King's Fund

Total purchasing

A step towards new primary care organisations

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The Total Purchasing National Evaluation Team (TP-NET)

The national evaluation of total purchasing pilots 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, but also involves the National Primary Care R&D Centre; Universities of Edinburgh, Bristol, Southampton, York and Birmingham; the London School of Hygiene and Tropical Medicine; and the London School of Economics and Political Science. More information about the evaluation as a whole is available from: Gill Malbon, King's Fund, 11–13 Cavendish Square, London W1M 0AN.

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Contents

Foreword

Health authorities and GPs participating in Primary Care Groups (PCGs) may find it helpful to note the findings from the three year evaluation of Total Purchasing Pilots (TPPs). TPPs had some similarities with PCGs in that they consisted, in the main, of groups of fundholding GP practices which came together to purchase goods and services outside fundholding on behalf of their patients. However, they varied widely in size - from single fundholding practices, to groups of practices of 80,000 patients in the first wave, on which this pamphlet concentrates. Budgets were allocated by the health authorities. Few of the projects attempted to purchase more than a limited range of the goods and services potentially available, and from the second year on, the scheme was known to be temporary. Nevertheless, the way in which GPs organised themselves to work together on behalf of their patients does provide lessons for the development of PCGs and I commend this pamphlet to you.

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Summary

The evaluation of the Total Purchasing Pilots (TPPs) provides important lessons for the development of the new primary care organisations envisaged in the English, Welsh and Scottish NHS White Papers. Despite originating in a very different context, total purchasing was essentially about groups of practices working together to develop services with a shared budget. This report summarises the lessons learnt from their development and effectiveness. They are highly relevant and are drawn from a series of research working papers, listed at the end.

Primary Care Groups (PCGs) in England, and Local Health Groups in Wales, will take on important new responsibilities over a ten-year timescale. The experience of TPPs shows that the start-up stage will pose some important challenges. After their preparatory year and first two years of purchasing, TPPs had made progress in building their 'organisations' but still had some way to go to meet all the prerequisites for effective commissioning. TPPs were not ready to take on comprehensive commissioning responsibilities but operated as selective purchasers, focusing on particular areas of interest and concern.

The pattern of achievements by TPPs was strongly linked to the pace of their organisational development. Overall, the achievements in their first two years of purchasing were incremental, small-scale and primarily within the primary care setting. In the new, more strategic areas covered by total purchasing – including maternity, mental health and emergency admissions – TPPs made less progress than they had hoped. The larger multi-practice projects took longer to become 'high achievers' than smaller projects, because they needed to develop more complex and robust organisational arrangements and relationships to function effectively.

The implications for the future development of primary care organisations are significant.

- Future performance of these organisations is likely to be strongly linked to the development of organisational capability and the associated management resources. The larger scale of PCGs, and their Welsh and Scottish counterparts, compared with TPPs means that organisational development will be a still greater challenge. Primary care organisations will need to develop a management infrastructure that enables them to function corporately, with opportunities for different levels for the engagement of GPs in management and service development, linked to appropriate incentives and sanctions. Leadership, competent managers, improved information systems and IT investment will be crucial.

- New primary care organisations are to be based on a partnership model, unlike total purchasing which proved to be a GP-led model of commissioning. PCGs will need to develop new ways of genuinely involving community nursing and other professionals, and working jointly with local authorities and other agencies to set priorities and invest resources effectively to improve health as well as health care.

- Assessment of population-based needs remained largely undeveloped by TPPs. Given that primary care organisations will have explicit responsibilities for addressing the wider public health agenda, this area will need significant attention, including an increased contribution from public health specialists.

- Total purchasing has proved an important mechanism for developing and extending the range of services offered in the primary care setting, and for shifting the boundaries of secondary care. By contrast, there have been many more problems in securing changes in secondary care, especially the transfer of resources. In the long term, the greatest contribution of primary care organisations could be as developers of primary and community services rather than as commissioners of secondary care *per se*. Also, given the experience of TPPs as selective purchasers, it is unrealistic to expect most primary care organisations to be able to take on commissioning responsibility rapidly for most hospital and community health services.

- Although the larger primary care organisations will have more budgetary clout than TPPs, real changes in the way secondary care is delivered, and shifts of resources, are likely to be dependent on the effectiveness of Health Improvement Programmes and longer-term service agreements as mechanisms for joint working and accountability.

- Holding budgetary responsibility is important as a lever for change but it is not enough on its own. Organisational development and effective working relationships between GPs, clinicians and other professionals will be central. The potential of budgets for generating service contestability will act as an incentive for such partnerships to work.

- The evidence suggests that budgetary management worked best when all GPs were involved and had some experience of seeing themselves as part of a single clinical group. Primary care organisations will need to ensure that practice-based information on patterns of activity and expenditure is shared and reviewed. But they will also need to be able to pool budgets for the most equitable and efficient management of resources across the organisations.

- With a continued pressure for efficiency and a reduction in NHS management costs, the effective deployment of management costs will depend on agreeing the respective roles and functions – 'who does what' – of health authorities, local authorities and primary care organisations to eliminate any duplication. However, in the short term, management costs may be necessarily higher because health authorities will have to continue to operate as important commissioners locally, while at the same time investing to develop the functions of primary care organisations.

1. Total purchasing and the policy context of new primary care organisations

This report summarises the findings to date from the evaluation of the national Total Purchasing Pilots (TPPs) in England and Scotland. The evaluation was funded by the Department of Health; it began in October 1995 and was completed in December 1998. This report is based primarily on the experience of the first-wave TPPs. A final evaluation report will be available in early 1999.

A TPP comprised a group of standard fundholding (SFH) general practices – or a large single practice – which volunteered on a three-year pilot basis to take a delegated budget from their local health authority/board (HA/HBs) to commission potentially all the hospital and community health services (HCHS) for their registered populations. These included accident and emergency, maternity, mental health, and continuing and community care services (called here 'total-purchasing-related services') which had previously been excluded from SFH. Many involved in total purchasing seized the opportunity, not only as a means to commission secondary care services but also as a way of developing services within the primary care setting itself.

The 1997 and 1998 Health Service White Papers for England, Scotland and Wales set out a future for local health systems. Primary care organisations will have a central role in improving the health and health care of their patients and populations within the context of the local Health Improvement Programmes[1,2,3]. This is a ten-year strategic agenda of evolution and change. Instant transformation is neither expected nor realistic. In England and Wales, Primary Care Groups and Trusts (PCGs and PCTs) and Local Health Groups (LHGs), respectively, will take on the responsibility for commissioning hospital and community health services as well as providing primary care. In Scotland, HBs will continue to commission hospital care, while Primary Care Trusts (PCTs) and Local Health Care Cooperatives (LHCCs) will plan and develop the provision of primary and community health services. They will have some influence in achieving a strategic shift in the delivery of care from hospital to the community through a Joint Investment Fund (JIF) controlled by the PCTs.

PCGs in England, and their counterparts in Wales and Scotland, will be a pivotal feature of future local health systems and their contribution will be an integral part of Health Improvement Programmes. In contrast, TPPs have been comparatively small-scale projects with experimental time-limited status. However, the fundamental building block of new primary care organisations is general practices working together, and with other primary care practitioners, in large groupings to develop services.The experience of building TPP organisations, and their effectiveness in securing improvements, therefore provides important lesson for the development of primary care organisations in all three countries.

This report:

- defines the extent to which TPPs developed as effective commissioning organisations, reports TPPs' achievements in their first two 'live' years of purchasing (1996/97, 1997/98) and the factors influencing their performance; and;

- considers the implications of the total purchasing initiative for the development of primary care organisations from April 1999.

2. Developing effective commissioning organisations and the link to performance

New primary care organisations will need to develop robust organisations to take on and fulfil their new responsibilities and functions. With respect to commissioning, the experience of TPPs demonstrates that the start-up stage poses challenges and takes considerable time and investment. After one year's preparation (1995/96) and two years' purchasing (1996/97 and 1997/98), TPPs were still at an early stage in developing effective commissioning organisations[4]. Table 1 summaries the extent to which TPPs met the prerequisites for effective commissioning.

The extent to which first wave TPPs attained their main purchasing/commissioning objectives in two purchasing years (1996/97 and 1997/98) was reviewed and the factors associated with higher and lower levels of TPP achievement identified[12,13,14]. The nature of these achievements is reported in more detail in Appendix 1.

There was a strong link between the pace of TPPs' organisational development and their ability to achieve objectives. This link is particularly highlighted by the following findings.

- Overall achievements by TPPs were incremental, small-scale, locally generated and focused on developing services in the primary care setting. Many of the achievements related to building organisational capability rather than negotiating specific changes to secondary care. TPPs found it much more difficult to make progress in the new service areas included in total purchasing than to bring about primary care developments and change elective hospital services already included in standard fundholding.

- TPPs were more likely to attain higher levels of performance over time – a higher proportion of TPPs in the second year of purchasing were achieving more of their stated objectives compared to the first year.

- The larger multi-practice projects took longer to become 'high achievers' than smaller projects, because they needed to develop more complex and robust organisational arrangements and relationships to function effectively. In contrast, smaller projects were able to make early progress without such investment.

- The multi-practice organisations that achieved most had developed more 'complex' organisations (multi-tier management and planning structures), employed a specific project manager, developed reasonable or good relations with their local health authority, developed a dialogue with local providers, invested in information technology and encouraged the involvement of non-lead GPs and a wide range of participation from other staff in the practices within the project. They also had higher management costs.

Table 1: The extent to which TPPs met the prerequisites for effective commissioning

Information for commissioning and priority setting	• Most TPPs relied on the experience and views of the GPs when setting their purchasing objectives; formal assessment of patients' needs proved difficult. Understanding and use of techniques for assessment of population health needs was generally underdeveloped[5]. • Most TPPs perceived their information systems, and the quality of the cost and activity data to which they had access, to be inadequate. Most attempted to obtain and use adequate information about local services[5]. • Informing and involving patients in purchasing decisions was not an early priority. • Setting priorities was an implicit process rather than an explicit and open debate among stakeholders. TPPs operated as *selective* purchasers, focusing on particular areas of interest and concern to the leading GPs.
Budgets and budgetary management	• Setting budgets was one of the most serious practical problems for both first-and second-wave TPPs in their preparatory periods. Most health authorities (HAs) used elements of the national capitation formula to estimate the fair share of expenditure to which each TPP was entitled. However, this was usually moderated with reference to past levels of service use and spending. Despite adjustment, this 'target' share of the TPP was often substantially different from its recent expenditure, and negotiations ensued concerning the speed at which the TPP could be shifted to its fair allocation[6]. • The desire and capacity to take on responsibility for devolved budgets varied amongst TPPs. In 1997/98 (the second 'live' year of purchasing), 69% of first-wave TPPs chose to purchase at least some services directly and negotiated some contracts independently in selected service areas[7]. Other services were 'co-purchased' with the HA, with projects holding an indicative or shadow budget in these areas. Certain services were top-sliced or 'blocked back' to the HA to purchase, including highly specialised or district-wide services (e.g. renal services, blood products, head/spinal injuries and health promotion). • Because TPPs were selective purchasers, they had fewer problems in managing financial risk[8]. A small number of projects took the precaution of developing risk assessment strategies or set aside contingency funds. Larger, multi-practice TPPs found it harder to manage their budgets as effectively as the smaller and single-practice projects. TPPs tended to use traditional responses to financial pressures (e.g. putting patients on waiting lists) rather than altering referral or treatment thresholds.
Equity and accountability	• The majority of HAs were concerned to pursue a fair budget allocation process for all their devolved purchasing bodies, whether they were TPPs or not. However, few HAs sought to monitor equity of use of services between TPP and non-TPP populations. • TPPs were incorporated within the overall accountability regime of the local HA. Financially, as with SFH, there was strict accountability, but no system of value-for-money assessments of TPP decisions and little concern to ensure pilots attained national policy goals. 'Downward' accountability to patients and the public was weak[9].
Transaction and management costs	• TP added to, rather than reduced, total health system transaction costs locally (i.e. all the management and administrative costs incurred at the project level, at the health authority and by local providers). The bulk of these costs was incurred at practice level (85%) and were particularly associated with the time of the GPs. However total purchasing appeared to have reduced costs for acute providers because the SFH practices within the TPPs also began to undertake their fundholding contracting collectively through the TPP[10]. • The total direct management cost of managing TPPs, including their SFH costs, was estimated at £6–8 per capita. Consequently, the total management costs of commissioning in a district with a combination of the HA, single-practice SFH and TPPs could be in the order of £17–18 per capita[11]. • Since projects were managed by a few people with high workloads, the sustainability of the TPPs was questionable. In many cases, it was difficult to identify potential successor lead GPs or there were doubts about whether the level of HA input could be sustained, given the requirement to support other local commissioning initiatives.
Support from health authorities	• TPPs were generally well supported by their local HAs, which provided some additional skills and expertise for commissioning, although this varied according to the objectives of the projects.

3. Implications for the development of new primary care organisations in England, Wales and Scotland

The implications of the research findings for the development of the new primary care organisations in England, Wales and Scotland need to be considered in the light of differences between them and TPPs. The differences and similarities are set out in Table 2.

Most significantly, unlike TPPs, new primary care organisations will be a central component of local health systems. They will have a significant and legitimate role in the creation of local Health Improvement Programmes and in their implementation. TPPs clearly had to struggle as minor players, being small-scale projects with pilot status. In comparison with TPPs, new primary care organisations will be bigger and comprise a mix of practices with varying levels of commissioning experience and different ideologies. New primary care organisations will have a much wider range of responsibilities and functions, and PCGs and LHGs will be compulsory while practices can 'opt out' of LHCCs in Scotland. The implications are considered below.

Challenge of organisational development

The experience of total purchasing clearly indicates that performance was strongly linked to the development of organisational capability, and that this in turn was associated with the level of management costs in a project (see section 2).

The larger scale of PCGs, LHGs and PCTs/LHCCs means that organisational development will be a greater challenge, particularly given that the new organisations are likely to contain a mix of SFH practices and non-fundholders with varying levels of experience, and practices both ideologically opposed to and committed to managing budgets for care. However, PCGs are expected to develop gradually and not to be 'all singing/all dancing' from April 1999. For some, their development phase may be two or three years.

The heavy reliance of TPPs on a small number of individuals, who had high workloads as a result, raised questions about the sustainability of the TPP model. Larger TPPs often progressed slowly because not all practices in the project were actively involved, which meant that the behaviour and resource consumption of some of the practices were often uncontrolled. The challenge for primary care organisations will be to develop a management infrastructure that enables 50 –100 GPs and other primary care professionals to function corporately, while the GPs largely remain independent contractors and other staff are either employed by them, by the local community trust or by the PCT in Scotland. Complex arrangements are likely to be required that provide different opportunities for, and levels of, engagement in the management of the organisation, linked to appropriate incentives and sanctions. Management skills will be crucial. Improved access to sources of information on costs, quality and activity will be required, with associated IT investment in the early stages, which should be supported by the new national information and IT strategy *Information for Health*[15].

GP-led organisation versus a partnership model

New primary care organisations will embrace nursing, social services and lay representation within corporate governance arrangements. They will potentially be an important focus for multi-agency partnership working at a local level. In contrast, total purchasing has proved to be a GP-led model of commissioning and based on the views of GPs. Priority setting has been an implicit and largely GP-dominated process. If PCGs, and their Welsh and Scottish counterparts, are to adopt a genuine partnership approach they will need to develop new ways for debating and setting priorities that engage other interest groups, particularly community nursing, local authorities – including their housing, regeneration and education services as well as their social services – and local people.

Table 2: Comparison of TPPs, PCG/Ts, LHGs and PCTs/LHCCs.

TPPs	*PCGs (England) and LHGs (Wales)*	*PCTs and LHCCs (Scotland)*
• Small (approximately 30,000 population; range 8,000-80,00 population)	• Large (approximately 100,000 population; range 50,000-150,000 population)	• Large (but small LHCCs possible; range 25,000-150,000 population)
• Responsible for commissioning potentially all hospital and community care services	• Responsible for commissioning potentially all hospital and community care services	• PCTs responsible for planning and providing primary and community health services through LHCCs. Not responsible for commissioning hospital services
• GP-led	• GP- and nurse-led	• Primary care team led
• Volunteer and highly selective practices, and time-limited (three years)	• Compulsory: all practices and not time-limited	• Practices can 'opt out' of participation in LHCCs, but all will be accountable to the PCT
• Rural and suburban	• All parts of England and Wales	• All parts of Scotland
• Many simple/informal projects	• More complex formal organisations	• More complex organisations
• Ring-fenced TP budget and SFH budget (GMS not included)	• Moving towards integrated budgets, including SFH, TP and GMS	• Moving towards integrated community health services, prescribing and GMS budgets
• Some pilots still with indicative budgets and some with fully delegated budgets after two years	• Moving towards delegated and independent budgets (i.e. legally the responsibility of PCGs and LHGs)	• Moving towards delegated and independent budgets for primary and community health services at PCT level and for prescribing at LHCC level
• Intended to be a purchasing organisation rather than concerned with the provider role of practices (although in practice did influence provider roles)	• Responsibilities for commissioning services plus health improvement and primary care development	• Responsibilities for health improvement and primary and community care development. Responsibility for development of overall service through Health Improvement Programme and JIF
• No structure of 'clinical governance' between the GPs in different practices	• Arrangements for clinical governance aimed at improving quality and consistency of primary care delivery	• Arrangements for clinical governance aimed at improving quality and consistency of primary care delivery

SFH, Standard fundholding; TP, Total purchasing; GMS, General medical services.

The evidence of total purchasing shows that the assessment of population-based needs was highly underdeveloped. Given that new primary care organisations are to have responsibilities for the wider public health of their communities, they will need to give much more attention to this area than was given under total purchasing. Greater support and input from public health specialists – including health promotion staff – will be essential, although this may be problematic given the limited expertise available in some districts. The public health role of community nursing could be nurtured (e.g. in collecting data relevant to needs assessment). Co-terminosity of primary care organisation boundaries with local authorities (compulsory in Wales, encouraged in England and Scotland) is likely to increase the possibilities for improving public health as well as developing social services – for example by linking with local authority community consultation processes and forums.

Prospect for integrated care

Integration can be pursued through structural reorganisation, planning or budgetary incentives, or by a combination of these strategies. Total purchasing was designed to use budgetary delegation to give GPs, for the first time, an interest in potentially all the hospital and community health services used by their patients, thereby encouraging vertical integration. For example, the TPPs had an incentive to act to avoid inappropriate hospital admissions and to facilitate earlier discharge from the acute sector. Horizontal integration had to occur more informally because the TPPs were not in a position to take on budgets for the social care of their patients – instead, they engaged in more informal collaboration and budget alignment activities with their local social services counterparts.

The TPP evaluation revealed a number of different ways in which budgetary delegation to primary care level encouraged new forms of vertical integration that cut across existing organisational boundaries. A common example was the appointment of a liaison nurse to assess acute inpatients; they could facilitate early discharge to appropriate facilities – either at home or in some form of residential or nursing home – to prevent 'bed blocking' and thereby reduce the dependence of the TPP on expensive acute hospital provision. Other examples included: the development of 'care pathways' (or shared protocols) between hospital specialists and community nurses to reduce the reliance on hospital services for the management of chronic diseases; extending the use of local community hospitals to shorten acute lengths of stay; and pre-admission clinics, again to minimise length of stay. One TPP developed intermediate care which was jointly funded by the NHS and the local social services, thereby combining vertical and horizontal integration in a single initiative[4]. Three examples of horizontal integration between health and social services are given in Box 3, in Appendix 1.

These examples of integration demonstrate how the delegation of a wider budget – beyond the scope of SFH – succeeded in encouraging GPs to take some responsibility for their patients' resource use, irrespective of whether this occurred in hospital or in the community, and to consider the potential for making better use of facilities in secondary care in which they previously had little or no direct interest. In future, England and Wales will continue to use primary-care-based commissioning as a lever to encourage both horizontal and vertical integration. For example, all or most of the care of the patients in PCGs in England, and LHGs in Wales, will increasingly come from the same budget. This will encourage practices to make the best use of their resources wherever their patients receive treatment in order to generate a surplus that can be reinvested in local services.

In Scotland, the approach will be different. Rather than relying on the incentives for vertical and horizontal integration generated by devolving an ever-widening scope of budget to groups of GPs, there will be a Joint Investment Fund (JIF) in each district which is to be spent exclusively on initiatives that involve both hospital and community providers, thereby fostering vertical integration. Joint plans or bids will be drawn up to justify the use of the JIF within the framework of the local Health Improvement Programme. GPs and other members of the primary care team will concentrate on horizontal integration by developing primary and community care services within a single financial envelope for general medical,

prescribing and community health services in the LHCCs and PCTs, but they will not be required to commission/purchase any secondary care. It remains to be seen how the Scottish system will make GPs conscious of the resource implications of their referral behaviour to secondary care under this arrangement.

Primary care development versus commissioning

The evidence shows that, although the focus of total purchasing was ostensibly on purchasing of hospital and community health services, particularly secondary care, it has proved in practice to be an important vehicle for developing and elaborating services in the primary care setting (other than general medical services). The development of community health services and intermediate care schemes, involving specialists working in the community, has shifted the boundary with secondary care. It is possible that, in the long term, the greatest contribution of the new primary care organisations will be to the development of primary and community care rather than to secondary care commissioning *per se*. Indeed, the Scottish White Paper anticipates this evolutionary conclusion.

In principle, PCGs and their counterparts will be strategic players in the development and implementation of Health Improvement Programmes. In contrast, TPPs were 'micro-fixers' rather than strategists. Achieving strategic shifts in patterns of services has been problematic for TPPs – they often experienced resistance from trusts over the release of resources to invest in new forms of primary and intermediate care. In addition, it was often realised that changes to the acute hospital sector could only sensibly be implemented on a wider scale than a single TPP. Whereas the larger PCGs and LHGs in England and Wales are likely to carry more purchasing weight than TPPs, in England at least, there are likely to be fewer trusts and longer-term service agreements. This means that the potential for shifting contracts may be reduced in comparison with the situation that faced the TPPs. In Wales, however, it is explicit that the LHGs will be able to inform HAs that they wish to work with an alternative provider if agreed standards or costs have not been achieved. The participation of primary care organisations in the development and monitoring of Health Improvement Programmes is likely to prove a crucial mechanism to achieve strategic change in the pattern of service delivery, particularly if any significant shift of resources from acute and mental health trusts is to be achieved.

Also, in principle, the English and Welsh proposals mean that PCTs and LHGs will be able to commission almost all health care. The selective approach of TPPs to purchasing services indicates that PCGs and LHGs will need flexibility with respect to the range of services they commission and the pace at which they take on wider responsibilities. It may be unrealistic to expect most primary care organisations to be able to take comprehensive responsibility rapidly for commissioning hospital and community health services (HCHS).

However, in devolving commissioning responsibilities, it will be important to commission services at the appropriate population level – practice, primary care organisation, groups of primary care organisations, HA-wide – to avoid the continuation of a piecemeal approach to commissioning. This will involve some system-wide trade-offs between local sensitivity and responsiveness and overall equity and efficiency of service delivery. It should be possible to develop a framework for an appropriate and evidence-based pattern of commissioning for different scales of population in relation to the expertise available to each level[11].

Resource allocation and budgets

The experience of total purchasing supports the principle of devolving budgets to groups of practices, with the potential for them to contract independently. TPPs that received their own budgets and contracted independently made the most progress. However, the evidence also indicates that holding budgets is unlikely to be *sufficient* as a lever for change – progress will also depend on organisational development (see above) and relationships with clinicians and others. The potential of budgets for contestability will act as an

incentive for such constructive partnerships to work. The JIF in Scotland, which may consist of whole services or of resources, and which will be controlled by PCTs, might act as a similar lever for constructive partnership, as might commitment to the development and implementation of the Health Improvement Programmes.

If primary care organisations are to use their resources effectively, and particularly if they are to develop GPs' roles as effective gatekeepers to secondary care and efficient prescribers, all GPs will need to be involved in the collective management of resources. The evidence from total purchasing suggests that budgetary management worked best when GPs, other than just the lead GPs, were involved and had some experience of seeing themselves as part of a single clinical group[8]. Engendering good inter-practice relations and supporting less motivated practitioners will be essential in primary care organisations if they are to function effectively as commissioners and providers of primary care. Sharing practice information on the patterns of activity and expenditure is likely to be an essential tool underpinning this process. A balance will need to be struck between practice-based budgeting and subsequent management of expenditure and the ability to pool resources and manage them equitably and efficiently across the organisation as a whole.

Changing roles of health authorities/boards and primary care organisations and management cost implications

The evidence of total purchasing clearly demonstrates that the new primary care organisations (even at early stages) will depend on investment in an effective management infrastructure. The larger size of the new primary care organisations, compared with TPPs, might yield some economies of scale, but the evidence from TPPs shows that, at least in the short term, such economies may be offset by the increased costs involved in the coordination of activity across the greater number of practices and GPs[10].

Such investment, however, will need to be planned as part of a strategic approach to managing the changing roles of HA/HBs and primary care organisations. In England the government is providing an additional £3 per head on top of the HAs' own management cost as a contribution to PCG management costs[1]. Certainly, the management costs of the pluralistic approach to commissioning by HAs, SFHs and TPPs – with total management costs of up to £17–18 per head – will be unaffordable. In the long term, the effective deployment of management costs, and any reduction of costs, will depend on agreeing the respective roles and functions of HAs, local authorities and primary care organisations, and eliminating the overlap of functions that characterise the current approach. In particular, new ways of fulfilling the tasks associated with operational commissioning will need to be tested to secure the most effective and efficient distribution of management costs. Efficiency savings might be generated in areas of core costs, family health services and IT functions.

Wakefield HA was a unique district-wide TPP (based on devolving budgets to practices grouped into five geographical localities). It showed that it is possible to adopt a strategic approach to reviewing the respective roles of the HA and localities, and to reducing management costs[4].

In the short term, the pressure on management costs is likely to be particularly intense. HAs will have to continue to operate as important commissioners locally, while at the same time investment is needed to develop the functions of primary care organisations. But if these organisations are to succeed, HAs/HBs will increasingly need to 'let go' – by devolving and sharing functions, and management costs, with the new organisations.

Appendix 1. Achievements of total purchasing pilots

Overall achievements

Figure 1 shows the TPPs ranked into five groups according to their level of achievement in their own terms and their level of achievement in 'total purchasing service areas' for 1997/98. Achievements judged in 'own terms' meant without taking account of the scope or scale of the achievements. Achievements could include developments in the organisation of the project, internal and external relations, and information systems, as well as service changes and developments. Achievements in 'total purchasing service areas' included maternity, services for the seriously mentally ill, care of frail elderly people in the community, accident and emergency services, and emergency and unplanned medical admissions.

This pattern demonstrates that it proved more difficult to make progress in the more strategic TP-related areas. Furthermore, a wide variation in the level of achievement amongst TPPs is clearly evident, despite the fact that all the projects were volunteers and all were selected from SFHs (also volunteers). This suggests that the performance of future primary care organisations is likely to be variable – even more so in the case of PCGs and LHGs, which will be both larger and compulsory.

Figure 1: First-wave TPPs in five groups according to their level of achievement in their own terms (■) and in TP-related areas (■) 1997/98.

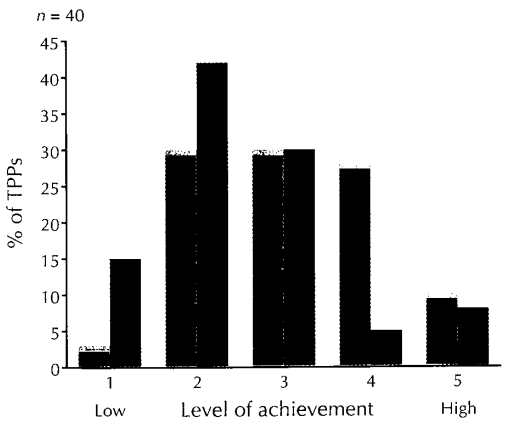


Table 3 shows the extent to which 1997/1998 achievements varied by specific service areas. It should be noted that achievements in the new areas covered by total purchasing were primarily primary care orientated.

Analysis of routine hospital data was undertaken to determine the impact of TPPs in achieving improvements in secondary care services. It supports the self-reported data on managing emergency services and early discharge shown in Table 3. In 1997/98, 49% of TPPs were classified as 'commissioning' – actively trying to manage secondary care through the use of independent contracts. Most of these commissioning TPPs instigated schemes which focused on reducing emergency admissions or length of stay. They used a range of alternative venues for care, including community hospitals, nursing homes and 'hospital-at-home' schemes. Most employed staff to facilitate these changes. The analysis of hospital activity statistics for their first 'live' year confirms that most of the commissioning TPPs succeeded in making the planned changes. However, many of the innovations introduced by TPPs will take time to fulfil their potential. The forthcoming analysis of the second 'live' year based on 1997/98 data will provide a fuller picture.

Progress in specific 'total-purchasing-related service areas'

A series of sub-studies was mounted involving samples of TPPs and, in some cases, of extended fundholding pilots. This was to investigate the effectiveness of total purchasing in the specific total-purchasing-related services of maternity, mental health, community and continuing care, and accident and emergency care[16,17,18]. The interim findings from three of these studies are shown in Boxes 1–3.

Table 3 Achievements and non-achievements of first-wave pilots by service area, 1997/98

Service area of four main purchasing objectives	*Total number of main objectives*	*Objectives reported* as achieved (%)
Early discharge (eg discharge coordinator)	18	72
Community and continuing care (integrated nursing, nursing home beds)	36	67
Maternity services (particularly community midwifery)	10	70
Managing emergency services (eg intermediate care and primary care projects)	16	75
Mental health services (primarily community-based)	20	75
Developing primary health care team	10	70
Information/needs assessment	22	64
Other*	40	72
	172	**70**

* Wide variety including oncology, cardiology, school health, palliative care.

These studies serve to illustrate the general findings reported above. In particular, they highlight: the relatively underdeveloped nature of the assessment of population-based needs and user involvement in the TPPs; the focus on securing incremental improvements at an operational level through developing and extending primary and community services; and the importance of local relationships, together with potential budgetary leverage, in making progress in bringing about service change.

They also show the importance for local primary-care-led commissioning of the national policy context. The contrasting experiences in implementing *Changing Childbirth* compared with mental health services (see Box 1 and 2) raises issues that have implications for how the future National Service Frameworks, discussed in the 1997 English White Paper, might be implemented. The clearer and more supportive the national policy, the easier the TPPs found it to bring about service changes in a short time.

BOX 1: MATERNITY

- The desire to achieve the objectives set out in *Changing Childbirth* was one of the main factors motivating GPs to become involved in maternity care. It appears that the philosophy and prescription for service development was a stronger influence on change than the identification of specific problems in the local delivery of services.
- Much of the impetus for service development was provider-driven and led by community midwives and directors of midwifery, with GPs then becoming enthusiastic supporters of change.
- Most TPPs' plans for maternity care received more generous resources for delivering care funded by trusts or the HA than other practices in the local area (in terms of the ratio of community midwives to women). This raises issues about equitable provision of services and the feasibility for 'rolling out' improvements within usual funding levels.
- Service developments appeared to precede and drive subsequent contracting for maternity care, rather than the other way round.
- TPPs and extended fundholders were more likely to be involved at a strategic level in planning maternity services than in contract negotiations. Few of the extended fundholders or TPPs were actively contracting for care. This suggests that TPPs' ability to gain the attention of providers lay more in the fact that they had the budgetary *potential* to purchase services for themselves rather than in their actual purchasing behaviour.
- Like HA purchasers, few TPPs were actively seeking women's views on care to inform service planning. Extended fundholders were more likely to do so.

BOX 2: MENTAL HEALTH

- The main aim of the TPPs and extended fundholders was to develop further primary-care-based services, primarily through practice-attached and practice-based counsellors, community psychiatric nurses, social workers and sessional input from psychologists and psychiatrists. Out of the 27 TPPs studied, 21 had chosen to strengthen local mental health teams by employing practice-based mental health staff to improve accessibility of services to patients.
- Improving communications between primary and secondary care was also a priority. This was particularly hampered by poor quality information and systems.
- Assessment of mental health needs in primary care is in its infancy, with half of all sites tending to rely on 'gut feelings' to determine service changes.
- There was also little involvement of users in service development, although there were notable exceptions in which users' views had been surveyed and use made of consultative groups.
- The prime focus was the development of services for those with moderate mental health problems (anxiety, depression) rather than the national priority to target those with severe mental health problems. Specialist mental health staff were concerned that this might divert resources away from those with more severe problems.

BOX 3: COMMUNITY AND CONTINUING CARE OF OLDER PEOPLE

- The majority of initiatives appeared to be directed at developing and improving the coordination of existing services at patient level, rather than developing new services or addressing strategic policy issues. Projects were seeking to respond to problems which they had identified, and which their patients commonly experienced, in their attempts to access good quality, 'seamless' community services. There was little reference to national or local policy or guidance.
- Projects were not involved in macro-level, strategic assessment of needs with either their HA or local authority, nor had they undertaken any systematic assessment of practice population needs or priority-setting exercises.
- Projects had begun to investigate the potential for integrated commissioning with the local authority – for example through work on costing total packages of health and social care and through discussions on integrated purchasing of joint care arrangements to improve management of admissions and discharges.
- There were examples of fairly sophisticated models of integrated provision, both horizontally and vertically. These included: a multi-disciplinary day centre at the local community hospital linked with the education and housing sectors; a proactive care team (PACT) approach to practice-based multi-disciplinary case management of elderly people; and an elderly resource team with input from a community care coordinator with direct access to a care budget.
- However, there was little evidence of joint client assessments based on user-defined needs and little voluntary agency input.
- Overall, total purchasing appears to have been a catalyst to take forward existing initiatives and to plan changes in the configuration of services designed to 'fix something that was obviously broken' locally and 'put things right for their patients'.

References

1. Secretary of State for Health. *The New NHS: Modern, Dependable*. London: The Stationery Office, 1997.

2. Secretary of State for Wales. *Putting Patients First*. Cardiff: The Stationery Office, 1998.

3. Secretary of State for Scotland. *Designed to Care*. Edinburgh: The Stationery Office, 1997.

4. Mays N, Goodwin N, Killoran A, Malbon G, on behalf of the Total Purchasing National Evaluation Team. *Total Purchasing: a Step towards Primary Care Groups*. London: King's Fund Publishing, 1998.

5. Mahon A, Stoddart H, Leese B, Baxter K. *How Do Total Purchasing Pilots Inform Themselves for Purchasing?* National Evaluation of Total Purchasing Pilots Working Paper. London: King's Fund, 1998.

6. Bevan G. *Resource Allocation within Health Authorities: Lessons from Total Purchasing Pilots*. London: King's Fund Publishing, 1998.

7. Robison J, Robinson R, Raftery J. *Contracting by Total Purchasing Pilot Projects, 1997/98*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, in press.

8. Bevan G, Baxter K, Bachmann M. *Survey of Budgetary and Risk Management of Total Purchasing Pilot Projects, 1996/97*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

9. Dixon J, Mays N, Goodwin N. *Accountability of Total Purchasing Pilot Projects*. National Evaluation of Total Purchasing Pilots Working Paper. London: King's Fund, 1998.

10. Posnett J, Goodwin N, Griffiths J, Killoran A, Malbon G, Mays N, Place M, Street A. *The Transaction Costs of Total Purchasing*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

11. Killoran A, Griffiths J, Posnett J, Mays N. *What Can We Learn from the Total Purchasing Pilots about the Management Costs of Primary Care Groups? A Briefing Paper for Health Authorities*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

12. Mays N, Goodwin N, Malbon G, Leese B, Mahon A, Wyke S. *What Were the Achievements of Total Purchasing Pilots in their First Year and How Can They Be Explained?* National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund Publishing, 1998.

13. Goodwin N, Mays N, McLeod H, Malbon G, Raftery J. Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England personal interviews and analysis of routine data. *British Medical Journal*, 1998; **317**: 256–259.

14. Malbon G, Mays N, Killoran A, Goodwin N. *Achievements of the TPPs in 1997/98: Emerging Themes and Lessons for the Future*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

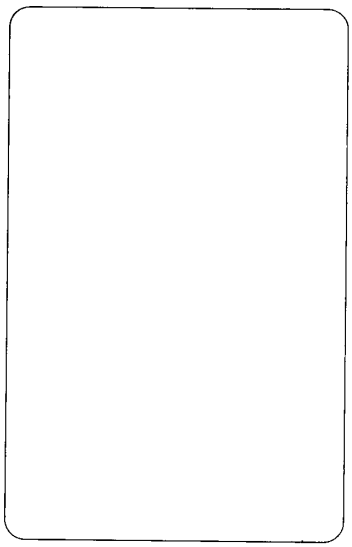
15. Department of Health. Information for Health: an Information Strategy for the Modern NHS 1998–2005, a national strategy for local implementation. Department of Health, NHS Executive, 1998.

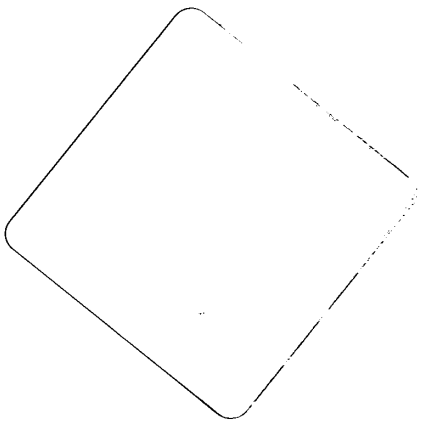
16. Wyke S, Hewison J, Piercy J, Posnett J, Macleod L, Page L, Young G. *National Evaluation of General Practice-Based Purchasing of Maternity Care: Preliminary Findings*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

17. Gask L, Lee J, Donnan S, Roland M. *Total Purchasing and Extended Fundholding of Mental Health Services*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

18. Myles S, Wyke S, Popay J, Scott J, Campbell A, Girling J. *Total Purchasing and Community and Contining Care: Lessons for Future Policy Developments in the NHS*. National Evaluation of Total Purchasing Pilot Projects Working Paper. London: King's Fund, 1998.

19. Department of Health. *Changing Childbirth: Report of the Expert Maternity Group*. London: HMSO, 1993.





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