encourage or discourage practices from holding budgets or becoming involved in purchasing/commissioning
- The experience of other local fundholding practices or commissioning groups
- How the GPs predicted the evolution of health policy and whether they saw fundholding as inevitable ('We'll all have to join fundholding so why not get in early')
- The lure of funds to develop the infrastructure of the practice for fundholding
- The quality of the services offered by local providers – if poor (in terms of quality and access) this may have galvanised GPs into greater involvement in purchasing of all types
- The relationship between GPs and local hospital consultants
- The health authority making decisions which were unpopular with the local GPs; for example, by disinvesting from a favoured provider such as a teaching hospital, local community hospital or A&E department or not investing in a favoured provider (for example, in a local private hospital offering a service competitive on quality and price).

Whichever approach is taken, as long as involvement by practices in forms of commissioning or purchasing remains voluntary, the differential capacity of practices and the differences in populations served in different areas indicate that a range of models of GP involvement will continue to be needed for a considerable time, even with greater external support. Therefore if the thrust of central policy is towards devolving purchasing, it is not plausible to force it into the shape of one favoured model, such as was the case with SFH, and expect success for all. Successful devolution is likely to mean diversity.

Appropriate mix of skills

In devolved purchasing models such as locality commissioning, where GPs' opinions about local services are sought, the skills required of GPs are mainly to have a good knowledge of local services and a flair for problem solving. However, where budgets are devolved from health authorities, a whole range of extra skills are required (which have been outlined above) such as:

- financial management (an average fundholding practice manages £1.7 million, but only 13 per cent of fundholding managers have qualifications in accountancy, although 53 per cent have 'A' levels or their equivalent [11]);
- knowledge of demands and needs of the population – the latter requires skills of needs assessment (usually found in epidemiologists and public health physicians) and both require good information on activity at practice level which information systems in hospital and general practice are increasingly able to provide;
- awareness of current evidence on the effectiveness and cost-effectiveness of alternative treatments;
- management, teamworking skills and an ability to delegate;
- ideally, a knowledge of the ethical principles of priority setting (in the absence of a national framework for rationing resources).

Some of these skills are in short supply in health authorities, and it is likely they will be even harder to find in localities and practices. In this respect, practices may not be an appropriate building block for purchasing services directly. In addition, the extent to which general practices are developed in organisational terms is very variable.[21] Many have noted the need for greater development of primary care staff to work as a team rather than in a hierarchy headed by GPs. Even within group practices, it is not always apparent how far the GPs themselves act as a functioning team rather than as a collection of individuals working autonomously. This pattern of working may be exposed more starkly if a new responsibility is taken on by the practice which is not directly related to providing primary care – for example, purchasing secondary care. This is illustrated in fundholding practices where usually one GP and one or two administrative staff are enthusiasts and the major drivers of the scheme, whereas the other GPs and staff are largely agnostic and simply tolerate the scheme as long as it does not impinge on them. The same may be true in other practices involved in

locality purchasing or GP commissioning. Part of the lack of participation in purchasing by the other partners or non-medical staff may be because of a lack of incentives or support. As argued earlier, staff in practices where the external environment is more demanding may particularly require a great deal of support. The Audit Commission's study of fundholding concluded that practices which were better organised and which had invested in better management *were* able to bring about more changes in local services than those which were less well-developed managerially.[21]

General practice, in general, may seem a strange basis for 'primary care-led NHS' at present, given the emerging consensus that morale in GPs is low and the numbers of trainees entering general practice has fallen to levels which are causing concern in the profession and, latterly, in the wider Health Service.[52, 53] While the status of GPs *vis-à-vis* their consultant colleagues may have risen because of fundholding and the emphasis in health policy on primary care as the focal point of the NHS, potential recruits may be put off by the prospect of becoming both an accountant and rationing agent for government in addition to having to be an ever-busier clinician. It would appear that some GPs have enthusiastically taken up the management role explicit in SFH by becoming powerful clinician-managers, while others have avoided this role, believing it to be inimical to general practice values.

All this points towards the need for significant investment in many practices or groups of practices to increase organisational capacity, especially where budgets are to be devolved to practices which have not so far had any experience of this – a point made in the recent review of fundholding by the Audit Commission.[21] This could be provided in the form of training (for example, in management or accountancy) with or without rewards to compensate (for example, extra remuneration to take on purchasing responsibilities), or more time off (for example, a sabbatical). However, whether the benefits would exceed these costs is unclear. The administrative and managerial costs of devolved purchasing schemes are likely to be significant in a health system operating on a fixed budget. However, when all, or the vast majority, of purchasing has been devolved from the health authority, one would expect to see some savings at the centre to offset, at least in part, the additional costs at the periphery.

Accountability

Developing effective means of making GP purchasers accountable for their decisions appears to be a major problem in all the countries which, like the UK, are experimenting with some form of quasi-market.[43] It was not until December 1994, after three and a half years of SFH that the Department of Health issued guidelines entitled *An accountability Framework for GP Fundholding*,[47] which suggested that the accountability of fundholders should from now on be demonstrated in four main areas: management accountability; accountability to patients and the wider public; financial accountability; and professional (peer) accountability.

The guidance suggested how accountability could be demonstrated in each area. For example, management accountability could be shown through submitting an annual practice plan to the health authority, announcing major shifts in purchasing intentions and reporting and reviewing performance with the health authority. Accountability to patients and the public could be shown through publishing information, involving patients in service planning and review, and dealing appropriately with complaints. Financial accountability could be strengthened by preparing annual accounts for review by the Audit Commission, having expenditure and activity monitored by the health commission monthly, and stating how the fundholder would contribute to the local efficiency targets set by the NHSE. Professional accountability would be through the General Medical Council and through clinical audit.

While helpful, the accountability framework offers guidance only: the extent to which health authorities and GP fundholders are actually following the guidance is unclear. For example, a review by the Association for Community Health Councils in England and Wales found that CHCs had difficulty obtaining even basic information about fundholders' purchasing plans and that consultation on them was rare.[54] The Association concluded that, 'progress depends very much on the goodwill of local fundholders'. Another example is the contribution of fundholders to local efficiency targets. Since fundholders have generally not had to 'sign up' to these through a corporate contract or other system, unlike the health authorities, it is doubtful whether they are contributing. The issue of accountability to the public of purchasing organisations (especially health authorities) has been debated recently by those considering

the merits of either having democratically elected representatives (for example, local authority councillors) on the board of the health authority purchaser, or making local authorities responsible for NHS purchasing at local level[55] (see Chapter 4).

Peer review or professional accountability for the *provision* of health services occurs through a variety of means: for example, through the system of medical audit; and through routine data on the processes of care which are often fed into statutory performance indicators, such as waiting times. However, currently there is no such peer review of the *purchasing* of health services by GP fundholders or by health authorities, except through the corporate contact drawn up between the latter and the regional offices of the NHS Executive. Because of the implications for equity, efficiency and quality of care as well as financial probity of potentially large numbers of relatively inexperienced purchasing organisations, such as fundholders and locality groups spending a significant amount of NHS funds (possibly where there may be conflicts of interest between purchaser and provider roles, as described below), it is likely that there will have to be greater scrutiny in future of their purchasing and, increasingly, their providing ability. This may take the form of formal accreditation of the purchasing organisation by the health authority or some other independent organisation ('Ofhealth' or, perhaps more memorably, 'Ofsick'!)

The pressure to relax the restrictions on what GPs whether a SFH or total purchasers can pay themselves to look after their own patients will result in a further related need for a body capable of accrediting both GPs, their facilities and their support staff to carry out more complex or specialised treatments. The suggestion in the NHSE's statement *Towards a Primary Care-Led NHS*[13] is that a reconfigured local health authority or some variant could take on these regulatory roles and could, therefore, purchase the primary care *provided* by the GP purchasers. In this way the purchaser-provider split would be reconstituted for primary care between individual or grouped general practices and the health authority, and for HCHS between NHS trusts and total purchasing groups of general practices.

However, new models of devolved purchasing, particularly where GPs actually hold a budget for care, are likely to stimulate greater peer review *within* the purchasing organisation. This is because, unlike health authorities,

GPs have direct control over the amount of care received by most of their patients, for example, in terms of the volume and type of referrals and drugs prescribed. GPs who share a budget (and the savings made) will be interested in scrutinising, for example, the referral and prescribing patterns of their colleagues. Where the health authority holds the budget for purchasing and GPs have influence but are not given any rewards through any 'savings' made (such as in locality purchasing, GP commissioning or as clinical commissioning directors, see Figure 1, on page 15), then there may be less incentive for internal peer review by GPs. In these cases, the health authority may need to take a more active role in peer review, although past efforts to influence referrals and GP prescribing by health authorities met with considerable resistance (indeed, fundholding was introduced partly to tackle this long-standing perceived problem).

Formal systems of accountability bear a particular burden when individual users are relatively uninvolved and powerless. Since 1991, there have been two major policies which aimed to 'empower' patients: *The Patient's Charter*[44] aimed to provide patients with more information about services; and the *Local Voices*[56] initiative in 1992 encouraged patients and the public to influence the shape of local services. The *Local Voices* initiative required all purchasers to canvas the opinions of the population they purchased care for, to give patients an opportunity to shape services. While there has been a lot of effort by health authorities to do so, major unresolved questions remain about how best to involve the public, how to incorporate their preferences into purchasing decisions and whether patients feel at all empowered by the process. Despite this, health authorities have made attempts to involve the public,[57] but far less activity has been in evidence in GP fundholding practices.[54]

Minimising conflicts of interest

If the GP primary care provider is also a purchaser, under current budgetary arrangements in which general medical services (GMS) and HCHS resources are separate, this could still lead to conflicts of interest (e.g. skimping on specialist care in order to protect fundholding 'savings', which can then be invested in the practice, or investing fundholding resources in services which primarily reduce the pressure on the GP, such as practice-based counselling, leaving the health authority to purchase services for more seriously disturbed people), although there is little evidence suggesting

this is a problem so far. However, a number of the total purchasing pilot sites are planning to pay their own GP colleagues to provide specialist services at practice level paid for out of their HCHS total purchasing budgets and are lobbying the NHSE to relax the regulations concerning what GPs can be paid from HCHS to care for their own patients.[58] The Government seems likely to respond by widening the range of procedures for which SFHs can pay themselves from their SFH or total purchasing budgets. The income could then, in principle, come to the practices in which the GPs have an equity share. As recently as 1992/93, GPs were allowed to set up limited companies and use funds from the fundholding budget to pay themselves directly (through the limited company) for providing care covered by the budget (for example, for providing diagnostic tests and minor procedures such as endoscopies). The impact was monitored by health authorities, and since the scheme resulted in abuse by several practices, it was soon stopped and replaced by new rules limiting the provision of 'secondary care' in general practices.[59] In other health systems, serious concerns have been raised about facilities in which doctors have a proprietary interest or where they provide a large range of ancillary services in their offices (e.g. dispensing drugs).[60]

There are more far-reaching implications for the delivery of primary care if the budget for general medical services (GMS) were to be integrated with the budget for HCHS and the budget were to be held by GPs. This is one of the ideas which was suggested for possible piloting in the October 1996 White Paper on primary care.[58] On the face of it, it makes sense to remove the divisions between these two budgets (or, indeed, the division with social services) since there are no such obvious divisions in the provision of care. A number of GP participants in the total purchasing pilots have argued to be given the complete primary and secondary care budget for their patients. This ignores the major potential conflict of interest that might result. For example, a conflict of interest may arise where a GP has a choice to invest in a service which could be provided by the hospital or by the practice in which the GP has a direct financial interest. Another example is where GPs in total purchasing sites contract for hospital A&E care (a lot of which is likely to be emergency primary care) and are also members of a local commercial or non-profit GP co-operative (providing out-of-hours emergency primary care). Since the salaries of GPs and other practice staff are currently paid through separate GMS funds, a formal integration of GMS and HCHS could push GPs into a difficult choice

between protecting or increasing personal incomes at the expense of buying needed services. Efficiency and the quality of patient care may be compromised as a result of these perverse incentives.

Therefore, if primary and secondary care budgets were integrated and controlled by GP purchasers, the purchasing and providing activities of GPs would have to be carefully monitored (see above for the section on accountability). But policing this area is likely to be difficult and expensive, and there may be resistance from GPs who see themselves as professionally accountable to the General Medical Council rather than to an organisation such as a health authority or other local regulatory or contracting body.

A joint budget for HCHS and GMS held by GPs would also blur the boundaries (and potential benefits) of the purchaser-provider split and create a new form of vertical integration. One response to this problem would be to set up a separate purchaser of GMS care at local level, for example, in the shape of the health authority or other organisation which could contract with individual practices or networks (see Chapter 4). This would spell the end of the national GP contract in favour of local individually negotiated contracts.[58] In some cases, the health care purchaser might purchase primary care in new ways rather than from general practices. For example, some community trusts are now employing their own GPs in order to provide out-of-hours services on contract to the health authority. Even acute trusts could be involved by providing GP and nurse-led services as an extension of their A&E services. The private sector might also be interested in tendering for health authority primary care business.[61]

Vertical integration would be greatly increased if the purchaser of GMS was a NHS acute trust. The advantages for the trust would be obvious – to protect income by creating incentives for the GPs to refer patients preferentially to its facilities. Alternatively, a case for a primary care trust has recently been made in which GPs and community managers would manage the trust to provide primary care services and would also be responsible for purchasing secondary care.[62] Some or all of the GPs could be salaried both in their provider and purchaser roles, potentially reducing some of the perverse incentives inherent in a system in which GPs are both purchasers and providers (see options 6 and 7 in Chapter 4). If GPs operating in this way were to remain as SFHs or total purchasers, this would

generate even more potential for conflicts of interest and perverse incentives.

These trends towards various forms of vertical integration involving primary and secondary care providers, which are discussed for possible experimentation in the October 1996 primary care White Paper,[58] are reminiscent of trends in California where organised physician groups have negotiated with health maintenance organisations (HMOs) to receive a capitation sum in order to purchase services in what they judge to be the most efficient way possible.[63] These groups bear much of the financial risk and allow HMOs to delegate much of the work of managing care. The HMO then takes on an oversight role which might be similar to one possible future role for integrated health authorities if all purchasing were to shift into primary care. In this example, there are, in effect, two purchaser-provider splits – between the HMO (the insurer, like the UK health authority) and the physician group (the contractually responsible purchaser) and between the physician group and the service providers.

Conclusions on current models

The discussion above has focused on how far the current plurality of purchasing organisations measures up to the stated desirable features of both the purchasing process and of purchasing organisations. Also discussed was how far the current models may be able to achieve these goals given the right incentives, support or regulation. The overall conclusion, therefore, is that further extensions of the role of GPs as purchasers can only sensibly proceed with careful monitoring and regulation.

Three dimensions of purchasing organisations featured prominently in the discussion – the size of the population covered, the level and mix of skills within the organisation itself, and the types of services to be purchased. The discussion thus far has hinted at a resolution of the tension between these dimensions. This is summarised in Table 3 which sets out the size of population covered, together with the type and mix of skills of the purchasing organisation which may be most suitable to achieve the desirable features of the *purchasing process* for three broad types of services – common elective surgery, emergency medical and uncommon or tertiary services. In shorthand, four types of purchasing organisation are listed: R, where the population covered is similar to the current Regional Office level of the

Table 3 A possible division of purchasing responsibilities for different types of health services

Processes required to meet the goals of purchasing	*Main types of services to be purchased*		
	Common and elective	**Less common and emergency**	**Rare or needing tertiary care**
Needs assessment	HA	HA	HA
Obtaining information about services	P, L	HA	HA
Influencing providers	P, L	P/HA	HA/R
Patient involvement and choice	?P, L	?HA	?HA
Setting appropriate priorities	P, L	HA	HA/R
Monitoring and maintaining equity	HA	HA	HA
Minimising transaction costs	HA	HA	HA
Managing financial risk	P, L	P, L, HA	HA

Key: R = purchasing at regional level
HA = purchasing at current health authority level
L = purchasing at locality or general practice group level
P = purchasing at individual practice level

NHSE; HA, where the population covered and type and mix of skills are similar to those currently at health authority level; L, equating to a locality group or network of practices; and P, purchasing at individual practice level. For simplicity, the table only includes the processes required to meet the goals of purchasing down the left-hand column since the qualities required of the purchasing organisations themselves (e.g. sustainability, accountability, etc.) seemed less directly connected with the types of services being purchased than with the intrinsic features of particular organisational forms. Table 3 sets out a possible division of labour between different levels and types of purchasing organisation which is similar to option 2 (Table 5) in the next chapter.

There are two main conclusions from Table 3 and the discussion so far. First, each of the different models of purchasing currently in existence has a different combination of merits and drawbacks in the selected dimensions discussed. The models which evolve or are permitted to develop in the NHS will depend on the choices made about the most appropriate dimensions on which to judge purchasing and purchasing organisations and the weight to be given to each. Second, further extensions of the role of GPs as purchasers can, therefore, only sensibly proceed with careful monitoring and regulation. In the next chapter, some options for future purchasing models are described, their merits and disadvantages are highlighted and areas where regulation or monitoring may be required are outlined.

Chapter 4

Some policy options for the future development of NHS purchasing

A number of possible policy responses to the limitations and potential problems of recent developments in the purchasing of health services in the UK have been touched on in the previous chapter. Many of the difficulties with current trends concern the increasing precariousness of the purchaser-provider distinction, the need to make GPs accountable for their purchasing and providing performance, and the lack of patient involvement in new and increasingly influential forms of purchaser organisation. While there appears to be unanimity about the desirability of maintaining a purchaser-provider split in some form, if a degree of contestability is to be built into the internal market, trends since 1991 have all tended, paradoxically, towards its erosion since they have involved giving GPs increasing influence over HCHS purchasing while directly involving them in providing an increasing range of primary care services. This trend has been continued in the October 1996 primary care White Paper.[58]

In part, the problem is magnified precisely because policy-makers wish to offer GPs, who have the advantage as purchasers of the insights derived from their provider status, a relatively high degree of autonomy coupled with control over their own budgets in order for them to have the incentive and opportunity to make creative purchasing decisions. Yet giving GPs responsibility for resource management on behalf of the State means that they have to be supported in so doing and regulated and held to account for their use of public money, particularly when the incentives inherent in managing a cash-limited sum include scope to make purchasing decisions directly with a view to their impact on GP income and workload. For example, the recent trend towards total purchasing of HCHS by collaborating groups of general practices theoretically increases the possibility that GPs will be influenced by such perverse incentives.

Eight options for the evolution of NHS purchasing

Given an understanding of recent developments, a range of possible options for the future of purchasing can be constructed, each of which in different ways attempts to respond to the limitations inherent in current models which were discussed in the previous chapter, particularly how to reduce the likelihood of conflicts of interest, how to make purchasers more accountable and how to make their patients more influential. Some of the models may be worthy of piloting a systematic evaluation.[58] Each option is based on the organising principle of some form of separation between purchaser and provider roles in the NHS, but each could, conceivably, exist *within* an NHS governed by a number of different types of governance or upward accountability from the current system based on ministerial appointees on health authorities to more democratic and representative approaches to public accountability. Some possible models of this type are discussed after each of the eight purchasing options has been discussed in outline.

The list of purchasing options is not intended to exhaust all possibilities. For example, all the options discussed here are predicated on the assumption that the finance allocated to purchasers of whatever type is generic; that is, it is not allocated exclusively for a particular service. However, it is perfectly possible to imagine, for example, a national cancer service with cancer service purchasers allocated funds only for cancer care in which these purchasers establish systems for efficient disease management which cut across existing service divisions. Standard fundholding is currently a not dissimilar model for purchasing exclusively elective care. Similarly, none of the options allows individual patients a direct role in purchasing their own care, rather they play a part in the more radical options by deciding which purchaser to enrol with, thereby affecting purchaser income.

The eight options fall into two main groups in terms of their degree of radicalism. The less radical options largely accept the location of the current purchaser-provider split in the NHS (and its partial erosion through fundholding), the existing national GP contract, the budgetary separation of HCHS, GMS and the resources of the local authority social services and current notions of patient enrolment with a general practice. They do relatively little to address the potentially perverse incentives and lack of accountability of purchasers, together with the absence of patient choice between purchasers discussed above, but they do have the obvious merit of not requiring major upheaval in the system.

The less radical options include the following possibilities:

1. *The modified status quo* – the current trend towards a plurality of purchasers would continue, but with a more explicit recognition of the likelihood that different forms of purchaser organisation and budgetary devolution will work better in different circumstances. As a result, the extension of the various models currently in existence (see Figure 1 on page 15) to new sites would be more closely regulated, and research would be carried out systematically comparing them with one another in different contexts to ensure a more appropriate mix of models. Standard fundholding would be accepted as only one of the possible ways forward with other models receiving official support and funding (for example, in recognition of the time GPs spend on their commissioning work under other arrangements).

The strengths and weaknesses of this option would be largely the same as currently exist until evidence suggested that one or more models appeared to work particularly well in specific circumstances.

2. *Purchaser specialisation* – a formally agreed division of purchasing responsibility would be introduced for different service areas between a number of different purchasing models based on acquiring knowledge as to which purchaser purchases which services best in which circumstances (for example, after undertaking the research suggested in option 1, above, or simply based on the epidemiological logic). For example, the system might give SFHs responsibility for purchasing elective acute care together with most or all of the other services currently included in the fundholding scheme and GP total purchasers the responsibility for purchasing the remainder of the acute services such as maternity care, with all the less common and emergency acute care purchased by the health authority. Care for mentally ill people and those with learning difficulties might be purchased jointly by the health authority and the local authority social services based on their relative expertise and a willingness to take on the responsibility and the management of the budget. High-cost, highly specialised ECRs could be decided by panels comprising GPs and public health physicians (see above for discussion of this) or planned on a regional basis with a budget 'top-sliced' from all the local purchasers. Each purchasing organisation would be allocated its own budget, ideally based on some form of weighted capitation. Whatever the precise division of

purchasing responsibilities, it would be worth considering the scope for linkage or virement between the budgets of the different levels or agencies involved in purchasing in order to ensure the most efficient and equitable use of resources between competing claims (see above, for discussion of this). Table 3, on page 52, provides one version of this *purchaser specialisation*.

While this approach might ensure that services were purchased by organisations with appropriate subject-area expertise and access to relevant information on needs and cost-effective responses, the system would be administratively complex. For instance, the system of linked budgets between smaller and larger purchasers could risk the demands of one destroying the budgetary autonomy of another – the demands of emergency care might always deplete the budgets of the SFHs. Another issue which would have to be resolved would be how to decide the relative priority and share of resources to be allocated to each of the broad service areas (e.g. between elective surgery and services for people with mental health problems). The system would also be complex for providers who would have to deal with a number of different types of purchaser. However, this might be little different from the current situation.

3. *Building on the GP total purchasing experiment* – primary care-based purchasing organisations directly holding their own capitation budgets for all HCHS, either based on groups of existing general practices as in the current total purchasing pilot projects, or in the form of new organisations not necessarily led by GPs, could be introduced. The local health authority would allocate a fair capitation budget to each of the purchasing organisations within its boundaries each of which could have a population anywhere between 15,000 (or whatever size of population is eventually shown to be the UK minimum for risk management) and 100,000 depending on local circumstances. The health authority would cease to purchase any services, but would instead be required to monitor and, if necessary, regulate the purchasing behaviour of the primary care-based purchasing organisation. The health authority would also set the local health strategy within which the purchasers operate and might market the services of specialist staff (e.g. in finance and public health) to the purchasers.

Since the GPs, as in the current TPPs, would be acting both as a purchaser and as a provider, it would be important to retain some local oversight of the purchasing process to minimise the effects of any conflicts of interest.

Very large primary care-based purchasing organisations might have to be refused in case they came to operate too much like the health authorities which they were intended to replace. They would also mean that patients had no effective local choice of purchaser.

4. *Total purchasing without the health authority* – this model would closely resemble option 3 above, but without monitoring and regulation by the local health authority or the setting of a local health strategy which the primary care-based purchaser would be expected to work within. Instead, monitoring and regulation could be provided by the regional office of the NHSE which would also allocate the budget to each purchaser, thus removing a level of management. In spring 1996, the Wakefield TPP announced plans to grow into a district-wide total purchaser with the eventual aim of replacing the health authority, which would gradually wither away in its current form. Although current legislation would prevent this occurring fully, the Wakefield plans are not dissimilar to this option and its predecessor.

The main problem with this option would be how to maintain effective oversight of the appropriateness of the local purchasing process and its relationship to national policy goals via a regional organisation. A system of sophisticated performance management would have to be developed to enable the regional office to deal with what could amount to four or five times as many purchasers as there are currently health authorities.

5. *GP commissioning* – this would consist of GP commissioning groups working within shadow or indicative budgets from the health authority and including most or all general practices in an area as proposed by the Labour Party. A notional fair capitation budget would be calculated for all practices in a health authority's area against which their use of resources would be monitored to ensure equity. However, practices would not be compelled to take part in commissioning. Those which did not would rely on the health authority to purchase services on their behalf. The health authority would thus remain in existence and be required to demonstrate that it had conscientiously incorporated into its purchasing intentions the views and priorities of the GP commissioning groups, which would have monies to pay selected GPs for their time spent on Health Service purchasing and priority setting, as fundholders are now.

Although the GP commissioning groups might have lower management costs than the fundholders they replaced, there would still be a relatively large number of local commissioning groups together with purchasing by the health authorities which would absorb significant amounts of resources to operate. In addition, there might have to be ways of resolving differences of view between the GP commissioning groups and their local health authorities, since the GP commissioners would not have the budgetary autonomy to go their own way.

The more radical options, by contrast, address more directly some of the issues and concerns identified in this book involving recent trends in NHS purchasing:

6. *Integrated primary care-based purchasing organisations* – this option would be similar to options 3 and 4 above, but with the important addition of integrated budgets covering both HCHS and GMS (i.e. a total health services budget for their patients). The purchasing organisation could either be based on existing general practices, in which case the local health authority would negotiate a contract with them for the *provision* of primary care and the organisation would purchase the rest, or it could be separate from general practices, in which case it could, in turn, contract with local GPs and others to provide primary care services and could also purchase other services. Alternatively, the organisation could employ its own salaried GPs to act as primary care providers and purchasers of other parts of health care. Under whichever form, the purchaser organisation would have the freedom, at least in theory, to choose how it obtains primary, secondary and tertiary care for its population (i.e. how vertically integrated it wishes to be).

The model, which is not based on existing general practices, reduces the scope for perverse incentives for the primary care provider and would be closer to a US health maintenance organisation conceptually than anything seen hitherto in the NHS. It would involve ending the national GP contract in favour of local contracts held either by the health authority or by the health care organisation, perhaps containing 'core' national standards (e.g. a periodic requirement to demonstrate competence to practise).[64]

In the future, patients with differing needs, at different stages in the life-cycle or with different beliefs about health care priorities might be enabled to enrol with different primary care-based purchasers who would guarantee to provide the full range of GMS and purchase those HCHS which they did not feel able to provide themselves in return for an agreed capitation fee from the NHS provided by the health authority. This might increase the level of choice of purchaser open to patients. The income of the organisation and its clinical staff, including its GPs, would be dependent on its ability to attract and retain patients by matching their needs with its services and quality standards. Unlike in current purchasing based on general practice, the general practice-based version of this option would make the personal incomes of the GPs dependent on their ability to attract patients and to manage all their health service requirements within the resultant budget. As a consequence, there may be greater accountability to individual patients. However, it would be particularly important under such a model to find an adequate means of compensating those primary care-based organisations a higher proportion of whose registered population than average consisted of heavy users of care to avoid adverse selection. Another requirement would be to ensure adequate oversight and regulation of the behaviour of these purchasers, if the income of providers were to be made dependent on their ability to manage their resources.

Ideas like this are already being discussed in the NHS and are described in the October 1996 White Paper.[58] Both community and acute trusts in the NHS are talking about offering to provide a primary care service, including general practice, on contract to a local integrated health commission in places where the current arrangements for general practice do not lead to an adequate service.

7. *Integrated health and social care purchasing organisations* – this would be like option 6, above, but the organisation responsible for a total health service budget would also be responsible for the social care element in the local authority social services budget. There have been calls from leading SFHs for some time to allow local mergers of the HCHS and social care budgets in order to purchase integrated packages of care, particularly for elderly people across the health and social care divide. A number of the TPPs have plans to experiment with local, informal mergers of health and social care budgets.

Although this option has a strong logic behind it in that people's needs do not divide neatly into health and social care elements, despite the current organisation of budgets and services, it would require either shifting a significant amount of local government finance into the NHS budget, which would be resisted by the local authorities, or it would require the local purchasing organisation to be accountable both to the health authority and to the local authority for different aspects of their purchasing. The *modus operandi* of the NHS and of local government are contrasting and might put the purchaser into an awkward position, for example, if there were a Labour central government running the NHS and a Conservative local council running the social services.

8. *A 'mixed economy' of NHS purchasing* – this option would be similar to 6 and 7, above, but based on allowing NHS and non-NHS bodies to contract to hold NHS funds in order to form a series of potentially competing health care organisations offering to secure for patients different health care packages based on a risk-adjusted capitation fee or voucher received from the NHS. There are already hints of a move towards some organisations of this sort in that some drug companies and private insurers have already expressed an interest in providing either a disease or a budgetary management service to SFHs and this role could be extended. The purchasing body might contract with GPs and other providers for them both to provide purchasing advice and services. NHS patients would be free to choose which of a number of competing organisations offering different health care packages to enrol with, each of which would be obliged to offer services for a range of conditions and types of need corresponding to an agreed definition of what the NHS should cover, but each could be encouraged to differentiate itself as to how these needs would be met. The system would either allow patients to 'top up' their NHS capitation fee using private insurance, or not, depending on the ideological slant of the prevailing government. The topped-up, 'NHS Plus' care could either be confined in its use to obtaining extra amenities or it could be used by individuals to augment their access to clinical services or it could be confined to waiting list-type treatments.

This model is closest of all to the Californian example discussed above (page 51), in which HMOs sub-contract their purchasing to capitation-funded physician groups which, in turn, purchase and/or provide health

care under the supervision of the HMO.[63] In this case, the HMO role would be played by the health authority (or possibly the regional office of the NHSE) on behalf of the NHS as a whole.

At present it is not legally possible for any organisation outside the NHS, public, private or professionally based, to use NHS funds to purchase care. But this may not always be the case. If purchasers were rigorously accredited, then this might open up the possibility of non-NHS organisations competing for NHS funds to purchase care (primary and secondary) for groups of practices or certain patient groups such as ethnic minority groups, elderly people, or mentally ill people (e.g. under a form of disease management arrangement), or, indeed, for all NHS patients willing to enrol with them. Although there is not space to discuss it here, this option also lends itself to an alteration of the financial base of the NHS. For example, the health care organisations might become 'sick funds' or social insurance funds collecting and managing the resources from an earmarked health service tax. These funds could be operated at arm's length from government and could include personal contributions.

This could lead to a rapid expansion of purchasers and competition between them. It would also require considerable monitoring and regulation (e.g. to prevent non-NHS health care purchasers refusing to accept high-cost patients). There would need to be regulation to prevent or mitigate potential conflicts of interest – for example, where purchasers developed a financial stake in local providers. If primary care were also to be purchased in the same way, this option, like a number of the previous ones, would lead to the loss of a national contract for GPs, to be replaced by a multitude of local contracts. It might also threaten the notion of a 'national service', in favour of competing local networks of purchasers and providers. However, the extent to which this came about would depend on the requirements placed on the purchasers to work within national policy goals. If this option were implemented allowing enrollees in the purchasing organisation to top up their NHS capitated payments to buy extra care, then access to health care in the UK might become less equitable than it currently is. This would need to be monitored across the country. For all the potential problems which such a system would bring, it would introduce a degree of demand-side choice and potential for competition into the NHS quasi-market which does not currently exist. This may become increasingly important if

unaccountable GPs and others are given freedom to make more and more purchasing decisions on behalf of groups of patients as current trends indicate.

Improving wider public accountability within the NHS

Each of the eight options for improving the demand side of the NHS could be considered in parallel with changes to the wider system of public accountability in the NHS which would particularly affect the structure and operation of the health authorities in their roles as 'insurers' and regulators of the purchasers. A number of changes have been proposed based on democratic and representative forms of accountability. These have been put forward as solutions to a perceived lack of democratic legitimacy of all current NHS purchasing bodies, including GP-based forms. In principle, each could exist in conjunction with any of the eight options for change to local purchaser organisation described above. Although there is not space here to develop and discuss these in detail, the main ones which have been canvassed are as follows:

1. Health authorities directly accountable (for example, for the services purchased on their behalf by primary care-based purchasers) to an elected tier of regional government in order to increase accountability in the NHS.

2. Increased purchaser accountability through the introduction of directly elected health authorities which could either be responsible for all purchasing or could operate as financing and regulatory bodies in relation to primary care-based purchasers and others, depending on which of the different options for purchasing sketched above were pursued.

3. Local government control of the NHS in whole or in part (e.g. just HCHS funds or including GMS) with the option to introduce some local sources of funding for the NHS. The local authority could either undertake the purchasing function directly or could act as the source of finance and regulation for local purchasers (see above for possible options). As well as enhancing democratic accountability of the NHS, this scheme would allow direct budgetary and managerial links with social services, housing and environmental health departments.

Each of these three options for enhanced democratic accountability would alter the composition of the insurer/regulatory body at local or regional level charged with ensuring that NHS objectives are achieved by whatever means. Although conventional representative democracy does not appear to have been very successful as a means of holding health care professionals to account for the efficiency, equity and acceptability of their actions in those systems which have tried to use it, it might have more to offer in a system which retains devolved and/or quasi-market characteristics at local level in the relations between purchasers and providers.[55]

Assessing the eight purchaser options

In Tables 4 to 9, which follow, an attempt is made to assess the potential of each of the eight options discussed above to meet the requirements for an adequate model of NHS purchasing. Each table sets out the requirements grouped under the two broad headings used in the preceding chapter to discuss current arrangements; namely, the ability of the option to undertake the *processes required to meet the goals of purchasing* and its ability to conform to the *qualities required of a purchaser organisation*. For each requirement (e.g. sustainability of the purchaser organisation), a judgement is made as to whether this is likely to be a problem and, if so, how likely it is that monitoring and regulation by the health authority or another NHS body will be required. In this way, some of the potential merits and drawbacks of each of the eight options can be grasped in summary form. However, it will be readily apparent that in each case judgements are being made on hypothetical options based on very limited empirical evidence of the performance of current purchasing arrangements. Furthermore, the tables make no allowance for the possibility that certain options might work better than others, but only in certain circumstances.

Overall, it can be seen that no single model appears from this speculative analysis to have the potential to meet all the requirements without considerable monitoring, regulation or external support from third parties. Broadly, the more radical options such as numbers 6, 7 and 8 may have the potential to increase patient involvement and choice and, thereby, improve accountability to individual patients. These are the weakest features of the less radical options. The more radical options may also reduce some of the perverse incentives (conflicts of interest) which may occur when GP service providers are also put in dominant positions as purchasers.

They would tend to replace purchasing based on the current pattern of general practices with more highly managed organisations dependent for their income on their ability to attract patients. These options would, on the other hand, require considerable external scrutiny – for example, in order to prevent discrimination against potentially high-cost patients or to ensure that purchasers in areas with populations with high requirements for services would not be disadvantaged. The transaction costs of the more radical options might also be higher. On the other hand, the less radical options might perform relatively well on activities such as needs assessment, managing financial risk and maintaining equity without doing a great deal to improve public or patient accountability or reducing potential conflicts of interest faced by GPs.

Of course, not all the criteria in Tables 4–9 are of equal importance for effective purchasing. For example, option 5 (GP commissioning) looks promising according to many of the requirements for adequate purchasing. However, perhaps the biggest concern about GP commissioning is whether or not the GP commissioners will be able to bring about the changes that they desire since they are reliant on the good offices of the health authority to purchase services on their behalf. This ability may vary considerably from place to place, depending on the relationships which have been built up between the GPs and the health authority and on the perceived legitimacy of the GP commissioners as arbiters of the use of NHS resources.

Table 4 Option 1: The modified status quo

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)	Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)	Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing			
Assessing patient needs		✓	
Obtaining adequate information about services		✓	
Influencing providers		✓	
Patient involvement and choice			✓
Setting appropriate priorities		✓	
Monitoring and maintaining equity			✓
Minimising transaction costs		✓	
Managing financial risk		✓	
Required organisational qualities			
Accountability			✓
Minimising conflicts of interest			✓
Sustainability		✓	
Appropriate mix of skills		✓	

Table 5 Option 2: Purchaser specialisation

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)	Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)	Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing			
Assessing patient needs	✓		
Obtaining adequate information about services	✓		
Influencing providers	✓		
Patient involvement and choice			✓
Setting appropriate priorities		✓	
Monitoring and maintaining equity		✓	
Minimising transaction costs		✓ →	?
Managing financial risk	✓		
Required organisational qualities			
Accountability			✓
Minimising conflicts of interest			✓
Sustainability		✓	
Appropriate mix of skills	✓		

Table 6 Options 3 and 4: Building on the GP total purchasing experiment and total purchasing without the health authority

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)		Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)		Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing					
Assessing patient needs			✓		
Obtaining adequate information about services	✓				
Influencing providers			✓		
Patient involvement and choice					✓
Setting appropriate priorities			✓	→	?
Monitoring and maintaining equity			✓	→	?
Minimising transaction costs			✓	→	?
Managing financial risk			✓		
Required organisational qualities					
Accountability					✓
Minimising conflicts of interest					✓
Sustainability			✓		
Appropriate mix of skills	?	←	✓		

Table 7 Option 5: GP commissioning

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)		Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)	Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing				
Assessing patient needs	✓			
Obtaining adequate information about services	✓			
Influencing providers				✓
Patient involvement and choice				✓
Setting appropriate priorities	?	←	✓	
Monitoring and maintaining equity	✓			
Minimising transaction costs	✓	→	?	
Managing financial risk	✓			
Required organisational qualities				
Accountability				✓
Minimising conflicts of interest			✓	
Sustainability	?	←	✓	
Appropriate mix of skills	✓			

Table 8 Options 6 and 7: Integrated primary care-based purchasing organisations and integrated health and social care purchasing organisations

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)		Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)		Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing					
Assessing patient needs	?	←	✓		
Obtaining adequate information about services	✓				
Influencing providers	✓				
Patient involvement and choice			?	←	✓
Setting appropriate priorities			✓		
Monitoring and maintaining equity			✓	→	?
Minimising transaction costs			✓	→	?
Managing financial risk			✓		
Required organisational qualities					
Accountability			✓		
Minimising conflicts of interest			✓		
Sustainability	?	←	✓		
Appropriate mix of skills	?	←	✓		

Table 9 Option 8: A 'mixed economy' of NHS purchasing

Requirements for an adequate model of NHS purchasing	Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)		Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)		Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)
Processes required to meet the goals of purchasing					
Assessing patient needs	?	←	✓		
Obtaining adequate information about services	✓				
Influencing providers	✓				
Patient involvement and choice	?	←	✓		
Setting appropriate priorities			✓		
Monitoring and maintaining equity					✓
Minimising transaction costs					✓
Managing financial risk			✓		
Required organisational qualities					
Accountability	✓				
Minimising conflicts of interest			✓	→	?
Sustainability	✓				
Appropriate mix of skills	?	←	✓		

Chapter 5

Conclusions

The rapid and unplanned development of a plurality of purchasers for HCHS in the NHS has, perhaps inadvertently, established the pre-conditions for further far more radical changes on the demand side of the internal market, as the wide range of outstanding questions and potential responses to them set out in earlier chapters suggests. This is not to say that all or any of the purchasing and wider governance options discussed in the previous chapter would necessarily be desirable or an improvement on the current situation. However, each in its different way offers a possible response to certain of the limitations and problems inherent in current trends to give GPs greater influence over HCHS purchasing; most especially, they have been designed to respond to the problems of public accountability, patient choice and appropriate incentives for GPs to act in the public interest both as purchasers and providers. Some of the more radical responses to these problems and to the opportunities offered by the new context of purchaser plurality in the NHS could fundamentally alter the nature of the NHS. As a consequence, they may be attractive to ideologues keen to introduce the disciplines of the market into the demand side of the NHS, possibly increase the level of funding going into public and private health care taken together and, at the same time, give individual patients greater influence over decisions affecting their health care. A number of similar proposals[65, 66] were put forward during the period of the NHS Review of 1987–89 which led to *Working for Patients*,[1] but did not find their way into the Government's eventual plans. They would have required very major changes not only to the organisation of the NHS, but also to the way in which funds were allocated. The advent of purchaser plurality in the NHS, but without matching changes in other aspects of NHS functioning, such as the degree of patient involvement and choice, appears likely to stimulate further political interest in these ideas (e.g. options 6 and 8 above). Indeed, the main media headline following the publication of the October 1996 primary care White Paper[58] was that supermarket chains might take over NHS general practice. The experience of the internal market and the growing belief that the ownership and control of provider and, now purchaser, bodies is less important than the principle

of retaining the public funding of health care, have both created a climate in which such ideas may become more acceptable than they were in the late 1980s.

Nonetheless, the potential disadvantages of such schemes remain the same. Demand-side contestability may increase still further transaction costs, make integrated care more difficult to achieve and threaten the equitable basis of the NHS. The challenge for defenders of 'core' NHS values is to be able to adapt to changing circumstances and put together an equally attractive package of demand-side changes which will pre-empt the need for potentially destabilising and inequitable experiments with new forms of budgetary decentralisation, mixed public–private finance and potentially inefficient user choice.

Whichever direction the next stage of NHS purchaser and provider development goes in, it is to be hoped that the Service will be given sufficient time to learn from the plurality of organisations which it has produced in the last four years and that all options will be tested against the basic aims of the NHS and the requirements of effective purchasing set out in this book. The consequences of having a complex and diversified set of purchasers have barely begun to be recognised. It is highly unlikely, for example, that a single 'best' way to purchase health care is waiting to be found. Simple comparisons between SFH, total purchasing, locality commissioning and GP-sensitive commissioning will be misleading without considering the service in question, the information required for cost-effective purchasing, the incentives facing the purchaser, the population context, the available supply of services and the balance of objectives which the purchaser is expected to attain on behalf of the NHS. The likelihood, therefore, is that a range of purchasing approaches might work in specific places with the right leadership, since experience suggests that there is rarely or ever a single, 'optimal' organisational response to a complex policy problem. Different types of purchaser may bring about different sorts of changes in services using different forms of leverage and influence (e.g. economic or political).

Armed with these insights, the challenge is to be able to specify the outcomes and behaviours which the NHS expects of its purchasers, identify factors which help and hinder these, devise an appropriate system of monitoring and oversight of the consequences and then allow the

precise mechanisms to develop through local discretion. This book is a small contribution to this task. It *is* evident, even at this stage, however, that decentralised purchasing involving providers in primary care will require them to be externally supported and regulated in ways which are only just beginning to be thought about. There is an inevitable trade-off between freedom and regulation in the development of NHS purchasing. The support role of the regulator may become increasingly important in the future, since the NHS is, paradoxically, placing an increasing reliance on general practice and primary care both as a setting for service provision and for purchasing just at a time when GP recruitment is said to be in crisis and morale among practising GPs is low. This phenomenon in itself may provide unplanned impetus towards still further unexpected changes in the nature of NHS purchasing.

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Since the advent of GP fundholding, the NHS has seen a proliferation of different approaches to health service purchasing and commissioning at local level. Each of these is aimed at encouraging decisions which are better informed by the needs of patients. All the main political parties seem to agree that, whatever else happens, purchasing in the future in the NHS will rely heavily on the skills and judgement of GPs.

However, as Nicholas Mays and Jennifer Dixon argue, a convergence of view does not amount to an adequate model of NHS purchasing. They show that current approaches fall short of meeting basic requirements in a number of key areas which have been relatively neglected in the policy debate until now.

Mays and Dixon discuss some potential, alternative models for structuring the demand side of the NHS quasi-market which might address the limitations of current approaches. As is often the case with public policy, they reveal how these models, in turn, generate new difficulties, particularly of health care regulation.

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