King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

The Transactions Costs of Total Purchasing

John Posnett

Nick Goodwin

Jenny Griffiths

Amanda Killoran

Gill Malbon

Nicholas Mays

Michael Place

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John Posnett
York Health Economics Consortium, University of York

Nick Goodwin
King's Fund, London

Jenny Griffiths
NHS Executive, North Thames Regional Office

Amanda Killoran
King's Fund, London

Gill Malbon
King's Fund, London

Nicholas Mays
King's Fund, London

Michael Place
York Health Economics Consortium, University of York

Andrew Street
York Health Economics Consortium, University of York

For further information on this part of the national evaluation contact John Posnett (tel 01904 433620/fax 01904 433628/email yhec@york.ac.uk). This working paper forms part of the output of the National Evaluation of Total Purchasing Pilot Projects which is led by the King's Fund

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This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proof-read.

The Total Purchasing National Evaluation Team (TP-NET)

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

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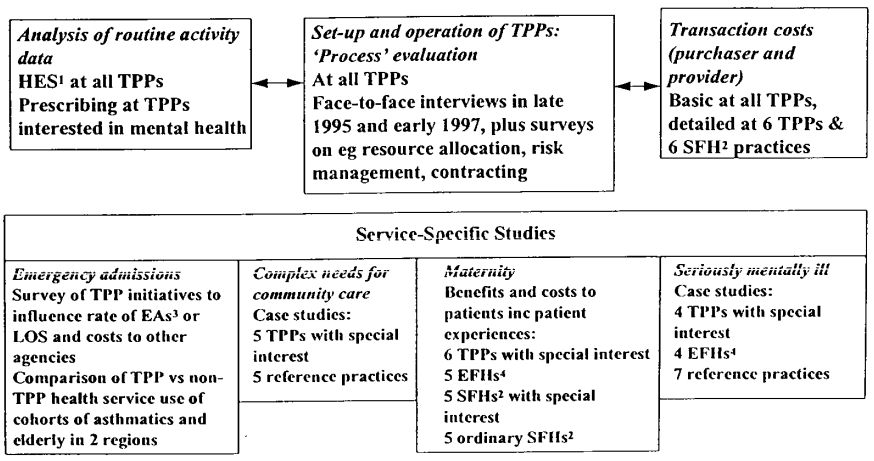
Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

Nicholas Mays
Co-ordinator, Total Purchasing National Evaluation Team (TP-NET)
King's Fund, London
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National Evaluation of Total Purchasing Pilot Projects
Main Reports and Working Papers

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Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Working Papers	
The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:	
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1 Introduction

The development of total purchasing represents perhaps the most significant organisational innovation in the NHS since the introduction of general practice fundholding (GPFH) in 1991. GPFH devolved budgetary responsibility for the purchase of selected hospital and community health services to general practitioners (GPs), and total purchasing extends the role of GPs by providing an opportunity for standard fundholding (SFH) practices to commission a full range of health services and to enter into collaborative arrangements with other practices to manage a shared budget.

Fifty-three first-wave Total Purchasing Pilot (TPP) projects in England and Scotland were established in April 1995 and, after an initial preparatory year, began functioning (although not necessarily commissioning) from April 1996. A second wave of TPPs entered their preparatory year in April 1996. The experience of these projects is being evaluated by the Total Purchasing National Evaluation Team (TP-NET).

The purpose of this paper is to report initial results from studies of the management costs, associated with TPP and to explore the relevance of current experience for the costs of establishing the new Primary Care Groups (PCGs) outlined in the Labour Government's White Paper on the NHS (Secretary of State for Health, 1997). Section 2 outlines the methodology. Section 3 reports estimates of the direct management costs of first wave and second wave TPPs, estimates of transactions costs from a sample of first wave projects and estimates the costs of health authority and GP purchasing. Section 4 examines the main determinants of differences in costs between projects and Section 5 explores the relevance of the findings for the establishment of PCGs since the government intends to introduce PCGs as a replacement for SFH while reducing the overall level of transactions costs within the NHS.

The report draws on data from three main sources: first, information on the direct management allowances of all first wave and second wave TPPs; and second, initial findings from a study of the transactions costs of total purchasing. Transactions costs are derived from estimates of the time staff devote to managing TPP and, unlike management allowances, include costs incurred by trusts and the host health authority. Finally, to facilitate comparison of TPP with other commissioning models, data are drawn from a survey of the functions and costs of health authorities and GP purchasers.

2 Methods

2.1 Direct Management Costs

A standard data collection form was sent to first wave TPP project managers and to lead managers at health authority/board level in January and February 1997 with a request for information on the management allowances of each TPP in 1995/96 and 1996/97. If the TPP did not have a cash allocation for 1996/97 for its management expenditure, but had a budget against which actual expenditure had to be claimed, staff were asked to estimate the year-end expenditure. Respondents were asked to itemise non-recurrent and recurrent costs.

The same method was used in January and February 1997 in a postal questionnaire to project managers at all second wave TPPs to collect management allowance information for their preparatory year (1996/97).

The data returned by the project manager and health authority lead were then collated and any discrepancies resolved, if necessary by sending the forms back for reconciliation. Direct management costs are defined as those costs identified explicitly with the operation of the TPP. Therefore, if a member of health authority staff is seconded to the TPP, or a specific proportion of his/her time is set aside for TPP work, these costs are included in the direct management costs of the project. However, estimates of other health authority staff time are excluded from direct management costs. Direct management costs can include the salary of the project manager, clerical costs, office expenses, locum fees, costs of GP time, computing and IT costs.

The costs exclude the management costs of fundholding in all but one of the projects where it proved impossible to separate the two sets of costs because the practices entered fundholding and total purchasing at the same time using the same management infrastructure.

All costs are expressed in 1996/97 prices by uprating 1995/96 costs using the GDP inflator.

2.2 Transactions Costs

Because no central guidance is available on how management allowances should be calculated, there is little *a priori* reason to believe that allocations reflect the actual management input associated with TPP. As a separate exercise we have measured the time inputs of all those involved directly in total purchasing (including staff at the host health authority and local providers) with the aim of estimating the transactions costs of total purchasing (see Appendix A for a description of the theoretical background to this part of the work).

Most of the information relevant to this part of the study has been collected from interviews at a sample of first wave projects drawn from the national TP pilots. A total of six projects was chosen at random after stratification. One further site which is not a first wave TPP was selected to pilot the interview schedules. In addition, data were collected using the same methodology in one second wave pilot.

Sample projects were selected to be representative, as far as is possible, of the main expected determinants of differences in transactions costs. On the basis of information collected at interviews carried out in mid 1995/96 at all projects as part of the wider evaluation, each of the first wave pilots was classified by three variables which could plausibly be expected to be associated with transactions costs, as follows:

- the presence or absence of a dedicated TP manager separate from existing practice or fundholding managers;
- single or multiple practices within the site;
- the number of trusts locally with which the site might contract.

Table 2.1 shows the initial classification on the first two variables, with characteristics of the sample projects shown in Table 2.2. In an attempt to control for other potentially important characteristics the sample was also balanced between urban and rural areas. All of the selected projects agreed to participate in the study.

A series of semi-structured interviews were then undertaken with the TP manager, lead GP, health authority lead and representatives of the main acute, community and mental health providers. Interviews were recorded and transcribed.

The aim of the interviews was to identify the range of additional *functions* or activities associated with total purchasing; the *resources* devoted to undertaking these activities and functions; and the *value* of resources used. Interviewees were asked to provide estimates of time spent in undertaking activities related to total purchasing, including any reductions in activity (e.g. fewer GPFH meetings) directly attributable to the introduction of the scheme. As well as their own time input, interviewees were asked to indicate the extent of involvement of their colleagues. When the interviewee was not confident about the accuracy of information relating to the involvement of others, interviews were also arranged with other key personnel identified during the primary interviews. Time inputs have been valued at salary plus on-costs on the assumption that employment costs are a good reflection of the opportunity cost of time.

Interviews were conducted between October 1996 and May 1997 and data were collected relating to the first two years in which the projects were operating. The first year is the preparatory year. In the second year most of the TPPs were 'live', but most were not operating as independent purchasers.

Table 2.1 Classification of first wave TPP projects

	TP Manager	No TP Manager	Total
Single Practice	4	11	15
Multiple practice	31	6	37
Total[1]	35	17	52

[1] Details of one project were unavailable at the time the sample was selected.

Table 2.2 Transactions costs sample projects

TPP	Number of Practices	Project Specific Manager	Nearby Providers
National Evaluation projects			
Site A	Multiple	Manager	2
B	Single	Manager	2
C	Multiple	Manager	4
D	Multiple	Manager	3
E	Single	No Manager	1
F	Multiple	No Manager	1
Additional projects			
G[1]	Multiple	Manager	2
H[2]	Multiple	Manager	4

[1] Project G acted as a pilot for the interview schedules. No cost or activity data for Project G are included in this report

[2] H is a second wave TPP

3 The Costs of Total Purchasing

3.1 Direct Management Costs of First Wave TPPs

Tables 3.1 and 3.2 show the 1995/96 and 1996/97 management allowances reported by the first wave projects. Data are available for up to 50 of the original 53 TPPs in the first wave because some of the original projects withdrew from the scheme.

There is a very wide range of costs (from £1,000 to £267,180) in the first 'live' year. A comparison of Tables 3.1 and 3.2 shows that there was little change in mean, median or range of absolute costs per TPP between the preparatory and first live year. This is primarily because start-up costs in the first year were replaced by a wider range of tasks associated with purchasing and commissioning in the second year as the ambition of the TPP increased. Tables 3.1 and 3.2 indicate that the larger TPPs spent more in absolute terms on direct management than the single-practice TPPs. This is largely attributable to the fact that total purchasing requires the development of a more corporate form of organisation in the multi-practice TPPs than previous practice-based fundholding. In addition, because TPPs were required to keep their fundholding budgets separate from their total purchasing allocations (which remained the technical responsibility of the health authority), multi-practice projects had to establish a separate management function for total purchasing, distinct from the standard fundholding management system of each practice.

Tables 3.3 and 3.4 show the same data in per capita terms. Tables 3.5 and 3.6 present the distribution of per capita costs by quartile for 1995/96 and the following year. There is little difference between start-up costs and the first year of total purchasing and little difference between single and multi-practice TPPs in per capita costs. The very wide range of costs reported above, and in the less reliable data collected previously (Mays et al., 1997), persists. It appears that the mean cost per capita in both years and in different sizes of TPP is around £2.80.

3.2 Direct Management Costs of Second Wave TPPs

Tables 3.7 and 3.8 show total and per capita management allowances for the second wave of 35 TPPs in their preparatory year (1996/97). Data are available for 29 of the 35 projects and exclude the Wakefield TPP which covers an entire district of 45 practices. A comparison with Tables 3.1 and 3.3 shows that the second wave projects had lower management costs in the preparatory period both in absolute and in per capita terms than the first wave.

The difference in allowances between first and second-wave TPPs may, in part, be related to their characteristics. While the mean population of the second wave TPPs is little different from the first wave (34,890 versus 33,327) and the median substantially lower (18,000 versus 28,500), the principal difference in the basic features of the two waves relates to the distribution of multi-practice TPPs. The second wave had more two-practice TPPs, fewer three, four and five-practice TPPs, and one TPP (excluding Wakefield) which is substantially larger than any of the TPPs in the first wave, having 15 practices (Malbon, Mays, Killoran and Goodwin, 1997).

3.3 Transactions Costs of Total Purchasing

Information on transactions costs is available for each of the sample projects from two main sources:

- the annual budgetary cost of staff dedicated to the management of total purchasing; and
- information on time spent by all of the main parties in activities related to the scheme.

This information is derived from the semi-structured interviews with representatives of GPs, the TP management team, the host health authority and the main acute, community and mental health providers.

For each project a detailed spreadsheet (Appendix B) has been prepared on the basis of this information for each of the years covered by the study. The spreadsheets show type, frequency and duration of all of the main meetings associated with the organisation of total purchasing; details of participants (including job title and organisational affiliation) and the time spent by each participant in travelling to and attending meetings and in preparation and follow-up.

Total costs

The incremental transactions costs of total purchasing (i.e. those costs over and above the costs of SFH) are estimated at £2.83 per capita in the first live year, 1996/97 (Table 3.9), with a range between £1.42 and £4.18. Total costs for the seven projects included in the study amounted to £802,966: an average of £115,000 per project. With a covered population of 1.75 million (Mays et al., 1997) the estimated costs of the first-wave pilots is £4.95 million.

The central estimate of the mean cost is very similar to the mean management cost of £2.82 for the first wave pilots in the same year (Table 3.4). Because the direct management cost is included within the estimate of transactions cost, the latter is expected to be higher because it also includes costs to trusts and to the host health authority. This suggests either that the sample selected for this part of the study has lower direct costs than the whole population of first wave pilots, or that our estimates are biased downwards because of incomplete recall. Either way our estimates of the total transactions costs are likely to be a lower bound.

There is no indication that transactions costs fall after the first year (see Appendix C). The majority of sites in the sample had higher costs in the first live year than in the preparatory year. For this reason, current estimates are likely to be lower than would be expected in the future as the range of activity is expanded.

Costs by sector

Eighty five per cent of costs (an average of £2.40 per capita in the sample) relate to the management and coordination of the TPP itself (Table 3.10). The bulk of these costs relate to the direct management costs of the project, but a significant cost (22%) falls on GPs involved in the scheme. Comparison of the figure of £2.40 with the estimated mean direct management cost for all of the first wave projects (£2.82) suggests that the sample may underestimate this component of total costs by around 18 percent.

The remaining 15% of the total cost falls on the host health authority (10.7%) and on local trusts (4.2%) in the form of the time of senior managers and clinicians devoted to negotiations with the TPP.

Additional costs incurred by acute trusts are relatively low, particularly in the preparatory year. In one project the introduction of TP is estimated to have reduced costs to the acute provider as a result of a reduction in the number of individual meetings with GP fundholders. The potential impact on community and mental health trusts is greater, primarily because existing information systems are inadequate to provide the level of activity and financial detail required by GP purchasers. In addition, many community and mental health trusts will have had few previous dealings with GP fundholders.

Costs by function

Table 3.11 shows the breakdown of transactions costs according to the functional activities described in Appendix A. The majority of the additional costs associated with TP are devoted to managing the relationship between the TPP and the health authority (27%) or to managing relationships between GPs within the project (51%). At present, only around one fifth (22%) of costs are related to the interaction between TPPs and local trusts.

Most of the additional transactions costs are incurred in coordination (between the HA and the TPP or within the TPP itself) and in monitoring (of the TPP by the HA, or of providers). These costs amount to 67% of the total (£1.88 per capita). The costs of activities associated more directly with contracting (search and information, and negotiation and contracting) represent around a third of the total. In our sample, the total costs of negotiation and contracting are actually lower with TPP than with SFH (Table 3.11), although this result is driven by substantial estimated cost savings reported by a trust at one project - no other projects reported a reduction of this kind.

3.4 Costs of Health Authority and GP Purchasing

In a separate study, Griffiths has undertaken a survey of the functions and costs of health authority and GP purchasers (early results are reported in Griffiths, 1996). The study covered 11 health authorities, 41 GP fundholders (including two multifunds) and 10 TPPs. Table 3.12 gives an overview of expenditure by the main functional headings used in the study.

Total costs

The costs of GP fundholding average £4.92 per capita, approximately half the costs of health authorities for half of the range of sub-functions (42 of the total of 90 sub-functions of health authorities) identified in the study. The costs of total purchasing (including the costs of fundholding) average £6.62 per capita, with an implicit *incremental* cost of total purchasing over SFH averaging £1.70 per capita. This may be compared with the estimates of £2.82 and £2.40 derived from the work on direct management costs at all TPPs and the transactions cost study at a sub-sample.

Health authority costs

Health authorities spend 61 percent overall (£5.99 per capita) on core infrastructural functions: headquarters and statutory functions; resource and information management; and core Family Health Services administration. The second largest function (in terms of expenditure) is strategy and policy implementation. No other individual function absorbs more than 10 per cent of total expenditure.

Health authorities spend an average of 10 per cent (£1.07 per capita) on primary care development and support for primary care-led purchasing. The contracting function costs an average of £0.78 per capita: 8 per cent of the total.

The costs of GP purchasers

Bearing in mind that the range of functions undertaken by GP purchasers is considerably narrower than the functions of a health authority, the pattern of expenditures is similar. The identified core functions (fund administration, database creation and maintenance, financial and contract control, annual accounts, financial audit, information and IT, internal business management, personnel, training and development, accommodation and overhead costs) account for 65% of the total costs of GP fundholding and 56% of the cost of total purchasing. Core infrastructure costs range (on average) from £3.18-3.74 per capita.

Both GP fundholders and total purchasers spend proportionately more of their management resources on contracting than health authorities: for total purchasers, the absolute expenditure is also higher (£0.93 per capita compared with £0.78). Strategy and policy development and implementation is also a significant function for GP purchasers. GP fundholders mainly invest time on *Health of the Nation* strategy implementation, evidence-based practice, medicines management and prescribing, local needs assessment, primary care services development, review of GP referrals and referral decisions, mental health services development and other service reviews.

Total purchasers spend almost twice as much on this function as fundholders (£1.38 compared with £0.71). They invest primarily in evidence-based practice, evaluation and audit, needs assessment, policies on priorities and choices, acute services and financial strategy, primary care services development, maternity services, emergency services and demand management, and joint work with social services and community care.

Variations in costs

The study is based on management allowances rather than on actual costs, but as with the study of the direct management costs of total purchasing, the range of allowances between both fundholders and total purchasers is wide. For the 41 GP fundholders included in the study, management allowances range from £3.20 to more than £7.00 per capita. The variation amongst the 10 total purchasers is relatively smaller, with a range from £4.50 to £7.65 per capita.

Some fundholders are apparently spending in excess of £4.00 per capita on core management functions, with population sizes ranging from 6,000 to 20,000. Others spend up to £1.00 per capita less than the average (the average is £3.18). There are some fundholders who appear to invest either nothing or very little in the functions summarised as strategy and policy, public information and involvement, and monitoring and performance management. At the other end of the scale some fundholders are spending more per capita on these functions than the average health authority.

Most TPPs were quite consistent in their levels of management investment in strategy and policy development and implementation (mostly between £1.10 and £1.70 per capita), public information and involvement (between £0.12 and £0.30) and monitoring and performance management (£0.25 to £0.50). These figures exclude obvious outliers.

The one function on which TPPs displayed a wide range of costs was contracting - from £0.50 to £1.20 per capita, again excluding outliers. TPPs differ in the amount of time spent in defining quality standards and information requirements in contracts, and in financial and contract control. This may reflect differences in priority or ambition, or it may simply be a reflection of the fact that different TPPs within the sample are at different stages of development.

Table 3.1 Direct management costs of first wave TPPs for 1995/96, adjusted to 1996/97 prices, by size of TPP[1]

Size of the TPP	Mean £	Median £	Range £	(n)
Single practice TPP	39,764	37,504	7528-84077	18
Two or more practices	111,979	94,530	5137-339075	32
Three or more practices	118,963	104,805	5137-339075	29
Four or more practices	129,723	116,677	5137-339075	20
All TPPs	86,554	67,488	5137-339075	50

[1]1995/96 management costs have been adjusted to 1996/97 prices using the GDP inflator (2.75%)

Table 3.2 Direct management costs of first wave TPPs for 1996/97 by size of TPP

Size of the TPP	Mean £	Median £	Range £	(n)
Single practice TPP	41,588	35,000	10,442-98,857	18
Two or more practices	108,600	95,000	1,000-267,180	31
Three or more practices	114,68	105,750	1,000-267,180	28
Four or more practices	125,684	117,562	1,000-267,180	20
All TPPs	84,264.14	58,278.00	1,000-267,180	49

Table 3.3 Direct management costs of first wave TPPs per capita for 1995/96, adjusted to 1996/97 prices, by size of TPP

Size of the TPP	Mean £	Median £	Range £	Mid-range £	(n)
Single practice TPP	2.72	2.69	0.51-5.46	1.29-3.63	18
Two or more practices	2.89	2.78	0.11-7.49	1.88-3.54	32
Three or more practices	2.94	2.81	0.11-7.49	2.11-3.63	29
Four or more practices	2.75	2.65	0.11-6.14	1.41-3.67	20
All TPPs	2.83	2.78	0.11-7.49	1.76-3.57	50

Table 3.4 Direct management costs of first wave TPPs per capita for 1996/97 by size of TPP

Size of the TPP	Mean £	Median £	Range £	Mid-range £	(n)
Single practice TPP	2.70	2.76	0.69-4.73	2.05-3.63	18
Two or more practices	2.87	2.77	0.02-6.97	1.69-3.84	31
Three or more practices	2.86	2.75	0.02-6.97	1.72-3.79	28
Four or more practices	2.73	2.75	0.02-5.80	1.75-3.23	20
All TPPs	2.82	2.77	0.02-6.97	1.75-3.75	49

Table 3.5 Direct management costs of first wave TPPs per capita for 1995/96 (at 1996/97 prices)

Cost per capita	n	%
£1.50 or less	12	24
£1.51-£2.71	13	26
£2.72-£3.50	12	24
£3.50 or more	13	26
All TPPs	**50**	**100**

Table 3.6 Direct management costs of first wave TPPs per capita for 1996/97

Cost per capita	n	%
£1.75 or less	12	24
£1.76-£2.77	12	24
£2.78-£3.72	14	28
£3.73 or more	12	24
All TPPs	**50**	**100**

Table 3.7 Direct management costs of second wave TPPs for 1996/97 by size of TPP

Size of the TPP	Mean £	Median £	Range £	(n)
Single practice TPP	39,536	34,494	5,000-86,571	12
Two or more practices	56,995	40,000	9300-132560	17
Three or more practices	64,806	40,349	9300-132560	10
Four or more practices	75,822	41,698	34,000-132,560	7
All TPPs	49,770.50	39,000.00	5000-132560	29

Table 3.8 Direct management costs of second wave TPPs per capita for 1996/97 by size of TPP

Size of the TPP	Mean £	Median £	Range £	Mid-range £	(n)
Single practice TPP	3.03	2.17	0.59-7.53	1.60-3.70	12
Two or more practices	1.96	1.49	0.48-4042	0.81-3.52	17
Three or more practices	1.61	0.97	0.48-4.42	0.70-2.48	10
Four or more practices	1.43	0.97	0.48-3.32	0.64-2.20	7
All TPPs	2.40	2.09	0.48-7.53	0.97-3.57	29

Table 3.9 Total transactions costs across all sectors in first live year (1996/97)

Project	Project population	Transactions costs	
		Total £	Per capita £
Site E	12,943	46,043	3.56
B	33,196	101,900	3.07
F	37,847	135,833	3.59
C	28,461	79,609	2.80
H	32,460	61,385	1.89
A	73,000	104,013	1.42
D	65,652	274,183	4.18
Total[+]	**283,559**	**802,966**	**2.83**

[+] may not equal column sum because of rounding

Table 3.10 Transactions costs by sector, first live year (1996/97)

Sector	Transactions costs	
	Cost per capita £	%
TP site	2.40	84.9
(GPs)	*(0.67)*	*(23.5)*
(TP management)	*(1.73)*	*(61.3)*
Health Authority	0.33	11.7
Acute Trusts	0.03	1.0
Community Trusts	0.07	2.3
Other	0.01	0.2
Total[+]	**2.83**	**100**

[+] may not equal column sum because of rounding

Table 3.11 Transactions costs by function, first live year (1996/97)

Function	Transactions costs	
	Cost per capita £	%
HA/TPP	0.70	24.9
coordination		16.8
search/information		1.6
contracting		0
monitoring		6.5
TPP	1.62	57.4
coordination		26.1
search/information		31.3
TPP/Trust	0.50	17.7
search/information		10.2
contracting		-9.7
monitoring		17.3
Total[+]	**2.83**	**100**
Coordination	1.21	42.9
Search/information	1.22	43.0
Contracting	-0.27	-9.7
Monitoring	0.67	23.8

[+] may not equal column sum because of rounding

Table 3.12 Management costs of Health Authorities and GP Purchasers

Functions	Health Authority n = 11		Standard Fundholders n = 41		Total Purchasers n = 10	
	£	%	£	%	£	%
Core Functions	5.99	61	3.18	65	3.74	56
Contracting	0.78	8	0.68	14	0.93	14
Strategy and Policy Implementation	1.43	14	0.71	14	1.38	21
Strategy and Development: primary care	0.54	5	--	--	--	--
Primary Care Led Purchasing Support	0.53	5	--	--	--	--
Public Information and Involvement	0.30	3	0.12	2	0.19	3
Monitoring and Performance Management	0.35	4	0.24	5	0.37	6
Total[+]	**9.93.**	**100**	**4.92**	**100**	**6.62**	**100**

[+] may not equal column sum because of rounding

4 Determinants of Cost

The transactions costs observed in the sample sites range from £1.42 to £4.18 per capita, with a mean of £2.83 in the first live year. The range of direct management costs is even wider: from £0.02 to £6.97, with a mean of £2.82. It is relevant to consider the possible determinants of differences between projects. Not surprisingly, no simple explanations are evident.

One obvious explanation for the difference in costs is that it is driven directly with their management allowances. This begs the question, however, of whether the management allowance is related in some systematic way to the expected costs of running the scheme.

4.1 Size of the TPP

Tables 3.3 and 3.4 suggest that there is no relationship between the size of a TPP (measured by the number of practices) and per capita management costs. This is confirmed in a separate regression analysis of all of the first wave TPPs in which we found no statistically significant relationship between per capita direct management costs and the number of practices.

Table 4.1 and Figure 4.1 show the relationship between transactions costs borne directly by the TP (i.e. excluding costs to the health authority and trusts) and the number of practices for our sample. The only clear relationship is that total costs per practice are higher in single-practice projects: for all of the other projects in the sample there is no obvious correlation. More relevant is the cost per capita, but here also there is no obvious evidence of lower costs as the size of the project increases.

The fact that we cannot detect any significant relationship between costs and the size of a TPP is not surprising. From a theoretical point of view, there are expected to be two opposing determinants of the relationship between size and the transactions costs of total purchasing.

Firstly, the costs of managing budgets will depend on the size of the budget, where size of budget is a proxy for the level of activity of the project and the number of transactions to be processed. If the management input is not perfectly divisible (i.e. some costs are fixed up to a capacity constraint), there will be economies of scale such that management costs per capita should decline as the size of the budget increases up to the point at which management capacity needs to be increased.

Secondly, the costs of coordination depend on the number of GPs and the number of practices. Other things equal, for a given number of GPs, the costs of coordination should be lower in a single-practice project than in a project with multiple practices, simply because

coordination within practice is likely to be less costly than coordination between practices. Similarly, the costs of coordination are expected to be higher as the number of GPs (and the project budget) increases.

These observations lead to two general conclusions:

- If the population covered by a TP scheme is large enough to reap economies of scale in management, a single-practice project is likely to have lower transactions costs than a multi-practice project of the same population size.

- If the population is too small to capture available economies of scale, combining a number of single practices into a multi-practice TP may reduce overall transactions costs, but the extent of this benefit will be eroded if the number of practices becomes too large.

The implication is that no general statement can be made about the relationship between costs and the size of a TP grouping other than to infer that using general practices as a building block for GP commissioning is likely to create difficulties because of the relatively small size of most practices in the NHS.

4.2 Organisational Structure

Table 4.2 shows the per capita direct management costs for all of the first wave TPPs classified by the complexity of their organisational structure. The classification ranges from 'simple' organisations which have few formal sub-groups other than the main executive board, through 'intermediate' in which a project board and other sub-groups exist alongside the executive board, to 'complex' characterised by a variety of sub-groups and a high degree of participation from external stakeholders. Mean costs per capita appear to be higher in TPPs with 'simple' or 'complex' structures. However, the correlation is not statistically significant and this suggests that the relationship between costs and organisational structure is not straightforward.

Another way to illustrate the causes of differences in costs is to examine the organisational structure in some detail. Information on the types of meetings associated with TP, their frequency and the types of personnel involved were collected as part of the interview process in the transactions cost study. Table 4.3 gives a summary for the sample projects.

There appear to be three main levels of interaction within a typical TP organisation: (I) the formal mechanism by which the HA discharges its responsibility to monitor and in some cases to guide the development of the TP; (II) the policy board of the TP itself, responsible for strategic direction and decision-making; and (III) day-to-day responsibility for management. The names given to these meetings vary a good deal, and interactions occur at many other levels as well, but these define the main parameters of organisational structure.

Level I meetings vary between sites in frequency and in the involvement of GPs and senior HA staff. Meetings typically take place quarterly, although in one project the group appears to meet twice per month. In some cases, the meeting involves all or some of the GPs involved in the TPP, and the range of HA representatives included varies enormously. It is self-evident that transactions costs are increased the more GPs and senior HA staff are involved and the more frequently the group meets.

However, in some of the projects involving GPs directly has been an important goal of the HA, and their inclusion in regular meetings with the HA has been seen as one means of encouraging their participation. In other cases, senior HA managers have regarded their own direct involvement as essential in order to discharge their statutory responsibilities with respect to the TPP and this may have much to do with local politics or with the degree of confidence in the TPP itself. Local factors such as these which make generalisation difficult.

In two of the projects, this level of interaction has been removed entirely after the development period. The HA now monitors the operation of the scheme through regular reports submitted by the TPP board and through the normal line management structure.

Meetings at Level II are typically held monthly, although in two of the projects these meetings occur (approximately) each week. In most cases, meetings are attended by all (or some) of the GPs involved in the project, by the TPP manager and by representatives of the HA or other advisers who may attend periodically. The more GPs are involved in meetings of this kind, the more transactions costs are increased. However, there are trade-offs. In some projects, participating GPs appear to be content to delegate most of the routine responsibility for the TPP to the management team and the lead GP. But this depends on local factors. In other projects, where the history of cooperation between practices may be less good, GPs are more likely to be actively involved in the decision-making process. The question of incentives is also important. The more remote are GPs from the management of the budget, the less likely they are to accept financial responsibility for clinical decisions.

Level III typically involves a weekly meeting between the lead GP(s) and the TP management team.

In all of the projects, regular meetings are supplemented with a range of other meetings including meetings of practice staff, meetings with providers, clinical sub-groups, training and others. The range and frequency of these additional meetings appears to depend on how active the TPP is in promoting service change. GPs tend to be more heavily involved in meetings of this type when the project is active in promoting service development; less so if the emphasis is on contracting.

4.3 Costs and Achievement

Transactions costs will also be a function of the level of activity within the TPP. It is important to remember that the costs measured here are almost certainly an underestimate of the costs which are likely to arise when total purchasers become more proactive in driving service change. In part, this is because as activity increases, so the involvement of GPs, consultants and trust managers also increases.

Table 4.4 shows the reported level of achievement of first wave TPPs in the first live year against per capita management costs. The definition of 'achievement' is based on the judgement of the TPP itself of its ability to implement its main purchasing objectives, irrespective of their scale and the service area involved. The wide range of costs within each achievement group is worth noting, together with the indication that higher-achieving TPPs also have higher management costs. This is what would be expected.

Table 4.5 focuses on the reported level of achievement of the first wave TPPs in 1996/97 in service areas included for the first time in total purchasing (services outside SFH and General Medical Services). By this more demanding definition of achievement, the highest achieving group of TPPs had higher management costs than the lowest group.

Finally, Table 4.6 shows the level of management costs of first wave TPPs by the nature and level of their future ambitions for purchasing in 1997/98. The table shows a positive relationship between higher management costs and a greater level of ambition. This may be because these TPPs have established the management infrastructure to allow more ambitious planning for the future, although it may equally reflect the fact that TPPs with lower management costs have accepted this as a constraint on their ambition.

4.4 Features of TPPs with High and Low Management Costs

Another way of exploring differences in TPP costs is to look in more detail at their activities and at the composition of management costs. Table 4.7 summarises a range of information on the 12 TPPs in the lowest quartile of per capita management costs in 1996/97 (£1.75 and under). Table 4.8 shows the same information for the 9 TPPs in the highest quartile of management costs (over £3.73).

The low spenders were less likely to have received a budget, less likely to have purchased directly (25% had done so), less likely to have many contracts of their own and more likely to be low achievers with low ambitions for the future. By contrast, the high spenders were more likely to have received a budget, more likely to have contracted directly, more likely to have appreciable numbers of their own contracts and to be high achievers with high ambitions for the future.

Tables 4.7 and 4.8 also include information on whether the TPP received a cash allocation or budget for its management costs as against those which had to claim for actual expenditure. The tables also include details of the scope of management spending, particularly on GPs. It can be seen that TPPs which received a cash sum for management or a predetermined budget tended to spend more than those which had to justify each item of expenditure.

It is also apparent that the high spending TPPs are distinguished from the low spending TPPs by the extent to which they received funds to pay not only for locum cover for their lead and other GPs to take part in total purchasing activity, but also by how frequently they received an allowance for each GP to take part in the TPP and sometimes an allowance per practice so that other practice staff could participate. Four of the 12 TPPs in the lowest group received no reimbursement either for locums or for GP time involved in total purchasing, whereas only one of the high spending TPPs out of eight was in this position.

These data suggest that not only were high spenders more likely to be among the more active and achieving TPPs in the first 'live' year, but they did so by paying for the involvement of more GPs and practices. Tables 4.7 and 4.8 also indicate that the presence of a project manager with dedicated time for total purchasing was not as important a distinguishing factor between high and low management cost as the extent to which GPs and other practice staff were reimbursed for their time spent on TPP activities.

4.5 Summary

There is no evidence of a statistically significant relationship between the size of a TPP (measured by the number of practices) and per capita management costs, nor should one be expected. The relationship between size and management cost is confounded by the effect of two factors working in opposite directions. On the one hand, because of economies of scale, the per capita cost of managing budgets is expected to decline up to some point as the size of the budget is increased. On the other hand, as the number of practices increases, the costs of organising the TPP are expected to increase. In part, this is because of the direct costs incurred in compensating GPs for their time, and, in part, it is the result of the need for a more complex organisational structure.

There is no agreement as yet on the most appropriate organisational form for a TPP of given size, and the complexity (and cost) of the organisational structures created in support of TPP vary widely. As TPP develops, and in particular as the respective roles of the health authority, GPs and the TP management team evolve, there is likely to be a move towards a greater degree of homogeneity.

There is evidence that the extent of self-reported success is positively related to per capita management costs and to the degree of sophistication of the TPP organisational structure. Small projects have been able to succeed, in their own terms, with relatively low costs and a low degree of organisational development. On the other hand, the larger TPPs which have achieved most are those with the highest level of investment in organisational development.

One implication is that if the new PCGs are to function effectively at the scale envisaged (with a covered population of approximately 100,000) (Secretary of State for Health, 1997), this cannot be achieved without significant investment in organisational development.

Table 4.1 Transactions costs by project, first live year (1996/97)

Project	Number of practices	Number of GPs	Covered population	TPP costs only			Total costs		
				Total £	Average per practice £	Average per 1000 patients £	Total £	Average per practice £	Average per 1000 patients £
E	1	7	12,943	37,819	37,819	2,922	46,043	46,043	3,557
B	1	12	33,196	60,627	60,627	1,826	101,900	101,900	3,070
F	5	25	46,113	93,129	18,626	2,461	135,833	27,167	3,589
C	5	20	28,461	75,003	15,001	2,635	79,609	15,922	2,797
H	7	23	32,460	57,363	8,195	1,767	61,385	8,769	1,891
A	8	36	73,000	90,040	11,255	1,233	104,013	13,002	1,425
D	10	35	65,652	266,548	26,655	4,060	274,183	27,418	4,176

Figure 4.1 Transactions costs by project, first live year (19967/97)

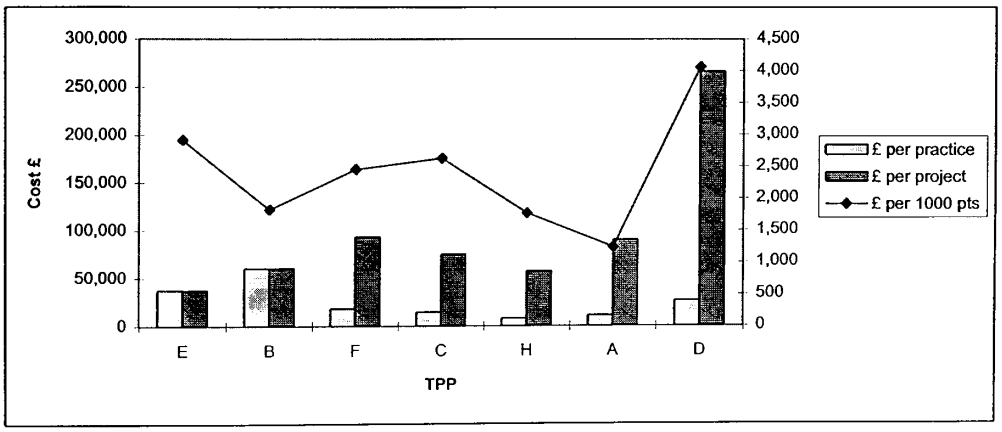

Table 4.2 Direct management costs of first wave TPPs per capita for 1996/97 by organisational complexity of TPP

Organisational complexity	Mean £	Median £	Range £	Mid-range £	(n)
Simple	2.97	2.82	0.22 - 5.80	2.46 - 3.78	18
Intermediate	2.52	1.91	0.71 - 6.97	1.43 - 3.44	17
Complex	3.01	3.01	0.69 - 4.73	2.51 - 3.87	14
All TPPs	2.82	2.77	0.02 - 6.97	1.75 - 3.75	49

Table 4.3 Organisational structure

Project	A	B	D	F	H	E
HA/TPP Board	1*4[1]	1*24	1*4	1*3	1*4	
	GPs	Dir Corp mgt	GPs	GPs	Lead GP	
	TP mgr/team	Dir Corp mgt	Proj mgr	Chief exec	Prac mgr	
	Ass Dir Comm	Sen acct	Dir Fin	Dir Fin	Exec dir	
	Dir	Con PH	Dir PH	Dir PH	Dir fin	
		Dir Proj mgt	Dir P care	Non-exec	Dir PH	
			Non-exec	LMC rep	non-exec	
				Reg off rep		
				TP mgr		
				Proj mgr		
Steering Group	1*48	1*12	1*48	1*12	1*12	1*8
	GPs	GPs	Lead GPs	Lead GP	Ass prac mgr	Gps
	TP mgr/team	Dir Corp mgt	Proj mgr	TP mgr	Loc dir	TP mgr
	Ass Dir Comm	Dir Fin	Phar mgr	Dir Fin	Fin mgr	Prac mgrs
	Con PH	Dir PH	Dental mgr	Dir Contact		Loc mgr
		Non exec	Provider reps	Proj mgr		
		Dep Purch mgr		Info analyst		
		TP mgr/team				

[1] 1*4 means that the TPP Board meets quarterly; 1*12 means monthly; 1*24 means twice per month, etc.

Table 4.3 (cont.) **Organisational structure**

Project	A	B	D	F	H	E
Executive	1*48 Lead GP TP mgr	1*48 Lead GP GPs TP mgr Ass prac mgr Lead GP TP mgr	1*25 Lead GPs Proj mgr	1*6 TP mgr Proj mgr Info analyst	1*52 Lead GP Prac mgr Ass prac mgr	1*12 TP mgr Prac mgrs Ass loc mgr
Operation					1*12 Prac mgr Loc dir	
Practice Mtgs			1*4 GPs		1*6 GPs	
Other Mtgs	Providers Sub groups	Providers Regional mtgs Workshops	Providers CHC mtgs Sub groups	Providers Equity grp Patient mtgs Contract mtgs Town mtg	Providers Reg insurance Sub groups Patient mtgs Pub relations Consortium mtgs	Providers Training Sub groups

[1] 1*4 means that the TPP Board meets quarterly; 1*12 means monthly; 1*24 means twice per month, etc.

Table 4.4 Direct management costs per capita of first wave TPPs for 1996/97 by level of TPPs' achievements in their own terms (all service areas)

Level of own achievements	Mean £	Median £	Range £	Mid-range £	(n)
Low (1 and 2)	2.74	2.80	0.22 - 5.80	1.71 - 3.45	18
Middle (3)	2.76	2.77	0.71 - 4.73	2.30 - 3.58	15
High (4 and 5)	3.28	3.25	0.69 - 6.97	1.67 - 4.32	11
All TPPs	2.82	2.77	0.02 - 6.97	1.75 - 3.75	44

Table 4.5 Direct management costs of first wave TPPs for 1996/97 by level of achievement in TP-related service areas

TP-specific achievements	Mean £	Median £	Range £	Mid-range £	(n)
Low (1 and 2)	2.65	2.77	0.02 - 5.80	1.71 - 3.33	31
Middle (3)	3.14	2.90	2.30 - 4.73	2.40 - 3.89	6
High (4 and 5)	3.68	3.98	0.69 - 6.97	2.47 - 4.61	7
All TPPs	2.82	2.77	0.02 - 6.97	1.75 - 3.75	44

Table 4.6 Direct management costs of first wave TPPs per capita for 1996/97 by level of future ambition, 1997/98

Future ambition	Mean £	Median £	Range £	Mid-range £	(n)
More objectives planned and in TP-specific areas	3.15	2.97	0.69 - 6.97	2.47 - 3.96	31
Same level of objectives planned and in TP-specific areas	2.79	2.04	1.27 - 5.80	1.28 - 5.04	4
More objectives planned, but not in TP-specific areas	2.24	2.33	0.71 - 3.79	0.99 - 3.37	6
Same level of objectives planned, but not in TP-specific areas	1.45	1.80	0.02 - 2.58	0.02 - 2.58	3
All TPPs	2.82	2.77	0.02 - 6.97	1.75 - 3.75	44

Table 4.7 **Activities and composition of management costs of first wave TPPs with management cost per capita (1996/97) in the lowest quartile (less than £1.75)**

Cost per capita 1995/96, at 1996-97 prices £	Cost per capita in 1996-97 £	Method of Financing Direct Management Costs	Level of Reimbursement to Individual GPs/Practices	Number of practices in the TPP	Whether purchased directly?	Total number of contracts	Achieved effective external links	Managed to keep within budget	Level of own achievements (1 Low-5 High)	Level of TP-specific achievements (1 Low-5 High)	Level of TPPs' future ambition*	Whether specialist TP-site manager?
1.99	1.27	Budget	None	2	No	0	No	Yes	4	2	2	Yes
0.51	0.71	Budget	Locum costs only	1	Yes	6	Yes	Yes	3	2	3	No
2.42	1.67	Budget with some FH and TPP savings	Locum fees	5	Yes	0	Yes	Yes	4	2	1	Yes
0.92	1.08	Reimbursement of costs	Locum costs only	1	N0	0	No	Did not receive a budget	3	2	3	Yes
0.11	0.02	1995/96 Regional allowance only 1996/97 From FH and TP savings	None	8	No	0	No	Did not receive a budget	1	1	4	Yes
0.94	1.69	Reimbursement of costs and FH savings	GP sessions at meetings	4	missing	missing	missing	missing	missing	missing	missing	Yes
1.42	1.43	Budget	All lead GPs and all locum cover fees	10	No	0	Yes	Did not receive a budget	2	1	1	Yes

*For coding on future level of ambition: 1= More ambition for the future and in TP-specific areas 2= Same level of ambition and in TP-specific areas
3= More ambition for the future, but not in TP-specific areas 4= Same level of ambition and not in TP-specific areas

Table 4.7 cont. **Activities and composition of management costs of first wave TPPs with management cost per capita (1996/97) in the lowest quartile (less than £1.75)**

Cost per capita 1995/96, at 1996-97 prices £	Cost per capita in 1996-97 £	Method of Financing Direct Management Costs	Level of Reimbursement to Individual GPs/Practices	Number of practices in the TPP	Whether purchased directly?	Total number of contracts	Achieved effective external links	Managed to keep within budget	Level of own achievements (1 Low-5 High)	Level of TP-specific achievements (1 Low-5 High)	Level of TPPs' future ambition*	Whether specialist TP-site manager?
0.73	1.43	Budget (small - £25k)	Lead GPs only	4	No	0	Yes	Did not receive a budget	1	1	3	Yes
1.03	0.69	Budget (small - £21k 1995/6; £13k 1996/7) and FH savings	GP time Locum cover	1	Yes	2	No	Yes	4	4	1	Yes
2.37	1.66	Budget	None	3	missing	missing	missing	missing	missing	missing	missing	Yes
2.47	0.87	Allowance	GP time only	3	missing	missing	missing	missing	missing	missing	missing	Yes
1.36	1.32	Budget (set at £35k for all sites in TBF)	none	1	No	0	Yes	missing	2	2	2	No

*For coding on future level of ambition: 1= More ambition for the future and in TP-specific areas
2= Same level of ambition and in TP-specific areas
3= More ambition for the future, but not in TP-specific areas
4= Same level of ambition and not in TP-specific areas

Table 4.8 **Activities and composition of management costs of first wave TPPs with management cost per capita (1996/97) in the highest quartile (more than £3.73)**

Cost per capita 1995/96, at 1996-97 prices £	Cost per capita in 1996-97 £	Method of Financing Direct Management Costs	Level of Reimbursement to Individual GPs/Practices	Number of practices in the TPP	Whether purchased directly?	Total number of contracts	Achieved effective external links	Managed to keep within budget	Level of own achievements (1 Low-5 High)	Level of TP-specific achievements (1 Low-5 High)	Level of TPPs' future ambition*	Whether specialist TP-site manager?
2.38	4.00	Allowance	GP time	6	No	3	Yes	No	2	2	1	Yes
5.85	4.61	1995/96 Budget 1996/97 Mainly TP budget savings	All lead GPs, all participating practices ad all locum cover fees	5	Yes	6	Yes	No	5	5	1	Yes
3.47	4.73	Allowance	Locum fees	1	Yes	22	Yes	Yes	3	3	1	No
7.49	6.97	Budget	All lead GPs, all participating practices, all locum cover fees	3	Yes	7	Yes	Yes	4	4	1	No
4.70	3.96	Cash Allocation	All lead GPs all participating practices, all locum cover fees	5	Yes	5	missing	missing	3	2	1	Yes
6.14	5.80	Poor Data - combined FH and TPP	Poor data	8	No	0	No	Did not receive a budget	2	1	2	No

* For coding on future level of ambition: 1= More ambition for the future and in TP-specific areas 2= Same level of ambition and in TP-specific areas
3= More ambition for the future, but not in TP-specific areas 4= Same level of ambition and not in TP-specific areas

Table 4.8 cont. **Activities and composition of management costs of first wave TPPs with management cost per capita (1996/97) in the highest quartile (more than £3.73)**

Cost per capita 1995/96, at 1996-97 prices £	Cost per capita in 1996-97 £	Method of Financing Direct Management Costs	Level of Reimbursement to Individual GPs/Practices	Number of practices in the TPP	Whether purchased directly?	Total number of contracts	Achieved effective external links	Managed to keep within budget	Level of own achievements (1 Low-5 High)	Level of TP-specific achievements (1 Low-5 High)	Level of TPPs' future ambition*	Whether specialist TP-site manager?
3.05	3.84	Mix budget and fundholding savings	GP time and locum time	3	No	0	Yes	missing	3	2	1	No
2.48	3.78	Budget	GP time	1	Yes	1	Yes	Yes	2	2	3	No
5.46	4.13	Budget	GP sessions at meetings all locum cover fees	1	Yes	missing	Yes	Yes	5	2	1	missing
1.49	3.98	Budget	GP time & locum time	2	Yes	2	Yes	Yes	4	5	1	No
3.95	3.89	Budget	GP sessions at meetings all locum cover fees high IT	3	Yes	6	missing	missing	2	2	1	Yes
4.44	4.32	Budget (set at £35k for all sites in TBF)	none	1	Yes	2	Yes	Yes	5	4	1	missing

* For coding on future level of ambition: 1= More ambition for the future and in TP-specific areas
2= Same level of ambition and in TP-specific areas
3= More ambition for the future, but not in TP-specific areas
4= Same level of ambition and not in TP-specific areas

5 Discussion

5.1 Summary of Current Evidence

Despite the fact that the evidence marshalled in this report has been drawn from a number of sources, some of which are based on relatively small samples, there are a number of consistent themes emerging:

- The level of management expenditure in health authorities, GP fundholders and TPPs varies widely in a way which does not appear to be related in any systematic way to the characteristics of the populations served by these organisations. This indicates a lack of consistency in the process by which management allowances are negotiated. However, the *appropriate* level of investment in management is not known.

- There is some evidence that higher management expenditure is associated with greater levels of self-reported achievement and ambition in the first-wave TPPs, although the direction of causality is by no means clear. Lower per capita costs are not necessarily an indicator of greater efficiency.

- The relationship between size and cost is not straightforward. Economies of scale in the fund management function are expected to lead to lower per capita costs in larger organisations (up to some point). On the other hand, there is evidence that one of the most significant determinants of differences between TPPs in their level of management spending is the extent to which individual GPs are actively engaged in the project, and the extent to which GPs are reimbursed for their time. One implication is that in multi-practice TPPs the costs of coordinating GPs across different practices will tend to rise as the size of the project increases, unless and until there is no managerial benefit in involving more practitioners directly in steering the project.

- To date, most of the additional costs associated with total purchasing have fallen on the TPP itself, on GPs and on the host health authority. Additional costs to providers have been relatively low, although this is partly a reflection of the relatively low level of direct engagement between TPPs and providers at this stage since TPPs remained *selective* rather than comprehensive purchasers in the first 'live' year (1996/97). Most of the costs are associated with budget management and with coordination between practices and between the TPP and the health authority. Relatively little is expended directly on the contracting process.

- The national evaluation of total purchasing has shown that the piloting approach adopted by the NHS Executive has led to wide range of interpretations of what constitutes total purchasing (Strawderman, Mays and Goodwin, 1996; Mays, Goodwin, Killoran and Malbon, 1998). This is reflected in the wide range of management costs and organisational structures reported in this paper. The evaluation has also shown that facilitating the involvement of GPs in the commissioning process cannot be achieved without a significant investment in organisational development. Those projects which are investing in developing organisational and managerial infrastructure tend to be those which are achieving change in new TP service areas such as mental health, emergency admissions, A & E and community care for the elderly.

5.2 The Costs of Primary Care Commissioning

Total purchasing is the closest analogy we have to the Primary Care Groups (PCGs) announced in the recent White Paper (Secretary of State for Health, 1997). However, it would be wrong to infer that the costs of the proposed structure of primary care commissioning will be the same as the current costs of total purchasing. In part, this is because costs will depend on the precise way in which PCGs are organised. In part, it is because current estimates of the cost relate to a situation in which total purchasing operates for a limited section of the population in parallel with fundholding and health authority commissioning: one of the important characteristics of the proposals contained in the White Paper is that PCGs are intended to be universal. It should also be noted that the proposed size of a PCG (covering a population of approximately 100,000) is larger than most of the existing TPPs.

The White Paper sets out an evolutionary approach to establishing PCGs. PCGs are to take on increasing degrees of commissioning, including budgetary responsibilities, with the development of associated functions. A totally decentralised commissioning system is ultimately envisaged with PCGs having responsibility for virtually all health care and subsuming current health authority and fundholding commissioning roles. Although this devolution will inevitably be staged over time, the coverage of PCGs from the outset is to be universal. This has significant implications for management costs. The possible future costs of this end stage of development are discussed below.

The expected transactions costs associated with the introduction of universal primary care commissioning depend the average size of a typical PCG, and on three further factors: the perceived aims of the scheme and the extent to which budgetary responsibility is to be delegated to practice level; the extent to which some of the current functions of health

authorities can be reduced or transferred to local commissioners; and the extent to which transactions costs are reduced as fundholding is subsumed within a new form of 'total purchasing'.

The aims of primary care-led commissioning

The potential costs of any extension of GP commissioning will depend to a significant extent on the aims of the scheme. In general, GP commissioning and fundholding have been rationalised either as a means of making GPs directly accountable for the resource consequences of clinical decisions, or as a means of improving patient access and service delivery through the inclusion of a primary care perspective in the commissioning process.

Experience suggests that achievement of the first objective depends on the extent to which GPs are actively engaged in the management of a budget. In many multi-practice projects, it appears that GPs are content to delegate financial responsibility to the lead GP and the TPP management team. This undoubtedly reduces transactions costs, but it also reduces the extent to which GPs face direct incentives to alter their own practice. Unless peer pressure is strong, the aim of engaging all GPs within a local group will probably require notional budgets set at practice level (even if budgets are aggregated for management purposes) and it requires significant investment in coordination within a local commissioning group.

On the other hand, if the aim is not so much to influence the behaviour of GPs as providers and as gatekeepers, but rather to include a primary care perspective in the commissioning of services, the need for the direct involvement of all GPs in an area may be reduced and with it the transactions costs of the scheme. Periodic meetings between a relatively small number of GPs, the PCG management team and the health authority to contribute to local planning will not be particularly demanding of time or resources.

Even so, the potential costs of GP involvement should not be underestimated. In many of the existing TPPs, GPs are not fully reimbursed for their time input to the scheme. They accept this situation because total purchasing is voluntary, is still in the development stage and because they see themselves as pioneers. Any more general roll-out of primary care commissioning may be more difficult to achieve without significantly higher expenditure to compensate GPs who are less well motivated than participants in the existing pilot projects for their time.

In practice, the 'minimalist' model, in which GPs are involved only as advisers to the PCG, is unlikely to be sustainable in the long run. The essence of the PCG concept is that practices must act *collectively* rather than individually in managing a common budget. Within this

framework, the referral and prescribing behaviour of any individual practice may have consequences for the whole group. It is difficult to see how the group can be successful in maintaining expenditures within budget unless each practice accepts its collective responsibility and agrees to be bound by the decisions of the group. Given the likely size of a typical PCG in terms of the number of practices and GPs involved, the collective responsibility model of primary care commissioning must be expected to require a relatively complex organisational structure and, in turn, relatively high management costs.

Health authority functions

It is reasonable to assume that under a model in which responsibility for most health care commissioning is devolved completely to PCGs, some of the functions of the host health authority could be reduced. The impact on transactions costs depends on three factors: the extent to which some of the current functions of health authorities may no longer be required in the absence of fundholding; whether some new functions relating to PCGs will be introduced, or existing functions enhanced; and the extent to which some of the current functions of the health authority will be devolved to PCGs.

We have discovered no cases in which the costs of the host health authority have been reduced as a result of the introduction of total purchasing, and in most cases, additional costs have been evident. However, this is not surprising in a situation in which total purchasing exists alongside fundholding and health authority commissioning. The relevant question is the extent to which costs may be expected to change in the long run as some form of primary care commissioning becomes universal.

Some of the existing functions of health authorities may be reduced in the long run if fundholding is subsumed within a locality commissioning scheme. In particular, some of the 'Core Functions B' (approximately 13% of management expenditure) identified in Griffiths (1996, page 10) such as allocation of budgets to SFHs and financial audit of fundholders, and some of the functions identified under the heading 'Support to Primary Care-led Purchasing' such as support for GP fundholding and assistance to GPs in the purchasing role (see Table 3.12) could be eliminated. Management allowances for fundholding would fall within this category.

Other functions are likely to be enhanced. For example, allocation of budgets to PCGs, audit and performance management of PCGs and support for PCGs.. More significantly, there may be increased demands on public health, finance and information functions.

None of these effects is easy to quantify, but the most likely outcome is that the balance of costs is broadly neutral; with the additional costs associated with a District-wide system of PCG commissioning likely to consume any potential reductions in costs associated with abolishing fundholding. This is one of a number of issues which needs further research or modelling on the basis of the expectations of the NHS Executive about the most likely outcomes.

Many of the existing functions of health authorities could, in principle, be devolved to PCGs. For example, Griffiths (1996) suggests that approximately 60% (by cost) of the current functions of health authorities are also functions of GP commissioners. This is probably an upper bound. However, since the assumption is that these functions will be transferred rather than eliminated the net cost impact on the health system as a whole should be zero.

So far, this analysis suggests that a development in which fundholding is replaced by universal primary care commissioning is unlikely to reduce transactions costs overall, but could be achieved in a way which is broadly cost neutral. However, there are two important caveats.

- Firstly, cost neutrality assumes that transferring functions from the health authority to a PCG can be achieved without additional costs. In practice, this is unlikely to be the case because each health authority will have more than one locality. An average authority might have 4 or 5 localities, or even more depending on size. The smaller the PCG and (paradoxically) the greater the extent to which functions are transferred from the health authority, the greater the potential increase in transactions costs overall.

  The cost impact of duplicating functions is exacerbated to the extent that there may have been economies of scale in some of these functions at health authority level. A possible outcome is that PCGs work together to create a 'purchaser support agency' to facilitate sharing the costs of common functions.

- The second caveat relates to the timescale over which change can be implemented. If, as the White Paper proposes, the level of responsibility accepted by PCGs will vary, there will be an interim period in which costs are increased as primary care commissioning is expanded without any corresponding reduction in the functions of the health authority until the last PCG in the health authority area is fully fledged as a commissioner of services.

The time period over which it will be possible to re-direct the current management costs associated with fundholding is unknown, but this will also introduce a source of cost duplication during the transition period.

The costs of fundholding

It should be possible to make savings in the costs of managing funds at practice level. In part, this is because the proposals in the White Paper will permit the current artificial distinction between budgets for SFH and total purchasing to be removed (at least in places which have TPPs), and, in part, there should be economies from combining the funds of individual practices.

Our evidence suggests that, as it is currently operated, total purchasing does not always involve the aggregation of the purchasing allocations of individual practices. In one of the projects in the sample used to calculate the transactions costs, the five practices in the TPP operated initially with separate practice-level purchasing allocations (this project is now operating as five separate TPPs). Even where the incremental budgets associated with total purchasing are managed as a whole, individual practices have not usually aggregated their existing budgets for fundholding and have not generally brought fundholding budgets within the management structure of the TPP.

Combining budgets for fundholding and total purchasing appears to be an important driver for reducing the transactions costs associated with primary care commissioning. There should be economies resulting from a removal of the artificial distinction between budgets for SFH and total purchasing, and also from combining the funds of individual practices. Quantifying the extent of any potential savings is difficult primarily because in most TPPs budgets remain separate and are separately managed.

On the basis of the available evidence (see Tables 3.11 and 3.12), the current combined costs of managing SFH and total purchasing budgets is around £7-£8 per capita. The minimum cost scenario is one in which all of the existing direct management costs associated with fundholding (approximately £5.00 per capita) are eliminated. This gives an estimate of around £2-£3 per capita, similar to the current incremental management costs of total purchasing over SFH. However, on the basis of our evidence and the discussion above, this is not a realistic scenario.

We have some independent evidence of the likely magnitude of potential savings, although any conclusions drawn on the basis of this evidence are naturally tentative. In one TPP in which the participating practices had no experience of fundholding before the creation of total purchasing, the direct costs of managing a combined SFH and TPP budget were £3.50 per

capita. Staff at another project indicated that they *believed* it would be possible to manage their combined SFH and total purchasing budgets with a reduction of 50% in the current costs associated with managing fundholding budgets.

This is extremely 'soft' information, but it offers an estimate in the range £3.50-£4.00 per capita to manage PCG commissioning, compared with a current estimated cost of around £7.00-£8.00 for the combined costs of managing budgets for fundholding and total purchasing. However, there are two important qualifications to make before accepting this estimate.

- Firstly, in round figures, the average direct management cost of fundholding is £5.00 per capita (Table 3.12). However, fundholding currently covers only around 50% of the population and this implies that the current management costs of fundholding are nearer to £2.50 per capita when measured across the whole population. Thus this is the relevant figure against which to compare the additional costs associated with the extension of primary care commissioning to universal PCGs. So, on the basis of the estimates above (£3.50-£4.00), it appears to be unlikely that such a scheme could be cost neutral overall.
- Secondly, no allowance has been made for the additional transactions costs imposed on providers. Our evidence suggests that there are potential savings to be made by acute providers as a result of a reduction in the number of purchasers. For community trusts and mental health trusts, however, the impact of the requirement to differentiate activity and costs by GP or by practice is expected to be more significant because of the current inadequacy of community and mental health services' information systems. Of course, some of these costs will be non-recurrent (e.g. installing new information systems), but others will be continuing such as collecting and analysing activity and cost data.

5.3 Conclusions

The transactions costs associated with the addition of total purchasing to the existing models of commissioning are significant. At present, most of these costs have been generated by the need for coordination between the GPs and practice managers within a TPP, and by the need for the health authority to offer strategic leadership to the scheme.

A significant part of the cost is borne by GPs participating in the scheme, some of which is not currently compensated. The future success of primary care commissioning through PCGs may depend ultimately on the continued willingness of GPs to make this commitment. The costs of compensating GPs and other primary care professionals should not be underestimated, particularly if one of the aims of primary care commissioning is to secure the involvement of *all* local professionals in the commissioning process.

The observed benefits of total purchasing may be modest to date (Mays, Goodwin, Killoran and Malbon, 1998), but if these benefits are thought to be worth preserving, it is relevant to consider whether alternative models could deliver these benefits at lower cost. The PCGs proposed in the White Paper are expected to be more efficient (that is, to have lower per capita management costs) than the current mixed system in which fundholders, TPPs and the health authority operate in parallel. However, because the proposals also involve an extension of the coverage of primary care commissioning to all practices, it is difficult to see how management costs can be lower in aggregate. If management costs are restrained in a way which is not realistic, the result is likely to be slow progress and low achievement.

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APPENDIX A

Theoretical background: Transactions cost economics

The context within which this study is framed is defined by the 'new institutional economics' (or transactions cost economics) due originally to Coase (1937,1991) and Oliver Williamson (1975, 1987). Within this context the objective of analysis is to compare the costs of economic activity in different forms of organisation.

The specific type of economic activity which is of relevance here is the transaction between a consumer (or their agent) and a supplier of health care. In broad terms the total costs of such a transaction are the costs of producing and delivering health care (costs of production) and the costs of organising activity in such a way that a contract between the supplier and the consumer can take effect and can be enforced. These costs of contracting are transactions costs. *Our working definition is that all costs not directly attributable to the production of health care are transactions costs.*

Transactions costs arise primarily because of uncertainty and imperfect information. Some of the most important sources of cost are:

The costs of search and information. The costs of search include costs borne by consumers or their agents in identifying health needs, types of health care which are appropriate and in identifying the characteristics of available suppliers (such as price and quality). Search costs are, broadly, the costs of obtaining relevant information.

The costs of negotiation and contracting. Negotiation costs include the costs of agreeing with suppliers on the characteristics and price of the services to be provided and, where relevant, incorporating these into a mutually acceptable contract.

The costs of monitoring and enforcement. The performance of suppliers against the agreed contract need to be monitored over time, particularly where the incentives facing suppliers are inconsistent with those of the consumer or their agent. Where the agreed terms of a contract are violated, further costs may be incurred in enforcing contract compliance.

In its broadest application transactions cost economics addresses the comparative costs of organising transactions directly (between consumer and supplier) and indirectly through the medium of a firm or other agency. In the context of health an equivalent comparison might be between the costs of organisation in a centrally planned and coordinated NHS and the costs of organisation within an internal market.

However, given the aims of the national TPP evaluation, the objective of this study is more circumscribed: the focus here is on the relative transactions costs associated with alternative models of purchasing within an internal market. In particular, our aim is to estimate the increment in transactions costs with the introduction of total purchasing into the range of purchasing models. All of the broad categories of transactions costs are relevant, but to these we have added a fourth:

The costs of coordination and organisation. One of the features of the total purchasing pilots is the fact that (typically) practices are grouped together into a single purchasing unit with a shared budget. Transactions costs will arise in coordinating members of the group, some of whom may have divergent interests.

Our estimates of the incremental transactions costs associated with total purchasing are classified according to these four main types.

Much of the literature on transactions cost economics applies to the evolutionary development of organisational structures in place of market exchange. The aim of minimising the transactions costs of exchange is typically seen as a dynamic factor influencing the evolution of organisations. However, while it may be argued that total purchasing has evolved from fundholding, this cannot be considered a 'natural evolution' because the structural form taken by the total purchasing pilots is constrained by NHS policy. In this sense there can be no presumption that current forms are those in which transactions costs are minimised. Part of our objective is to consider ways in which changes in the current scheme might lead to a reduction in costs.

APPENDIX B

Meeting-related transactions cost in first 'live' year
for (1996/97) for each sample first wave project

Table B1 **Project C: meetings related transactions costs in first live year**

Activity / Meeting Year 2 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates				Grade	Cost based on salary
					preparation & follow-up	meeting or activity	travel	total		
					hrs	hrs	hrs	hrs		£
HA TPP Board (TP Pilot Sub-committee)										
GPs	GP	M1	4	4	0.00	2.00	1.00	48.00	GP	1,560
Business manager	TPP	M1	1	4	0.00	2.00	1.00	12.00	SMP13	281
TP development manager	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP13	187
Chief Executive	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP1	300
Directors	HA	M1	2	4	0.00	2.00	0.00	16.00	SMP10	421
Chair	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP10	211
Locality manager	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP17	160
CHC rep	CHC	M1	1	4	0.00	2.00	1.00	12.00	SMP25	175
Project steering group 2										
GPs	GP	C2	5	12	0.00	1.50	0.00	90.00	GP	2,924
Business manager	TPP	C2	1	12	4.00	1.50	0.00	66.00	SMP13	1,545
Practice managers	TPPN	C2	4	12	0.00	1.50	0.00	72.00	SMP21	1,231
Management Meetings										
TP development manager	HA	M1	1	12	0.00	1.50	0.60	25.20	SMP13	590
Business manager	TPP	M1	1	12	1.00	1.00	0.00	24.00	SMP13	562
Practice managers	TPPN	M1	3	12	0.00	1.00	0.40	50.40	SMP21	862
Clinical Subgroups										
Main reporting back										
Business manager	TPP	S3	1	12	0.00	1.50	0.00	18.00	SMP13	421
Practice managers	TPPN	S3	4	12	0.00	1.50	0.00	72.00	SMP21	1,231
GPs	GP	S3	5	12	0.00	1.50	0.00	90.00	GP	2,924
Nine subgroups, meetings may be (bi) monthly or quarterly										
Practice managers	TPPN	S3	1	108	0.00	1.00	0.00	108.00	SMP21	1,847
GPs	GP	S3	2	108	3.00	1.00	0.00	864.00	GP	28,072
Provider meetings										
Business manager	TPP	N3	1	4	15.00	2.00	1.00	72.00	SMP13	1,685
GPs	GP	N3	2	4	12.00	2.00	1.00	120.00	GP	3,899
Clinicians, hosp staff	AcTC	N3	4	1	0.00	1.00	0.00	4.00	Con	164
Cardiologists	AcTC	N3	6	1	0.00	2.00	0.00	12.00	Con	492
Neurologist	AcTC	N3	1	1	0.00	1.00	0.00	1.00	Con	41
General managers	AcT	N3			0.00	2.00	0.00	0.00	SMP17	0
Business Development manager	AcT	N3	1	3	0.00	2.00	0.00	6.00	SMP17	120

Table B1 (continued) **Project C: meetings related transactions costs in first live year**

Activity / Meeting Year 2 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates: preparation & follow-up	Time estimates: meeting or activity	Time estimates: travel	Time estimates: total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Meetings with HA										
Fundholder meetings										
Business manager	TPP	M1	1	4		1.00		4.00	SMP13	94
HA sub-committee										
Business manager	TPP	M1	1	4		2.00		8.00	SMP13	187
Acute Providers										
Trust 1										
Business manager	TPP	N3	1	1	0.00	2.00	0.50	2.50	SMP13	59
Practice manager	TPPN	N3	1	1	0.00	2.00	1.00	3.00	SMP21	51
Business Development manager	AcT	N3	1	1	0.00	1.00	0.60	1.60	SMP17	32
TP development manager	HA	N3	1	1	0.00	1.00	0.00	1.00	SMP13	23
GPs: Mid year review	GP	M3	1	2	0.00	1.50	0.50	4.00	GP	130
Information (given at SFH mtg)	AcT	S3	1	12	2.00	0.00	0.00	24.00	SMP26	337
Trust 2	*TPP representative attended exisiting meetings*									
Practice manager	TPPN	N3	2	1	0.00	2.00	0.50	5.00	SMP21	86
Trust 3	*TPP representative attended existing meetings*									
GP	GP	N3	1	1	0.00	1.50	0.50	2.00	GP	65
Community Providers	*TPP representative attended existing meetings*									
Trust 4										
Business manager	TPP	N3	1	1	0.00	1.50	1.00	2.50	SMP13	59
GPs	GP	N3	2	1	0.00	1.50	1.00	5.00	GP	162
Practice manager	TPPN	N3	1	1	0.00	1.50	1.00	2.50	SMP21	43
Training Sessions										
TP development manager	HA	S1	1	5	0.00	7.00	1.00	40.00	SMP13	936
Business manager	TPP	S2	1	5	0.00	7.00	1.00	40.00	SMP13	936
Practice managers	TPPN	S2	1	5	0.00	7.00	1.00	40.00	SMP21	684
Trust reps	AcT	S3	1	4	0.00	2.00	0.60	10.40	SMP17	208
Business Development manager	AcT	S3	1	4	0.00	2.00	0.60	10.40	SMP17	208

Table B2 **Project B: meetings related transactions costs in first live year**

Activity / Meeting live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
HA TPP Board										
Dep Acute Purchasing manager	HA	M1	1	12	0.00	2.00	0.75	33.00	SMP13	772
Dir Corporate Management	HA	M1	1	12	3.50	2.00	0.75	75.00	SMP10	1,975
Dir Finance	HA	M1	1	12	0.00	2.00	0.75	33.00	SMP10	869
Dir Public Health	HA	M1	1	12	0.00	2.00	0.75	33.00	SMP10	869
Non executive director	HA	M1	2	12	0.00	2.00	0.75	66.00	SMP10	1,738
GPs	GP	M1	3	12	0.00	2.00	0.75	99.00	GP	3,217
Fundmanager	TPP	M1	1	12	0.00	2.00	0.75	33.00	SMP13	772
Support staff	TPPN	M1	1	12	0.00	2.00	0.75	33.00	SMP26	464
Purchaser Development Meetings										
Dir Corporate Management	HA	C1	1	24	3.50	2.00	0.50	144.00	SMP10	3,791
Support staff	HA	C1	1	24	24.00	0.00	0.50	588.00	SMP26	8,265
Senior Accountant	HA	C1	1	24	0.00	2.00	0.50	60.00	SMP17	1,200
Consultant Public Health	HA	C1	1	24	0.00	2.00	0.50	60.00	SMP5	1,922
Dir Project Management	HA	C1	1	24	0.00	2.00	0.50	60.00	SMP10	1,580
Region wide TPP										
Dir Corporate Management	HA	S1	1	4	0.00	2.00	2.00	16.00	SMP10	421
Conferences/Workshops										
Dir Corporate Management	HA	S1	1	3	0.00	7.00	2.00	27.00	SMP10	711
Executive Board										
GP lead	GP	C2	1	48	0.00	3.50	0.00	168.00	GP	5,459
GPs	GP	C2	2	48	0.00	3.50	0.00	336.00	GP	10,917
Fund manager	TPP	C2	1	48	0.00	3.50	0.00	168.00	SMP13	3,932
Medical Advisor	TPPN	C2	1	48	0.00	3.50	0.00	168.00	SMP24	2,554
Asst Practice Manager	TPPN	C2	1	48	0.00	3.50	0.00	168.00	SMP21	2,873
Internal Meeting										
GP lead	GP	C2	1	48	0.00	0.75	0.00	36.00	GP	1,170
Fund manager	TPP	C2	1	48	0.00	0.75	0.00	36.00	SMP13	843
General work										
GP lead	GP	C2	1	260	0.50	0.00	0.00	130.00	GP	4,224
Exchange Group mtgs										
GP	GP	S2	1	4	0.00	2.00	1.50	14.00	GP	455
Acute Providers										
Trust 1										
Contract negotiation										
Chief Exec	AcT	N3	1	1	0.00	1.00	0.00	1.00	SMP1	37
Contracts Manager	AcT	N3	1	3	1.45	1.00	0.00	7.35	SMP17	147
Dir Contracting	AcT	N3	1	1	45.00	1.00	0.00	46.00	SMP10	1,211
Finance Manager	AcT	N3	1	3	1.45	1.00	0.00	7.35	SMP17	147
Dir Finance	AcT	N3	1	1	45.00	1.00	0.00	46.00	SMP10	1,211
GPs	GP	N3	1	1	0.00	1.00	1.00	2.00	GP	65
Fundmanager	TPP	N3	1	3	0.00	1.00	1.00	6.00	SMP13	140
Quarterly review										
Contracts Manager	AcT	M3	1	4	2.00	1.50	0.00	14.00	SMP17	280
Chief Accountant	AcT	M3	1	4	2.00	1.50	0.00	14.00	SMP17	280
Information requirements										
Info staff	AcT	S3	1	12	2.00	0.00	0.00	24.00	SMP26	337

Table B2 (continued) **Project B: meetings related transactions costs in first live year**

Activity / Meeting live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Trust 2										
Contract negotiation										
Dir Strategic Development	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211
Contracts manager	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP17	160
Business managers	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP17	160
Information	AcT	N3	1	1	3.00	0.00	0.00	3.00	SMP26	42
Finance	AcT	N3	1	1	12.00	0.00	0.00	12.00	SMP26	169
Fundmanager	TPP	N3	1	4	0.00	2.00	1.50	14.00	SMP13	328
Quarterly review										
Dir Strategic Development	AcT	M3	1	4	1.00	2.00	0.00	12.00	SMP10	316
Contracts manager	AcT	M3	1	4	1.00	2.00	0.00	12.00	SMP17	240
Information staff	AcT	M3	1	4	3.00	2.00	0.00	20.00	SMP26	281
Fundmanager	TPP	M3	1	4	0.00	2.00	1.50	14.00	SMP13	328
Specific Issues	eg emergency care, obstetrics, orthopaedics									
Dir Strategic Development	AcT	S3	1	3	2.00	0.50	0.00	7.50	SMP10	197
Contracts manager	AcT	S3	1	3	1.00	0.50	0.00	4.50	SMP17	90
Information staff	AcT	S3	1	3	1.00	0.50	0.00	4.50	SMP26	63
Business manager	AcT	S3	1	1	10.00	0.00	0.00	10.00	SMP17	200
Trust 3										
Contract meetings										
Dir Contracts & Marketing	AcT	N3	1	2	0.00	2.00	1.50	7.00	SMP10	184
Contracts Manager	AcT	N3	1	2	0.00	2.00	1.50	7.00	SMP17	140
Head of A&E	AcT	N3	1	1	0.00	2.00	1.50	3.50	SMP10	92
Fundmanager	TPP	N3	1	2	0.00	2.00	0.00	4.00	SMP13	94
Provider meetings										
Dir Contracts & Marketing	AcT	N3	1	2	0.00	1.00	1.50	5.00	SMP10	132
Dir Contracting: trust 1	AcT	N3	1	2	0.00	1.00	0.00	2.00	SMP10	53
Dir Contracting: trust 3	AcT	N3	1	2	0.00	1.00	1.50	5.00	SMP10	132
Contract monitoring										
Dir Contracts & Marketing	AcT	M3	1	12	0.00	0.15	0.00	1.80	SMP10	47
Deputy Dir Finance	AcT	M3	1	12	0.00	0.50	0.00	6.00	SMP13	140
Community Mental Health										
Trust 4										
Contract meetings										
Corporate contracts manager	CMH	N3	1	4	0.00	2.00	1.00	12.00	SMP17	240
Contracts information manager	CMH	N3	1	4	0.00	2.00	1.00	12.00	SMP17	240
Dep Dir Finance	CMH	N3	1	4	0.00	2.00	1.00	12.00	SMP13	281
Hospital manager	CMH	N3	1	4	0.00	2.00	1.00	12.00	SMP17	240
Information staff	CMH	N3	1	1	21.00	0.00	0.00	21.00	SMP26	295
Fundmanager	TPP	N3	1	4	0.00	2.00	0.00	8.00	SMP13	187
Specific issue - casualty										
CExec - trust 4	CMH	S3	1	1	2.00	0.00	0.00	2.00	SMP1	75
CExec - HA	CMH	S3	1	1	2.00	0.00	0.00	2.00	SMP1	75
Corporate contracts manager	CMH	S3	1	1	1.50	0.00	0.00	1.50	SMP17	30
Fundmanager	TPP	S3	1	1	2.00	0.00	0.00	2.00	SMP13	47
Quarterly review										
Corporate contracts manager	CMH	M3	1	4	1.00	2.00	1.00	16.00	SMP17	320
Contracts information manager	CMH	M3	1	4	1.00	2.00	1.00	16.00	SMP17	320
Specific manager	CMH	M3	1	4	10.00	2.00	1.00	52.00	SMP17	1,040
Fundmanager	TPP	M3	1	4	0.00	2.00	0.00	8.00	SMP13	187
Monitoring										
Info staff	CMH	M3	1	12	3.50	0.00	0.00	42.00	SMP26	590

Table B2 (continued) **Project B: meetings related transactions costs in first live year**

Activity / Meeting live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates				Grade	Cost based on salary
					preparation & follow-up	meeting or activity	travel	total		
					hrs	hrs	hrs	hrs		£
Trust 5										
Strategy meetings										
Assoc Dir Contracts	CMH	S3	1	8	1.50	3.00	1.00	44.00	SMP13	1,030
Dep Dir Finance	CMH	S3	1	8	0.00	3.00	1.00	32.00	SMP13	749
Consultants	CMH	S3	2	8	0.00	3.00	1.00	64.00	Con	2,622
Contracts Assistant	CMH	S3	1	8	1.00	0.00	0.00	8.00	ANC5	85
Fundmanager	TPP	S3	1	8	0.00	3.00	0.00	24.00	SMP13	562
Pre-meetings										
Assoc Dir Contracts	CMH	N3	1	8	1.00	1.00	0.00	16.00	SMP13	375
Dep Dir Finance	CMH	N3	1	8	0.00	1.00	0.00	8.00	SMP13	187
Consultants	CMH	N3	2	8	0.00	1.00	0.00	16.00	Con	656
Internal meetings										
Assoc Dir Contracts	CMH	S3	1	6	0.50	1.00	0.00	9.00	SMP13	211
Dep Dir Finance	CMH	S3	1	6	0.00	1.00	0.00	6.00	SMP13	140
Associate directors	CMH	S3	2	6	0.00	1.00	0.00	12.00	SMP13	281
Contracts Assistant	CMH	S3	1	6	0.50	1.00	0.00	9.00	ANC5	96
Information changes										
Info staff	CMH	M3	1	1	20.00	0.00	0.00	20.00	SMP26	281

Table B3 **Project E: meetings related transactions costs in first live year**

Activity / Meeting first live year 1/4/96 to 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates				Grade	Cost based on salary
					preparation & follow-up	meeting or activity	travel	total		
					hrs	hrs	hrs	hrs		£
HA TPP Board										
Lead GP	GP	M1	1	4	0.00	2.50	1.50	16.00	GP	520
Practice manager	TPP	M1	1	4	0.00	2.50	1.50	16.00	SMP21	274
HA exec. director	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
HA director of finance	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
HA director of public health	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP5	320
HA non-exec. director	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
Project steering group										
Assistant practice manager	TPP	C1	1	12	0.00	2.50	0.75	39.00	SMP25	570
HA locality director	HA	C1	1	12	2.50	2.50	0.75	69.00	SMP10	1,817
HA finance manager	HA	C1	1	12	2.50	2.50	0.75	69.00	SMP17	1,380
Executive Board										
Lead GP	GP	C2	1	48	0.00	2.50	0.00	120.00	GP	3,899
Practice manager	TPP	C2	1	48	0.00	2.50	0.00	120.00	SMP21	2,052
Assistant practice manager	TPP	C2	1	48	0.00	2.50	0.00	120.00	SMP25	1,755
Practice meeting										
Lead GP	GP	C2	1	48	0.00	0.15	0.00	7.20	GP	234
Other partners	GP	C2	6	48	0.00	0.15	0.00	43.20	GP	1,404
Current topic meetings										
Practice manager	TPP	S1	1	12	0.00	1.50	0.00	18.00	SMP21	308
HA locality director	HA	S1	1	12	0.00	1.50	0.00	18.00	SMP10	474
Specialist services meetings										
Practice manager	TPP	S1	0.75	5	0.00	2.00	1.50	13.13	SMP21	224
Assistant practice manager	TPP	S1	0.75	5	0.00	2.00	1.50	13.13	SMP25	192
HA supporting staffwork	HA	S1	1	5	7.00	0.00	0.00	35.00	SMP26	492
Consortium meetings										
Practice manager	TPP	C1	1	6	0.00	2.00	1.50	21.00	SMP21	359
Assistant practice manager	TPP	C1	1	6	0.00	2.00	1.50	21.00	SMP25	307

Table B3 (continued) **Project E: meetings related transactions costs in first live year**

Activity / Meeting first live year 1/4/96 to 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Regional insurance consortium										
Practice manager	TPP	C1	1	12	0.00	2.00	1.50	42.00	SMP21	718
Regional involvement	R	C1	1	12	0.00	2.00	1.50	42.00	SMP10	1,106
HA supporting staffwork	HA	C1	1	12	7.00	0.00	0.00	84.00	ANC5	892
Patients advisory group										
GP	GP	S2	1	8	0.00	2.00	0.00	16.00	GP	520
Chiropodist	TPPN	S2	1	8	0.00	2.00	0.00	16.00	SMP27	216
Receptionist	TPPN	S2	1	8	0.00	2.00	0.00	16.00	ANC4	140
Practice nurse	TPPN	S2	1	8	0.00	2.00	0.00	16.00	NF	200
Public relations and evaluation										
Lead GP	GP	S2	1	25	0.00	1.00	0.00	25.00	GP	812
HA Monitoring meetings										
HA exec. director	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP10	211
HA locality director	HA	M1	1	4	0.00	2.00	0.00	8.00	SMP10	211
Acute and Community Provider										
Trust 1										
Contract negotiation										
Practice manager	TPP	N3	1	6	0.00	3.00	1.50	27.00	SMP21	462
Contracts mananger	AcT	N3	1	6	0.00	3.00	0.00	18.00	SMP17	360
Acute Provider										
Trust 2										
Contract negotiation										
Practice manager	TPP	N3	1	4	0.00	2.50	1.00	14.00	SMP10	369
Contracts mananger	AcT	N3	1	4	0.00	2.50	0.00	10.00	SMP21	171

Table B4 **Project A: meetings related transactions costs in first live year**

Activity / Meeting live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates: preparation & follow-up	Time estimates: meeting or activity	Time estimates: travel	Time estimates: total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
HA TPP Board										
GPs	GP	M1	4	4	0.00	2.00	0.00	32.00	GP	1,040
TP manager	TPP	M1	1	4	0.00	2.00	0.00	8.00	SMP13	187
TP Assistant	TPP	M1	1	4	0.00	2.00	0.00	8.00	SMP26	112
Asst Dir Commissioning	HA	M1	1	4	0.00	2.00	1.00	12.00	SMP13	281
Director	HA	M1	1	4	0.00	2.00	1.00	12.00	SMP10	316
Executive Board										
GP Chair	GP	C2	1	48	2.00	2.50	0.00	216.00	GP	7,018
GP Vice-Chair	GP	C2	1	48	3.00	2.50	0.00	264.00	GP	8,578
GPs	GP	C2	2	48	3.00	2.50	0.00	528.00	GP	17,155
TP manager	TPP	C2	1	48		2.50	0.00	120.00	SMP13	2,809
TP Assistant	TPP	C2	1	48		2.50	0.00	120.00	SMP26	1,687
Asst Dir Commissioning	HA	C1	1	48	1.00	2.50	1.00	216.00	SMP13	5,056
Consultant Public Health	HA	C1	1	24	0.00	2.50	1.00	84.00	SMP5	2,690
Internal meeting										
GP Chair	GP	C2	1	48	0.00	2.00	0.00	96.00	GP	3,119
TP manager	TPP	C2	1	48	0.00	2.00	0.00	96.00	SMP13	2,247
Acute Providers										
Trust 1										
Contract negotiation										
Dir Finance	AcT	N3	1	5	0.00	1.50	0.00	7.50	SMP10	197
TP manager	TPP	N3	1	4	0.00	1.50	0.00	6.00	SMP13	140
GP	GP	N3	1	4	0.00	1.50	0.00	6.00	GP	195
Recovery programme										
Dir Finance	AcT	S3	1	2	0.00	2.00	0.00	4.00	SMP10	105
TP manager	TPP	S3	1	2	0.00	2.00	0.00	4.00	SMP13	94
GP	GP	S3	1	2	0.00	2.00	0.00	4.00	GP	130
Trust 2										
Contract negotiation										
Dir Finance	AcT	N3	1	5	0.00	1.50	0.00	7.50	SMP10	197
TP manager	TPP	N3	1	4	0.00	1.50	0.00	6.00	SMP13	140
GP	GP	N3	1	4	0.00	1.50	0.00	6.00	GP	195
Trust 3										
Contract negotiation										
Dir Finance	AcT	N3	1	5	0.00	1.50	0.00	7.50	SMP10	197
TP manager	TPP	N3	1	4	0.00	1.50	0.00	6.00	SMP13	140
GP	GP	N3	1	4	0.00	1.50	0.00	6.00	GP	195

Table B4 (cont'd) **Project A: meetings related transactions costs in first live year**

Activity / Meeting live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Community Providers										
Trust 4										
Contract negotiation										
Dir Finance	CMH	N3	1	5	0.00	1.50	0.00	7.50	SMP10	197
TP manager	TPP	N3	1	5	0.00	1.50	0.00	7.50	SMP13	176
GP	GP	N3	1	4	0.00	1.50	0.00	6.00	GP	195
Contract monitoring										
Business Dev manager	CMH	M3	1	3	0.00	2.00	0.00	6.00	SMP17	120
TP assistant	TPP	M3	1	3	0.00	2.00	0.00	6.00	SMP26	84
Service Developments										
Discharge and bed blocking										
initial meetings										
Business Dev manager	CMH	S3	1	10	0.00	1.00	0.00	10.00	SMP17	200
Project nurse	TPP	S3	1	10	0.00	1.00	0.00	10.00	NG	145
TP manager	TPP	S3	1	5	0.00	1.00	0.00	5.00	SMP13	117
TP assistant	TPP	S3	1	5	0.00	1.00	0.00	5.00	SMP26	70
meetings with pc nurse										
Project nurse	TPP	S3	1	24	0.00	2.00	0.00	48.00	NG	698
Asst manager	CMH	S3	1	24	0.00	2.00	0.00	48.00	SMP21	821
Primary care nurse	CMH	S3	1	24	0.00	2.00	0.00	48.00	NF	601
meetings with acute unit										
Project nurse	TPP	S3	1	6	0.00	2.00	0.00	12.00	NG	175
Manager of acute unit	CMH	S3	1	6	0.00	2.00	0.00	12.00	SMP17	240
Drugs and alcohol										
Business Dev manager	CMH	S3	1	6	0.00	2.00	0.00	12.00	SMP17	240
Mental health manager	CMH	S3	1	6	0.00	2.00	0.00	12.00	SMP17	240
Dir of nursing	CMH	S3	1	6	0.00	2.00	0.00	12.00	SMP10	316
Psychiatry consultant	CMHC	S3	1	6	0.00	2.00	0.00	12.00	Con	492
Drug & alcohol CPN	CMHC	S3	1	6	0.00	2.00	0.00	12.00	NF	150
ECRs										
Business Dev manager	CMH	S3	1	6	0.00	2.00	0.00	12.00	SMP17	240
Mental health managers	CMH	S3	3	6	0.00	2.00	0.00	36.00	SMP17	720
TP manager	TPP	S3	1	6	0.00	2.00	0.00	12.00	SMP13	281
GP	GP	S3	1	6	0.00	2.00	0.00	12.00	GP	390
Emergency triage										
Chief Executive	CMH	S3	1	1	0.00	2.00	0.00	2.00	SMP1	75
Trust manager	CMH	S3	1	5	0.00	2.00	0.00	10.00	SMP17	200
Business Dev manager	CMH	S3	1	2	0.00	2.00	0.00	4.00	SMP17	80
TP Chair	GP	S3	1	6	0.00	2.00	0.00	12.00	GP	390
GPs	GP	S3	2	6	0.00	2.00	0.00	24.00	GP	780
NAHAT Presentation										
GP Chair	GP	S2	1	1	14.00	7.00	0.00	21.00	GP	682
TP manager	TPP	S2	1	1	14.00	7.00	0.00	21.00	SMP13	492
Commissioning meetings										
GP Chair	GP	S3	1	6	0.00	3.00	0.00	18.00	GP	585
Local councillor's meetings										
GP Chair	GP	M1	1	6	0.00	2.00	0.00	12.00	GP	390

Table B5 **Project D: meetings related transactions costs in first live year**

Activity / Meeting first live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	meeting or activity	travel	total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
HA TPP Board										
Lead GPs (inc. chair)	GP	M1	5	4	0.00	2.50	1.50	80.00	GP	2,599
Project manager	TPP	M1	1	4	0.00	2.50	1.50	16.00	SMP13	375
DHA director of finance	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
DHA director of primary care	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
DHA non-executive director	HA	M1	1	4	0.00	2.50	0.00	10.00	SMP10	263
Executive Board										
Lead GPs	GP	C2	5	48	0.00	2.50	0.00	600.00	GP	19,495
Project manager	TPP	C2	1	48	14.00	2.50	0.00	792.00	SMP13	18,538
Pharmaceutical project manager	TPPN	C2	1	48	0.00	2.50	0.00	120.00	SMP24	1,824
Dental project manager	TPPN	C2	1	3.5	0.00	2.50	0.00	8.75	SMP24	133
CoC director of contracts	AcT	S3	1	3	0.00	2.50	0.80	9.90	SMP10	261
CoC business manager	AcT	S3	1	6	0.00	2.50	0.80	19.80	SMP17	396
Additional ad hoc meetings										
Lead GPs	GP	C2	5	25	0.00	2.50	0.00	312.50	GP	10,154
Project manager	TPP	C2	1	25	0.00	2.50	0.00	62.50	SMP13	1,463
Presentations to CHC and council										
Lead GPs	GP	S2	5	6	0.00	2.00	1.00	90.00	GP	2,924
Project manager	TPP	S2	1	6	0.00	2.00	1.00	18.00	SMP13	421
Quarterly GPs meeting										
GPs	GP	C2	26	4	0.00	3.00	1.00	416.00	GP	13,516
Provider meetings										
Trust 1										
Contract Negotiation										
GP	GP	N3	1	4	0.00	2.00	1.00	12.00	GP	390
Project manager	TPP	N3	1	4	0.50	2.00	1.00	14.00	SMP13	328
Director of contracts	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211
Contract monitoring										
project manager	TPP	M3	1	48	0.00	0.75	1.00	84.00	SMP13	1,966
Fund / practice managers	TPP	M3	2	48	0.00	0.75	1.00	168.00	SMP21	2,873
business manager	AcT	M3	1	48	0.00	0.75	0.00	36.00	SMP17	720
Quality Group										
GP	GP	M3	1	12	0.00	2.00	1.00	36.00	GP	1,170
Project manager	TPP	M3	1	12	0.00	2.00	1.00	36.00	SMP13	843
Fund / practice managers	TPP	M3	5	12	0.00	2.00	1.00	180.00	SMP21	3,079
Business managers	AcT	M3	5	12	0.00	2.00	0.00	120.00	SMP21	2,052
director of nursing	AcT	M3	1	12	0.00	2.00	0.00	24.00	SMP10	632
director of contracts	AcT	M3	1	2	0.00	2.00	0.00	4.00	SMP10	105
clinical managers	AcT	M3	5	2	0.00	2.00	0.00	20.00	SMP17	400
Trust 2										
GP	GP	N3	1	4	0.00	2.00	1.00	12.00	GP	390
Project manager	TPP	N3	1	4	0.50	2.00	1.00	14.00	SMP13	328
Director of contracts	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211
Trust 3										
GP	GP	N3	1	4	0.00	2.00	1.00	12.00	GP	390
Project manager	TPP	N3	1	4	0.50	2.00	1.00	14.00	SMP13	328
Director of contracts	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211

Table B5 (continued) **Project D: meetings related transactions costs in first live year**

Activity / Meeting first live year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Trust 4										
GP	GP	N3	1	4	0.00	2.00	1.00	12.00	GP	390
Project manager	TPP	N3	1	4	0.50	2.00	1.00	14.00	SMP13	328
Director of contracts	AcT	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211
Trust 5										
GP	GP	N3	1	4	0.00	2.00	1.00	12.00	GP	390
Project manager	TPP	N3	1	4	0.50	2.00	1.00	14.00	SMP13	328
Director of contracts	CMH	N3	1	4	0.00	2.00	0.00	8.00	SMP10	211
Review of community trust merger (autumn 1996)										
GPs	GP	S3	5	2	0.00	7.00	0.00	70.00	GP	2,274
project manager	TPP	S3	1	2	0.00	7.00	0.00	14.00	SMP13	328
Review of rehab services (over 6months)										
GPs - meetings	GP	S3	2	16	0.00	2.50	0.00	80.00	GP	2,599
GP - wardrounds	GP	S3	1	12	0.00	2.50	0.00	30.00	GP	975
Review of physiotherapy (ongoing for the past year)										
Lead GP	GP	S3	1	6	0.00	1.00	1.00	12.00	GP	390
project manager	TPP	S3	1	6	0.00	1.00	1.00	12.00	SMP13	281
Trust 5										
deputy chief executive	CMH	S3	1	6	0.00	1.00	0.00	6.00	SMP6	185
contracts manager	CMH	S3	1	6	0.00	1.00	0.00	6.00	SMP17	120
head of physio services	CMH	S3	1	6	0.00	1.00	0.00	6.00	SMP10	158
Trust 3										
director of finance	CMH	S3	1	6	0.00	1.00	1.00	12.00	SMP10	316
deputy director of finance	CMH	S3	1	6	5.00	1.00	1.00	42.00	SMP13	983
therapist manager	CMH	S3	1	6	5.00	1.00	1.00	42.00	SMP17	840
Pharmacy project										
lead GP	GP	S2	1	25	0.00	2.50	0.00	62.50	GP	2,031
practice GP	GP	S2	1	25	0.00	2.50	0.00	62.50	GP	2,031
Fund / practice managers	TPP	S2	10	25	0.00	2.50	0.00	625.00	SMP21	10,690
pharmacists	TPPN	S2	2	25	0.00	2.50	0.00	125.00	SMP24	1,900
Community pharmacy project										
lead GP	GP	S2	1	5	0.00	2.00	0.00	10.00	GP	325
GPs	GP	S2	5	3	0.00	2.00	0.00	30.00	GP	975
Local pharmacists	TPPN	S2	5	5	0.00	2.00	0.00	50.00	SMP24	760
HA pharmacy adviser	HA	S2	1	3	0.00	2.00	1.50	10.50	SMP24	160
total dental project										
Lead GP	GP	S2	1	48	0.00	2.00	0.00	96.00	GP	3,119
Lead dentist	HA	S2	1	48	0.00	2.00	0.75	132.00	Den	2,640
Consultant Public Health	HA	S2	1	48	0.00	2.00	0.75	132.00	SMP5	4,228
Preparatory for new quality groups										
project manager	TPP	M3	1	4	0.00	1.00	1.00	8.00	SMP13	187
trust chief executives	AcT	M3	1	4	0.00	1.00	0.00	4.00	SMP1	150
trust contracts managers	AcT	M3	1	4	0.00	1.00	0.00	4.00	SMP17	80
SAVINGS										
Reduction in fundholding contract negotiations (2.5 meetings each in Feb. and Mar.)										
GP	GP	N3	1	-50	0.00	2.00	1.00	-150.00	GP	-4,874
trust director of contracting	AcT	N3	1	-50	0.00	2.00	0.00	-100.00	SMP10	-2,633
Fund / practice managers	TPP	N3	1	-50	0.00	2.00	0.00	-100.00	SMP21	-1,710
Reduction in fundholding contract update meetings										
GP	GP	N3	1	-300	0.00	1.00	1.00	-600.00	GP	-19,495
trust contracting manager	AcT	N3	1	-300	0.00	1.00	0.00	-300.00	SMP17	-6,001
Fund / practice managers	TPP	N3	1	-300	0.00	1.00	0.00	-300.00	SMP21	-5,131

Table B6 **Project F: meetings related transactions costs in first live year**

Activity / Meeting shadow year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
HA TPP Board										
HA chief executive	HA	M1	1	3	0.00	1.50	0.00	4.50	SMP1	169
Dir Finance & Information	HA	M1	1	3	0.00	1.50	0.00	4.50	SMP10	118
director of public health	HA	M1	1	3	0.00	1.50	0.00	4.50	SMP5	144
HA non executive director	HA	M1	1	3	0.00	1.50	0.00	4.50	SMP10	118
LMC representative	GP	M1	1	3	0.00	1.50	2.00	10.50	GP	341
regional office representative	R	M1	1	3	0.00	1.50	4.00	16.50	SMP10	434
GPs	GP	M1	2	3	0.00	1.50	2.00	21.00	GP	682
fund / business manager	TPPN	M1	1	3	0.00	1.50	2.00	10.50	SMP21	180
project manager	HA	M1	1	3	14.00	1.50	0.00	46.50	SMP13	1,088
Project steering group										
lead GP	GP	C1	5	12	0.00	2.50	2.00	270.00	GP	8,773
fund / business manager	TPPN	C1	5	12	0.00	2.50	2.00	270.00	SMP21	4,618
Dir Finance & Information	HA	C1	1	12	0.00	2.50	0.00	30.00	SMP10	790
Dir Contracting	HA	C1	1	12	0.00	2.50	0.00	30.00	SMP10	790
project manager	HA	C1	1	12	0.00	2.50	0.00	30.00	SMP13	702
information analyst	HA	C1	1	12	0.00	2.50	0.00	30.00	SMP26	422
Fund managers group										
fund / business manager	TPPN	C1	5	6	0.00	3.50	2.00	165.00	SMP21	2,822
project manager	HA	C1	1	6	0.00	3.50	0.00	21.00	SMP13	492
information analyst	HA	C1	1	6	0.00	3.50	0.00	21.00	SMP26	295
East end meetings with providers										
Trust 1										
Dir Contracting	AcT	N3	1	6	0.00	1.50	0.00	9.00	SMP10	237
GP	GP	N3	2	6	0.00	1.50	1.50	36.00	GP	1,170
fund / business manager	TPPN	N3	2	6	0.00	1.50	1.50	36.00	SMP21	616
project manager	HA	N3	1	6	0.00	1.50	1.50	18.00	SMP13	421
Trust 2										
Dir Contracting	AcT	N3	1	6	0.00	1.50	0.00	9.00	SMP10	237
GP	GP	N3	2	6	0.00	1.50	1.50	36.00	GP	1,170
fund / business manager	TPPN	N3	2	6	0.00	1.50	1.50	36.00	SMP21	616
Westend meetings with providers										
Trust 3										
Dir Contracting	AcT	N3	1	6	0.00	1.50	0.00	9.00	SMP10	237
GP	GP	N3	3	6	0.00	1.50	1.50	54.00	GP	1,755
fund / business manager	TPPN	N3	3	6	0.00	1.50	1.50	54.00	SMP21	924
project manager	HA	N3	1	6	0.00	1.50	1.50	18.00	SMP13	421
Trust 4										
Dir Contracting	CMH	N3	1	6	0.00	1.50	0.00	9.00	SMP10	237
GP	GP	N3	3	6	0.00	1.50	1.50	54.00	GP	1,755
fund / business manager	TPPN	N3	3	6	0.00	1.50	1.50	54.00	SMP21	924
project manager	HA	N3	1	6	0.00	1.50	1.50	18.00	SMP13	421

Table B6 (continued) **Project F: meetings related transactions costs in first live year**

Activity / Meeting shadow year 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates preparation & follow-up	 meeting or activity	 travel	 total	Grade	Cost based on salary
					hrs	hrs	hrs	hrs		£
Contracting team meetings										
contract accountants	HA	M1	2	12	0.00	2.00	0.00	48.00	SMP18	923
contracting staff	HA	M1	2	12	0.00	2.00	0.00	48.00	SMP26	675
project manager	HA	M1	1	12	0.00	2.00	0.00	24.00	SMP13	562
Equity modelling group										
GPs	GP	S1	4	4	0.00	2.00	1.00	48.00	GP	1,560
fund / business manager	TPPN	S1	2	4	0.00	2.00	1.00	24.00	SMP21	410
HA staff	HA	S1	4	4	0.00	2.00	0.00	32.00	ANC5	340
project manager	HA	S1	1	4	0.00	2.00	0.00	8.00	SMP13	187
Patient meetings										
GP	GP	S2	2	3	0.00	2.00	1.00	18.00	GP	585
fund / business manager	TPPN	S2	2	3	0.00	2.00	1.00	18.00	SMP21	308
Town forum										
GP	GP	S2	2	3	0.00	2.00	1.00	18.00	GP	585
fund / business manager	TPPN	S2	2	3	0.00	2.00	1.00	18.00	SMP21	308

Table B7 **Project H: meetings related transactions costs in first live year**

Activity / Meeting Year 2 1/4/96 - 31/3/97	Representing	Function code	Number of participants	Annual number of meetings	Time estimates				Grade	Cost based on salary
					preparation & follow-up	meeting or activity	travel	total		
					hrs	hrs	hrs	hrs		£
Project steering group - fortnightly first 6mth										
GPs	GP	C1	6	6	2	1.5	0.5	144	GP	4,679
TPP manager	TPP	C1	1	6		1.5	0.5	12	SMP13	281
Practice managers	TPPN	C1	4	6	2	1.5	0.5	96	SMP21	1,642
Locality Manager	HA	C1	1	6	2	1.5	1	27	SMP17	540
Project steering group - three weekly 2nd 6mth										
GPs	GP	C1	6	4	2	1.5	0.5	96	GP	3,119
TPP manager	TPP	C1	1	4		1.5	0.5	8	SMP13	187
Practice managers	TPPN	C1	4	4	2	1.5	0.5	64	SMP21	1,095
Locality Manager	HA	C1	1	4	2	1.5	1	18	SMP17	360
Objectives sub groups										
GP	GP	S3	2	8	2	1.5	0	56	GP	1,820
HP Co-ordinator	HA	S3	1	5	0	1.5	1	12.5	SMP19	231
Locality Manager	HA	S3	1	5	0	1.5	1	12.5	SMP17	250
Practice manager	TPPN	S3	1	6	0	1.5	0	9	SMP21	154
TPP Manager	TPP	S3	1	2	0	1.5	0	3	SMP13	70
management meetings										
TPP manager	TPP	C2	1	12	0	2.5	0.5	36	SMP17	720
practice managers	TPPN	C2	4	12	0	2.5	0.5	144	SMP21	2,463
assistant locality manager	HA	C2	1	12	0	2.5	1	42	SMP25	614
Acute Trusts										
Trust 1										
Lead GP	GP	N3	1	9	0	2	1	27	GP	877
TPP Manager	TPP	N3	1	9	0	2	1	27	SMP13	632
Trust Manager	ACT	N3	1	9	0	2	0	18	SMP17	360
Consultant	ACTC	N3	1	9	0	2	0	18	Con	737
Sitting in on SH contract meetings with acute and community trusts										
Lead GP	GP	N3	1	3	0	2	0.5	7.5	GP	244
TPP Manager	TPP	N3	1	4	0	2	0.5	10	SMP13	234
TPP Manager	TPP	M3	1	12	0	2	1	36	SMP13	843
Training										
Lead GP	GP	S2	1	2	0	7	1	16	GP	520
TPP Mananger	TPP	S2	1	2	0	7	1	16	SMP13	375
GP	GP	S2	6	2	0	7	1	96	GP	3,119
Practice Manager	TPPN	S2	4	2	0	7	1	64	SMP21	1,095
Asst Dir Finance	HA	S1	1	2	0	7	1	16	SMP13	375
Locality Manager	HA	S1	1	2	0	7	1	16	SMP17	320
TP Development Mananger	HA	S1	1	1	2	7	1	10	SMP13	234

APPENDIX C

Project-specific transactions costs

Table C1 **Summary of Transactions Costs by Sector: preparatory year**

Project	A	B	C	D	E	F	H	Total
	TOPPSTA	Latham House	Gleadless and Park	Ellesmere Port	Bewdley Medical Centre	South and West Devon	Wordsworth	
Preparation Year	£	£	£	£	£	£	£	£
Total Purchasing Project								
GP	41,426	26,610	33,209	31,630	22,075	23,637	12,444	**149,606**
Dedicated staff	37,649	18,269	18,269	219,772	25,730	93,444	21,923	**397,407**
Other staff	0	5,462	14,074	4,618	556	0	2,926	**27,636**
Health Authority								
Staff	10,450	16,118	13,403	950	10,746	41,322	7,079	**89,618**
Acute Trusts								
Managerial and clerical staff	4,038	4,613	0	-6,414	1,331	3,248	419	**3,197**
Consultants	656	0	0	0	0	1,967	1,004	**2,970**
Community Trusts								
Managerial and clerical staff	5,163	5,782	0	211	0	237	180	**6,409**
Consultants	983	0	0	0	0	0	430	**430**
Other								
CHC	0	0	241	0	0	0	0	**241**
Regional staff	0	0	0	0	1,106	434	0	**1,540**
Total	**100,366**	**76,854**	**79,197**	**250,767**	**61,544**	**164,290**	**46,404**	**679,055**
Project population	**73,000**	**33,196**	**28,461**	**65,652**	**12,943**	**46,113**	**32,460**	**218,825**
Per capita cost	**1.37**	**2.32**	**2.78**	**3.82**	**4.76**	**3.56**	**1.43**	**3.10**

Table C2 **Summary of Transactions Costs by Sector: first live year**

Project	A	B	C	D	E	F	H	Total
	TOPPSTA	Latham House	Gleadless and Park	Ellesmere Port	Bewdley Medical Centre	South and West Devon	Wordsworth	
First Live Year	£	£	£	£	£	£	£	£
Total Purchasing Project								
GP	41,036	25,506	39,737	42,157	7,389	18,374	14,377	**147,540**
Dedicated staff	49,003	29,230	29,230	219,772	29,874	74,755	36,538	**419,401**
Other staff	0	5,891	6,036	4,618	556	0	6,448	**23,550**
Health Authority								
Staff	8,343	24,113	2,829	7,817	6,586	41,322	2,924	**85,591**
Acute Trusts								
Managerial and clerical staff	698	6,701	905	-2,995	531	711	360	**6,214**
Consultants	0	0	697	0	0	0	737	**1,434**
Community Trusts								
Managerial and clerical staff	4,291	10,459	0	2,813	0	237	0	**13,508**
Consultants	642	0	0	0	0	0	0	-
Other								
CHC	0	0	175	0	0	0	0	**175**
Regional staff	0	0	0	0	1,106	434	0	**1,540**
Total	**104,013**	**101,900**	**79,609**	**274,183**	**46,043**	**135,833**	**61,385**	**698,952**
Project population	**73,000**	**33,196**	**28,461**	**65,652**	**12,943**	**37,847**	**32,460**	**210,559**
Per capita cost	**1.42**	**3.07**	**2.80**	**4.18**	**3.56**	**3.59**	**1.89**	**3.32**

Table C3 **Summary of Transactions Costs by Function: preparatory year**

Project		A	B	C	D	E	F	H	Total
		TOPPSTA	Latham House	Gleadless and Park	Ellesmere Port	Bewdley Medical Centre	South and West Devon	Wordsworth	
Preparation Year	Code	£	£	£	£	£	£	£	£
Health Authority and TPP Project									
Co-ordination & Organisation	C1	25,269	9,909	39,306	0	17,231	66,077	15,158	**147,681**
Search & Information	S1	0	470	3,334	0	7,139	5,651	473	**17,066**
Negotiation & Contracting	N1	0	1,384	2,237	0	0	0	0	**3,621**
Monitoring & Enforcement	M1	3,316	12,133	2,781	3,894	2,467	14,502	0	**35,777**
Subtotal		*28,585*	*23,896*	*47,658*	*3,894*	*26,837*	*86,230*	*15,631*	***204,145***
TPP Project									
Co-ordination & Organisation	C2	53,284	39,065	18,211	72,076	26,826	0	5,796	**161,974**
Search & Information	S2	0	0	13,329	308,888	3,481	5,139	2,170	**333,006**
Subtotal		*53,284*	*39,065*	*31,540*	*380,964*	*30,307*	*5,139*	*7,966*	***494,980***
TPP Project and Trusts									
Search & Information	S3	5,943	6,758	0	657	482	799	700	**9,397**
Negotiation & Contracting	N3	12,553	7,135	0	-218,009	2,145	72,121	22,107	**- 114,500**
Monitoring & Enforcement	M3	0	0	0	83,261	1,773	0	0	**85,034**
Subtotal		*18,496*	*13,893*	*0*	*-134,091*	*4,400*	*72,921*	*22,808*	***- 20,069***
Total		**100,366**	**76,853**	**79,197**	**250,767**	**61,544**	**164,290**	**46,404**	679,056

Table C4 **Summary of Transactions Costs by Function: first live year**

Project		A	B	C	D	E	F	H	Total
		TOPPSTA	Latham House	Gleadless and Park	Ellesmere Port	Bewdley Medical Centre	South and West Devon	Wordsworth	
First Live Year	Code	£	£	£	£	£	£	£	£
Health Authority and TPP Project									
Co-ordination & Organisation	C1	21,214	16,758	0	0	11,494	68,662	16,553	**113,468**
Search & Information	S1	0	1,132	936	0	3,590	6,110	929	**12,697**
Negotiation & Contracting	N1	0	0	0	0	0	0	0	**-**
Monitoring & Enforcement	M1	3,588	12,946	10,101	3,862	3,201	18,788	0	**48,898**
Subtotal		*24,802*	*30,836*	*11,037*	*3,862*	*18,285*	*93,560*	*17,482*	***175,063***
TPP project									
Co-ordination & Organisation	C2	52,447	46,007	11,903	70,380	17,705	0	10,951	**156,946**
Search & Information	S2	2,130	455	5,380	225,473	3,961	5,096	8,829	**249,192**
Subtotal		*54,577*	*46,462*	*17,283*	*295,853*	*21,665*	*5,096*	*19,779*	***406,138***
TPP project and Trusts									
Search & Information	S3	20,429	8,679	36,942	10,266	2,072	0	3,223	**61,181**
Negotiation & Contracting	N3	3,328	9,757	14,217	-158,394	4,020	37,178	11,688	**- 81,534**
Monitoring & Enforcement	M3	878	6,165	130	122,596	0	0	9,213	**138,105**
Subtotal		*24,634*	*24,601*	*51,289*	*-25,532*	*6,092*	*37,178*	*24,124*	***117,751***
Total		**104,013**	**101,900**	**79,609**	**274,183**	**46,043**	**135,833**	**61,385**	**698,952**

Total Purchasing National Evaluation Team (TP-NET)

The evaluation is led by Nicholas Mays, Director of Health Services Research at the King's Fund, London. The different consortium members are listed below, together with their research responsibilities.

KING'S FUND
11–13 Cavendish Square, London, W1M 0AN
T: 0171 307 2400 F: 0171 307 2807

Lead: Nicholas Mays
Other members: Nick Goodwin, Gill Malbon, Julian Le Grand, Jennifer Dixon, Amanda Killoran, Jo-Ann Mulligan

Project Responsibilities: Hertford, Hemel Hempstead, Hillingdon, New River, St Albans, Stevenage, Attleborough, South Bucks, Belper, Keyworth, Long Eaton, Melton Mowbray, Wakefield.

Other Main Responsibilities: Process evaluation co-ordination (Mays, Goodwin); A&E services and emergency admissions (Dixon, Mays, Mulligan); monitoring at all TPPs (Mays and Malbon); case studies (Mays, Goodwin, Killoran, Malbon).

NATIONAL PRIMARY CARE R&D CENTRE
Manchester: University of Manchester, 5th Floor, Williamson Building, Oxford Road, Manchester, M13 9PL
T: 0161 275 7600 F: 0161 275 7601
Salford: PHRRC, University of Salford, Davenport House, 4th Floor, Hulme Place, The Crescent, Salford, M5 4QA
T: 0161 743 0023 F: 0161 743 1173
York: YHEC, University of York, YO15 4DD
T: 01904 433620 F: 01904 433628
CHE, University of York, York, YO1 5DD
T: 01904 433669 F: 01904 433644

Leads: Brenda Leese (Manchester and CHE), Linda Gask (Manchester), Jennie Popay (Salford), John Posnett (YHEC)
Other members: Ann Mahon, Martin Roland, Stuart Donnan, John Lee, Andrew Street

Project Responsibilities: High Peak, North Lincolnshire, Rotherham, Sheffield South, Ellesmere Port, Knutsford, Liverpool Neighbourhood, Newton le Willows, Wilmslow, Ribblesdale, Southbank, North Bradford, York.

Other Main Responsibilities: Transaction costs (Posnett and Street); service provision for the seriously mentally ill (Gask, Roland, Donnan and Lee); service provision for people with complex needs for community care services (Popay); relations with health authorities (Leese and Mahon); maternity (Posnett).

DEPARTMENT OF SOCIAL MEDICINE, UNIVERSITY OF BRISTOL
Canynge Hall, Whiteladies Road, Bristol, BS8 2PR
T: 0117 928 7348 F: 0117 928 7339

Lead: Kate Baxter
Other members: Max Bachmann, Helen Stoddart

Project Responsibilities: Bewdley, Birmingham, Bridgnorth, Coventry, Solihull, Worcester, Saltash, South West Devon, Thatcham.

Other Main Responsibilities: Budgetary management (Baxter); risk management (Bachmann); use of evidence in purchasing (Stoddart); case studies (Baxter).

DEPARTMENT OF GENERAL PRACTICE, UNIVERSITY OF EDINBURGH
20 West Richmond Street, Edinburgh, EH8 9DX
T: 0131 650 2680 F: 0131 650 2681

Lead: Sally Wyke
Other members: Judith Scott, John Howie, Susan Myles

Project Responsibilities: Durham, Newcastle, Tynedale, Aberdeen West, Ardersier & Nairn, Grampian Counties, Lothian, Strathkelvin

Other Main Responsibilities: Maternity (Wyke); monitoring of participants' views (Wyke); prescribing (Howie); community care (Wyke and Scott).

INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF SOUTHAMPTON
129 University Road, Highfield, Southampton, SO17 1BJ
T: 01703 593176 F: 01703 593177

Lead: Ray Robinson
Other members: Philippa Hayter, Judy Robison, David Evans

Project Responsibilities: Dorset, Romsey, Trowbridge Bath & Frome, Winchester, Bexhill, East Grinstead, Epsom, Kingston & Richmond, Merton Sutton & Wandsworth, West Byfleet.

Other Main Responsibilities: Contracting methods (Robinson, Raftery, HSMC and Robison; case studies (Evans).

HEALTH ECONOMICS FACILITY, HSMC, UNIVERSITY OF BIRMINGHAM
40 Edgbaston Park Road, Birmingham, B15 2RT
T: 0121 414 6215 F: 0121 414 7051

Lead: James Raftery
Other member: Hugh McLeod

Main Responsibilities: Activity changes in inpatient services; contracting methods (with Robinson and Robison, IHPS); service costs and purchaser efficiency (with Le Grand).

HEALTH SERVICES RESEARCH UNIT, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE
Keppel Street, London, WC1E 7HT
T: 0171 927 2231 F: 0171 580 8183

Lead: Colin Sanderson with Jennifer Dixon, Nicholas Mays and Jo-Ann Mulligan (King's Fund), James Raftery (HSMC)
Other member: Peter Walls

Main Responsibility: A&E services and emergency admissions.

LSE HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE
Houghton Street, London, WC2A 2AE
T: 0171 955 7540 F: 0171 955 6803

Lead: Gwyn Bevan

Main Responsibilities: Resource allocation methods.

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