King's Fund

# Total Purchasing

## A profile of national pilot projects

Total Purchasing National Evaluation Team

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'Total purchasing' is potentially the most significant development in NHS purchasing of health services since the introduction of general practitioner fundholding in 1991. It offers fundholding practices the opportunity to purchase all of the health care not included in fundholding for the patients on their lists.

This report provides the first comprehensive picture of how the idea of 'total purchasing' is being implemented in all 53 'first wave' national total purchasing pilot projects in England and Scotland. It aims to answer the question: what is 'total purchasing'? Further reports from TP-NET – a research consortium led by the King's Fund Policy Institute – will follow in 1997 and 1998. They will attempt to assess the consequences of the 'total purchasing' initiative and draw lessons for the future.

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN



ISBN 1 85717 138 1

Distributed by Bournemouth English Book Centre
PO Box 1496
Poole
Dorset
BH12 3YD
Tel: 0800 262260
Fax: 0800 262266

## *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 for 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.

Full details of the individuals involved, their affiliations and main responsibilities in the study are listed at the end of the report.

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## *Acknowledgements*

The national evaluation of total purchasing pilot projects is funded by the Department of Health in England and the Scottish Office Department of Health. However, the views expressed in this report are those of the researchers involved and not those of the two Health Departments. Useful comments on an earlier draft of this preliminary report were received from the Departments and the NHS Executive in England.

The data in Appendix 2 on the four 'pioneer' total purchasing pilot projects were provided by the researchers involved in their separate evaluations – namely, Stephen Abbott, Susan Dolan, Jenny Jefferson and Nicola Walsh.

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# Abbreviations

| | |
|---|---|
| CHC | Community Health Council |
| CMHT | Community Mental Health Team |
| CPN | Community Psychiatric Nurse |
| DH | Department of Health |
| EL | Executive Letter |
| FHSA | Family Health Services Authority |
| GMS | General Medical Services |
| HCHS | Hospital and Community Health Services |
| HRG | Healthcare Resource Group |
| NHS | National Health Service |
| NHSE | National Health Service Executive (England) |
| SFH | Standard Fundholding |
| TP | Total Purchasing |
| TPP | Total Purchasing Pilot |

# Summary

'Total purchasing' (TP) is the latest development of the general practitioner fundholding scheme which was introduced into the UK National Health Service (NHS) in 1991/92. Under it, a general practice, or group of practices, is delegated a budget by the local health authority in order to purchase a range of hospital and community health services (HCHS) for their patients which would previously have been purchased by the health authority and which lie outside the standard fundholding (SFH) scheme. Unlike SFH, the final responsibility for the use of the resources delegated to practices undertaking TP currently remains with the local health authority and, unlike SFH, TP has been introduced on a pilot basis.

Following the establishment of four 'pioneer' total purchasing pilots (TPPs) in four NHS regions in 1994, which were a product of local initiative, the NHS Executive in England and the Scottish Office Department of Health announced a 'first wave' of national pilot projects in October 1994. As a result, 53 TPPs in England and Scotland began their local preparations for TP in April 1995 and, a year later, entered their first purchasing year (1996/97). A 'second wave' of TPPs begins purchasing in April 1997. The national TPPs are the subject of a before-and-after and comparative evaluation which is being undertaken between October 1995 and September 1998.

There is no template for TP. As a result, the way in which the scheme unfolds will depend on its local implementation which is a form of partnership between SFH general practices and their local health authority. This preliminary report provides a profile of the 53 'first wave' TPPs with the aim of beginning to answer the question: what is 'total purchasing'? It will be followed by further evaluative reports, as evidence becomes available on the consequences of TP. At present, it is not possible to say how successful TP will be as a means of securing beneficial change in health services through the involvement of volunteer general practitioners acting as agents on behalf of their patients.

Although the projects vary widely on almost every characteristic, the main features of the 53 'first wave' TPPs in April 1996 when they officially began to purchase could be summarised as follows:

- there were 16 single-practice and 37 multi-practice projects which included 62 separate purchasing entities or 'sites' and 191 general practices;
- the mean population per TPP was 33,000 (range 12,000–85,000) and the projects covered 1.75 million people or 3.3% of the population of England and Scotland, ranging between 2% and 20% of their local health authority or health board population;
- TPPs were present in all eight English regions and Scotland, but predominantly outside the main urban centres;
- approximately half of the practices in TP were first and second wave SFH practices (1991/92 to 1992/93) and half came from the third-to-sixth waves of fundholding (1993/4 to 1996/7);
- the management arrangements and structures of the TPPs varied considerably, although all involved practice and health authority staff working together in a variety of ways. 21/27 single-practice 'sites' had no dedicated TP manager, but 6/27 did. Likewise, 32/35 multi-practice 'sites' had a specialist manager for TP, but 3/35 did not;
- the direct management costs of running the projects in their preparatory year (1995/96) varied widely from £0–40,000 per year for single-practice 'sites' and £20,000–300,000 for multi-practice 'sites'. The equivalent per capita figures ranged from £0.26 to £8.05, with the more complex TPP organisations generally more costly to manage. However, these figures should be interpreted with great caution since they include start-up as well as recurrent costs, and TPPs vary widely in their size, complexity and level of ambition as purchasers;
- between April and October 1996, two TPPs dropped out of the national scheme; one a single-practice project without a dedicated TP manager; and one a multi-practice project, again without a specialist TP manager. The main reasons which could be ascertained for the withdrawal of these projects were the large amount of managerial work expected of the leading general practitioners coupled with a perceived lack of progress;
- in their first year of purchasing (1996/97), 'sites' were planning to purchase selectively, in that none of the 'sites' was attempting to purchase across

the complete range of services which health authorities are responsible for. Instead, they were tackling what they believed was feasible in the first year. Their purchasing intentions reflected either areas which the general practitioners in the 'sites' had a previous interest in, or areas where there was a clear local need for improvement, or where change could be made over a reasonable timescale. 6/62 sites were aiming simply to gather information in order to guide purchasing in future years. Only 12/62 sites had four or more specific purchasing intentions in the first year;

- the TPPs divided services into four groups: services which were entirely excluded from the scheme and for which they received no allocation, such as genitourinary medicine or highly specialised, costly services; services which were included in the TP allocation, but for which the resources were 'blocked back' to the health authority which then took on complete contracting responsibility on behalf of the TPP; services which were 'co-purchased', in which the TPP and the health authority collaborated over changes to contracts in a manner similar to general practitioner commissioning; and a limited range of services which the TPP purchased directly and where the health authority involvement was simply to ratify the contracts;
- the most frequently mentioned purchasing priority services for change in 1996/97 were emergency admissions and accident and emergency services (33 sites), community and continuing care (32), mental health care (29), maternity care (28), care of the elderly (14), early discharge from the acute medical and surgical sector (12) and other changes specific to accident and emergency services (12);
- 'sites' did not always express their purchasing objectives in terms of specific service areas, in which case they commonly described their objectives in terms of bringing about a general shift of resources and services from secondary to primary and community provision and/or protecting or enhancing the services of a local (usually small) hospital;
- budget setting has been a major difficulty in the preparatory period and the first year of purchasing. By the end of August 1996, four months into the financial year, 20% of health authorities with TPPs had still not agreed their allocations for 1996/97;
- data collected in the late summer of 1996 showed that 57% of projects were receiving a budget which was somewhere between an entitlement based on capitation and one based entirely on the costs of past activity, whereas 13% were funded by straight capitation and 30% simply on the basis of past expenditure unadjusted for any form of capitation;
- at the same time, 48% of TPPs reported that they had an agreement with their parent health authority which allowed them to use any 'savings' or surplus from their TP budgets to reinvest in services for their patients, although virement between TPP budgets and those for SFH and general medical services (general practitioners' own contracted NHS services) is not permitted at present;
- when asked to identify the main pros and cons of TP, 'lead' general practitioners highlighted the advantages in terms of being better able to influence services, being able to shift services from secondary to primary care settings and being at the forefront of innovations in arrangements for NHS purchasing. The overwhelming disadvantage of TP from the general practitioners' perspective was the additional work involved in relation to their available time;
- managers from the local health authorities involved directly with the TPPs identified patient-focused purchasing and better relations with the local general practitioners as the two main benefits of TP and the additional workload and additional management costs as the main disadvantages of the scheme;
- managers at the main local providers identified similar advantages of TP to those put forward by the health authority staff in terms of patient-focused purchasing and improved dialogue with local general practitioners. They also believed that the TPPs would be a catalyst for change in their trusts. The main drawbacks were in terms of the additional transaction costs which trust managers believed would be incurred with TP, greater inequity of access to services between patients of TPPs and other practices and the potential for destabilisation of local services if TPPs moved resources out of trusts into primary care provision.

It is apparent that there is no single version of TP. It reflects the freedom which each project has been permitted to decide how the concept of extending fundholding should be implemented locally. 'Total purchasing' by general practitioners is more a longer-term policy goal than a reality, since the TPPs are neither 'total' nor exclusively operating as 'purchasers'. They are heterogeneous hybrids of elements of SFH and GP commissioning models of local sub-health authority purchasing, in which the participating practices operate with varying degrees of autonomy from their parent health authorities. Many of the general practitioners continue their involvement in previous general practitioner commissioning and locality commissioning groups where these exist. The TPPs are selective purchasers in that they have all chosen to purchase a sub-set of the HCHS which they could potentially purchase directly, while allowing the health authority to continue to purchase the remainder, although with varying degrees of general practitioner influence.

The current form of TP, in which delegated budgets are held by practices which are technically sub-committees of the health authority, is likely to change in the near future. The primary care White Paper of October 1996, if implemented, would allow TPPs to hold budgets in their own right as in the current SFH scheme, to merge their SFH and TP budgets and, if they so wished, to apply to receive a fully integrated budget covering their general medical services activities, SFH and TP.

# 1. Introduction: background on total purchasing and the pilot projects

## *Origins of the national pilot projects and their evaluation*

The first official announcement concerning 'total purchasing' (TP) in the National Health Service (NHS) came in England in October 1994 as part of an NHS Executive Letter (EL) entitled, *Developing NHS purchasing and GP fundholding* (NHS Executive, 1994). In a section on expanded general practitioner fundholding, the NHS Executive (NHSE) explained that extensive consultation over the summer of 1994 had 'underlined the benefits of increasing both the numbers of general practitioners involved in fundholding and the range of services they can buy'. Subsequently, the range of goods and services in the standard fundholding (SFH) scheme was broadened, and pilot projects were announced in extending SFH to additional individual services such as maternity, osteopathy and chiropractic, mental illness services and other long-stay treatments. Finally, 'total purchasing', defined officially as 'where general practitioners in a locality purchase all hospital and community health services for their patients', was put forward as another, even more wide-ranging extension of the general practitioner fundholding idea to be introduced, unlike its predecessor, on a pilot basis. 'Total purchasing' would allow fundholding practices to purchase a range of services which were currently outside the scope of the SFH scheme, including emergency inpatient care, accident and emergency services, inpatient services for people with severe mental health illness, learning disability services, maternity services, community care, palliative care, regional specialisms (eg. dialysis) and health promotion.

The EL stated that four such TP projects were already under way in England in Bromsgrove (Worcestershire), Berkshire, Runcorn (Cheshire) and Worth Valley (West Yorkshire) and that they were to be joined from April 1995 by approximately another 25 pilot projects. In the event, 53 new projects in England and in Scotland were accepted onto the national TP scheme in the 'first wave' (see Appendix 1 for their identity). The EL also stated that, 'These [the pilots] will be evaluated to identify the most appropriate models' (NHS Executive, 1994). Ministers announced that *all* the projects would be the subject of external evaluation. In fulfilling this commitment to evaluation of a derivative of one of the central pillars of *Working for Patients* (Secretaries of State for Health, Scotland, Wales and Northern Ireland, 1989), the Department of Health (DH) undertook an open tendering exercise which resulted in an evaluation of the national TP pilot projects (TPPs) being commissioned from a research consortium led by the King's Fund Policy Institute. This report is the first preliminary statement about the progress of the national TPPs from this study. Other stand-alone evaluations of the first four 'pioneer' TPPs, referred to in the October 1994 EL, had previously been locally commissioned and are well advanced. Where appropriate, basic information about these four projects is included in the material presented (see Appendix 2).

Between the autumn of 1994 and April 1995, English Regions and the Scottish Office Department of Health were asked to use their local health authorities and former family health services authorities (FHSAs) in England and health boards in Scotland[1] to help identify suitable groups of SFH general practices which might be interested in the possibility of becoming part of the national TP initiative. A distinction was drawn between the 'national' TPPs and other locally inspired examples of extensions of general practitioners' involvement across a wide range of health service purchasing. The 'national' projects were linked closely to the NHSE's and Scottish Health Department's announcement and, thereby, to the extension of the model of general practitioner fundholding rather than to any of the other locality-based models of purchasing and commissioning which health authorities had been developing over the previous three years (Mays & Dixon, 1996).

1. Where 'health authorities' are referred to in the remainder of this document, this should be taken to include health boards in Scotland and health authorities in England

Brief application forms were devised to allow prospective projects to characterise themselves, together with their potential aims, and practices were encouraged to put themselves forward with appropriate colleagues. The level of interest stimulated by the previous experience of fundholding, the EL and the work of Regional, health authority and FHSA staff was high. After shortlisting, the NHSE and Scottish Office Department of Health gave official recognition to 53 new pilot projects (of which six were Scottish) to add to the four 'pioneer' sites which had already been in existence for about 18 months by this time. Whereas the four 'pioneers' had developed 'bottom-up' as a result of the long-standing interest of a few general practitioner fundholders in extending general practitioner fundholding to a wider range of services, the 53 volunteers became the 'first wave' of a NHSE-inspired initiative. In a sense, therefore, TP represents official recognition of a phenomenon which was already taking place informally in a number of places.

In April 1996, a 'second wave' of 34 volunteer TPPs was announced as part of the national scheme. Evaluation of both waves of projects is due to be completed in October 1998. Decisions as to whether they are to be extended beyond this point will be made by the Government between then and now.

## *Defining 'Total purchasing'*

EL(94)79 (NHS Executive, 1994), which brought the concept of TP to wide attention in the health policy community, said nothing about the aims, objectives or methods of the TPPs. Beyond a general belief in the merits of the idea of giving general practitioners more influence over NHS purchasing by budgetary means, there was no indication of what TPPs were expected to do or to achieve. However, two factors exerted a strong influence on the TP scheme. Firstly, unlike SFH in 1991, TP was to be a pilot scheme with an evaluation, although the projects were selected from among a group of volunteers. Secondly, it was not to be enshrined in legislation which would permit general practices to hold health authority money in their own right. Any resources which the TPPs might aspire to deploy would remain ultimately the responsibility of the health authority to account for their proper use. As a result, the scheme would rely heavily on the co-operation of the local health authority and was to be defined through its local implementation. Furthermore the label 'total purchasing' implied that the projects would not be 'commissioning' services, but would be actually 'purchasing' them (i.e. using their own budgets independently rather than merely influencing the decisions of others), while the legislative status of the TPPs implied that the projects could only operate in close co-operation with the responsible health authority.

Unlike SFH, which by 1994 had developed its own detailed rules and regulations, the TP concept was to be pursued simply according to the policies and guidance which applied to the health authorities in whose areas the TPPs were located. The rules faced by health authorities were to apply to the TPPs. For the rest, the development of the TPPs was to be a local matter with no recommended model or models for guidance. Thus, for example, each region was provided with a budget to allocate a minimum of £20,000 to each of its TPPs as a once-only payment in the first or preparatory year. Any additional or subsequent management support or financial contribution to the management costs of the TPP was to be negotiated locally with the health authority.

There were only two centrally determined 'facts' about the TPPs which it seemed safe to assume: firstly, that TPPs were composed exclusively of volunteer SFHs; and, secondly, that there should be no virement between the SFH and TP budgets of the practices in the TPPs. It remains to be seen to what extent even these two 'facts' will hold true in practice. Clearly, the logic of TP is to move towards an integrated budget for all hospital and community health services (HCHS), thereby, for instance, allowing practices to balance emergency and elective expenditure in-year as demand for one or the other alters.

Currently, the following may suffice as a working definition of total purchasing:

> *Where either one general practitioner practice, or a consortium of practices are delegated money by the relevant health authority to purchase potentially all of the community, secondary and tertiary health care not included in standard fundholding for patients on their lists.*

Notice that the definition states that the TPP may purchase 'all or most' care for their patients, in fact contradicting the 'total' in TP. This is based on the experience of the preparatory year, 1995/96, of the projects included in the current study, in which projects were permitted to choose which of the range of services purchased previously by the health authority they wished to take on. Hence a more appropriate term for TP at present might be 'selective purchasing'.

# 2. The evaluation of total purchasing pilot projects

## *Potential strengths and weaknesses of total purchasing*

In the absence of any detailed description of the aims and objectives of the TPPs from the NHSE, the evaluation consortium was reliant on the research brief prepared by the DH Research and Development Division for an indication of the effects which the architects of TP believed that the TPPs might produce. This indirectly offered an idea of the objectives of the scheme. The brief was clear; that TP was 'the extension of general practitioner fundholding' (Department of Health Research and Development Division, 1995), indicating that, in general terms, the Department and NHSE were expecting similar consequences to SFHs.

The aim of the evaluation was 'to assess the costs and benefits attributable to the *extension* of GP fundholding to total purchasing'. The objectives were to collect evidence on:

- 'the factors associated with successful set-up and operation of total purchasing;
- the costs and effectiveness of total purchasing;
- the benefits to patients through total purchasing'

in order to indicate the 'best models for further development of fundholder-based purchasing in a primary care-led NHS' (Department of Health, Research and Development Division, 1995, pp1–2). These objectives guided the design of the current study.

Under the *costs* of TP, the research was to include a focus on the operating costs of the scheme, transaction costs (i.e. the costs of negotiating, specifying and monitoring contracts and managing spending between purchasers and providers), and policies to minimise these costs, indicating a concern that the TPPs might increase the overall management and transaction costs in the NHS internal market by increasing the total number of purchasing organisations. The research was also to look at budgetary management, overspends and underspends and the use made of any 'savings' from TPPs' budgets. This suggested that there might be straightforward budgetary incentives in TP similar to those in SFH, linked to the ability of projects to make and spend their own 'savings'. It was not clear how this could be reconciled with the fact that the resources of the TPPs were to remain the responsibility of their parent health authorities.

The brief divided the *effects* of TP into two parts – 'benefits to patients' and 'effectiveness'. Under 'effectiveness', a range of aspects of health services where TPPs might be expected to bring about measurable changes, such as in referral and investigation patterns, quality standards in contracts, prescribing patterns, the balance between primary and secondary-based care and provider configuration were listed. There was also an interest in detecting any divergence between TPP, health authority and national purchasing priorities and strategies. 'Benefits to patients' suggested that the DH believed it possible that the TPPs might be able to improve responsiveness to patients' wishes in the services which they purchased, lower waiting times, improve access to primary and secondary care, raise levels of patient satisfaction and improve health outcomes. Researchers were encouraged to give some thought as to how these effects might be assessed. In addition, reference was made to the possible effects of participating in TP on the delivery of general medical services (GMS) provided by general practitioners under their national contract.

Finally, the research brief highlighted a number of specific services for special attention as part of the evaluation. The list included services which had not previously been included in the SFH scheme, such as accident and emergency services, emergency medical inpatient care, services for the seriously mentally ill and community care. There was a concern to assess the extent to which the TPPs opted to use different providers, altered the content of services, differed from the local health authority in their strategies and met the requirements of national policy where relevant (e.g. the *Changing Childbirth* initiative in England (Expert Maternity Group, 1993)) in these new service areas.

It is understandable why the research brief should have mentioned services such as accident and emergency and inpatient mental health services,

**Table 2.1** Potential strengths and weaknesses of general practitioner total purchasing of hospital and community health services identified to inform the design of the evaluation

**Potential strengths**

- Combination of best of 'top-down' (health authority) and 'bottom-up' (SFH) models of purchasing (i.e. needs vs demand focus; individual vs population focus; 'leverage' vs 'bite')
- Scope for service innovation and substitution leading to improvements in cost-effectiveness
- Sites act as 'vanguard' to secure service improvements and/or cost reductions in specific services which other purchasers can build on
- Sensitivity to local needs
- Clinician-to-clinician negotiations on service improvement

**Potential weaknesses**

- Fragmentation of NHS priority-setting and purchasing decisions and accountability for decisions
- Higher transaction costs (especially for providers) generated by larger numbers of smaller purchasing agencies
- Difficulty in managing unpredictable demand and associated costs (e.g. medical emergencies)
- Difficulty in finding a fair means of setting budgets for projects
- Deepening existing inequity between general practices
- Excessive reliance on expertise of a few 'lead' general practitioners, threatening sustainability
- No clear incentives at outset for practices to take part and for health authority to co-operate

since not only were they new to general practitioners as purchasers, but there were theoretical grounds for greater scepticism than had been the case with SFH about general practitioners' claims to be better purchasers of these services than their local health authorities. It was clear that general practitioners could directly influence the pattern of non-urgent services used by their patients through their referral behaviour, but it appeared less plausible that they would be able to influence the unplanned, unpredictable areas of health services such as attendances at accident and emergency departments. In addition, there was no clear evidence that fundholders had the knowledge or interest to pursue quality and cost improvements in services such as inpatient mental health services. While it was apparent that general practitioners received regular feedback on the quality and organisation of local elective services from the patients whom they referred and who returned to their care, it appeared far less likely that this would be the case for services such as residential care for people with learning difficulties or for far less commonly used, or highly specialised services. Glennerster *et al* had shown that fundholders were able to use the fact that they were 'closer to the pains and preferences of patients' to engineer micro-efficiency gains in relation to non-emergency services' (Glennerster *et al*, 1994), but there was no guarantee that these would be possible in other fields of care.

In order to tease out these issues and help develop the design of the evaluation, a list of potential strengths and weaknesses of TP was prepared (see Table 2.1). The potential strengths appeared to be bound up in the possibility that the TPPs might be able to combine the advantages of small-scale, personal, clinically informed purchasing, seen to be characteristic of SFH, with the broader, evidence-based population focus which might characterise health authority purchasing. This might be reflected in TPPs being able to purchase either better services at the same costs as their health authority counterparts or services of equal quality at lower cost. It would be important to design an evaluation to shed light on this. Including a list of potential drawbacks (see also Table 2.1) had the advantage of alerting the research consortium to possible areas where data should be collected to determine whether TP was able to overcome potential limitations. A number of potential problems stood out: namely, the possible reliance of TPPs on the energy and insight of a few leading general practitioners in each project; the ability of the TPP to stay within budget when demand for non-elective health care fluctuates; the difficulty of setting a fair budget for TPPs and the remainder of the local population; and, the higher transaction costs generated by having a larger number of smaller purchasing organisations requiring better information and more detailed contract specifications from providers. Finally, there was a concern that practices would lack clear incentives to

take part in the scheme. For example, there was to be no guaranteed management allowance, unlike in SFH. The ability to make 'savings' was not clear since the TPP monies remained the property of the health authority, unlike in SFH, and the health authority, might well be extremely resistant to the views of the TPPs, fearing a loss of its role. It was also likely that practices would have to work together in unfamiliar ways to form TPPs. As events turned out, the NHSE was overwhelmed with volunteer projects. As subsequently became apparent, the desire to bring about changes in local services, or a wish to be involved in the latest stage of fundholding, overcame any reservations which practices may have had.

## *The design of the national evaluation of total purchasing pilot projects*

The national DH-funded evaluation of the 'first wave' TPPs began data collection in October 1995 when the first set of visits were made to all the projects to interview key local participants in TP. The study is due to report finally in the late autumn of 1998, by which time the 53 'first wave' projects will have been followed for a preparatory year (1995/96) and through two purchasing and contracting cycles (1996/97 and 1997/98). The evaluation now also includes the 34 'second wave' TPPs which will be studied in a similar fashion, although less intensively, commencing in late 1996.

Since the timing of the launch of the national TP scheme, the number permitted to enter the scheme and the commitment to evaluate *all* the projects were decisions taken without reference to the design of the evaluation, the study could not be experimental. It was not possible, for example, to compare TPPs with groups of similar general practices eligible for the scheme, but not entered, and strictly matched on a range of features regarded as predictive of the likely costs and benefits of TP. In addition, it was clearly not feasible to insist that no other policy initiatives should be undertaken which might affect local patterns of provision or the apparent consequences of TP. Instead, where practicable, comparisons are being made in different parts of this evaluation between sub-samples of 'first wave' TPPs, extended SFH practices, SFH practices, non-fundholding practices and health authorities. Sometimes the focus is on the patients of different types of purchaser organisation; at other points, the focus is on the processes undertaken in the organisations themselves. In addition, there are important comparisons to be made between the 53 TPPs themselves.

The evaluation of the 'first wave' projects has a large number of interrelated components some of which are being carried out at all projects, others at sub-samples of TPPs:

- *establishment and operation of the TPPs (process evaluation)* – this part of the evaluation is being undertaken at all projects. It describes how TP has been implemented and is being undertaken through a combination of face-to-face interviews, diary cards, postal questionnaires, telephone interviews, analysis of routine data and the analysis of documents. The material in this early report comes from this part of the overall evaluation which enables comparisons to be made *between* different ways of implementing the basic TP concept with a view to informing future developments;
- *transaction costs* – the managerial and transaction costs associated with TPP purchasing compared to health authority purchasing, with and without the involvement of SFH practices, are being described and quantified in detail at a sample of TPPs;
- *activity changes* – the changes in activity (e.g. patient episodes, lengths of stay, levels of prescribing and prescribing costs, etc.) before and after the advent of TP are being compared with SFH and non-SFH populations at all TPPs in the study using routine NHS data;
- *purchaser efficiency and costs of services* – the TPPs' ability to negotiate lower cost, higher volume or better quality services are being compared with that of the local health authority, using routine activity and cost data at all TPPs;
- *costs and patients' experiences of specific services which general practitioners are purchasing for the first time* – four separate sub-studies are under-way examining the patterns of care, service costs and patients' reactions to specific services purchased by the TPPs in comparison with the same services purchased by health authorities. The particular emphasis here is an attempt to assess directly the benefits to patients of TP. The four services are

community and continuing care for people with complex needs, accident and emergency services together with emergency admissions, services for people with serious mental health problems and maternity care. In the case of the latter two services, the evaluation of the impact of TP has been linked to evaluation of pilot extensions of SFH. In each service area, the focus is on a sub-sample of TPPs which have made the particular service area a priority in their purchasing strategy.

The findings from the transaction costs, activity changes, purchaser efficiency and patients' experiences components will be presented in later reports. Further details about the evaluation are contained in a leaflet available from the King's Fund Policy Institute (Total Purchasing National Evaluation Team, 1996).

# 3. Nature of the report

## *Purpose of this report*

Approximately 12 months before the Audit Commission produced its evaluation of SFH in 1996, the Commission produced a *Briefing on GP fundholding* (Audit Commission, 1995), which contained facts about the fundholding scheme and about fundholders. The aim of this preliminary report based on findings from the first year of a three-year evaluation is very similar. TP is a potentially important development in general practice-led purchasing. It is also relatively new. There is considerable interest in the concept both at a political and managerial level. Yet, TP appears to mean different things to different people depending on whether they approach it from a SFH perspective or a non-fundholding perspective. This report goes some way to providing basic, non-evaluative, information about all the 'first wave' TPPs.

Each section of the report covers a different aspect of TP, each of which is relevant to ascertaining subsequently whether TP will be a success, to what extent and why. Thus the basic characteristics of the TPPs, such as their population size and the number of practices involved, may influence things such as their ability to manage within their budgets and their ability to agree on priorities. The organisational structure of the TPPs in terms of complexity versus simplicity may affect the management costs of the TPP. The precise management arrangements may determine the extent to which the project is influenced by the views and interests of the health authority as against being general practitioner-led, and this in turn may be relevant to understanding why some TPPs are able to make the changes which they desire and others not. The level of management support to the TPP may shape not only the project's management costs but also its ability to purchase a wide range of services successfully. How the TPP's budget is set will influence the extent to which TP can be implemented without creating local inequity between parts of the district health authority population. Understanding the purchasing objectives and purchasing intentions of the TPPs is clearly relevant to determining the precise nature of TP and its potential effect on the configuration of services provided under the NHS. It further offers a baseline against which each TPP's achievements can subsequently be assessed in its own terms. Finally, data on how the principal participants subjectively assess the pros and cons of TP and their views of the balance of costs and benefits over time are pertinent, firstly, to identifying issues for future data collection to ascertain whether participants' hopes and fears were justified and, secondly, to identifying whether the experience of purchasing under TP increases or decreases the support for the concept among key participants.

## *Methods and data used in this report*

The profile of the TPPs presented in this preliminary report comes from the component of the evaluation which focuses on the establishment and operation of the 'first wave' TPPs (see previous section on the design of the national evaluation). Most, but not all, of the data presented here were collected at the first set of site visits which were carried out at the 53 'first wave' TPPs between October 1995 and January 1996, midway through their preparatory year. Face-to-face, semi-structured interviews were conducted with representatives of the main parties involved in each TPP (the 'lead' general practitioner or general practitioners, as appropriate, the TPP manager, the manager at the local health authority most involved with TP, representatives from the principal local trusts used by the TPP and a local social services manager in contact with the project).

In each case, it was up to local staff to decide who was the most appropriate person to be interviewed. For example, on occasions, the member of health authority staff most involved with the local TPP was the director of finance, in other places the director of primary care or director of purchasing. On other occasions, it was found that the project did not have a single project manager and a number of fundholding managers had to be interviewed. Approximately seven to eight interviews were conducted at each TPP depending on the organisation of the project and its context. Each interview comprised a series of pre-set main questions, but each of these was supported by a range of supplementary questions and interviewer prompts which the interviewer was free to use as he or she

judged appropriate, given the initial responses to the main questions. Thus the interview guide was semi-structured to allow for flexibility, since it was envisaged that there would be considerable variation between projects and their settings.

The interviews were tape-recorded and the researcher also took detailed notes during the interview. An analysis guide was prepared in advance which the interviewer used to prepare a written summary of the interview, drawing out the main points made in relation to a series of questions determined *a priori*. An overall commentary on the TPP as a whole was also prepared. Thus, although the interviews allowed considerable scope for local variation, and for interviewees to bring up issues which the researchers had not raised directly, the analysis was structured in advance so that most of the data were summarised as responses to questions believed to be important for TP by the research team.

A range of documentary and basic factual information was collected from each TPP. This included purchasing intentions documents, papers on specific issues, such as resource allocation methods, and practice profiles derived from routine NHS data held formerly by the FHSAs in England.

Where necessary, the data derived from the site visits were updated by telephone interview or postal questionnaire; for instance, to ascertain whether any practices had withdrawn from the TPPs and to obtain information on the methods used to set the projects' budgets (see section 6).

Finally, this report includes some of the quantitative data derived from postcards sent each month to the 'lead' general practitioner, a 'non-lead' general practitioner, health authority lead, TPP manager, two local provider managers and a social services contact at each TPP. The postcard asks them to make a subjective assessment on two 10-point visual analogue scales of the extent of costs and benefits which they could attribute to TP that month. Respondents are left to define the costs and benefits for themselves. This simple method allows the monitoring of the balance of perceived costs and benefits over time between the different parties involved in the implementation of TP and has been used successfully in previous research on general practitioner fundholding (Howie, Heaney and Maxwell, 1995).

# 4. Characteristics of the total purchasing pilot projects

## *Number and size*

At the beginning of April 1996, there were 57 official TPPs in England and Scotland. Four of these projects – Bromsgrove, Berkshire, Runcorn and Worth Valley in West Yorkshire – were regional 'pioneer' projects which had developed the concept of TP from the bottom up, starting in 1994. These projects are being evaluated separately from the 53 national 'first wave' projects which are being examined through the national evaluation. A 'second wave' of pilot projects, also to be evaluated by the national evaluation, comprised 34 projects. Data on these projects, which do not start purchasing until April 1997, are not included in this report.

The 'first wave' TPPs are a mixture of volunteer practices who wished to develop TP themselves, together with other practices encouraged by health authorities to pilot the scheme. In April 1996, the 53 'first wave' TPPs comprised a total of 191 general practitioner practices involving 960 general practitioners (see Table 4.1). Of the 53 projects, 16 are single-practice projects and 37 are multi-practice projects.

The multi-practice projects were discovered to have three basic forms: firstly, an established consortium of general practices or a fundholdings multi-fund that had continued its association into TP; secondly, an entirely new coalition of practices brought together to form a consortium to undertake TP; and thirdly, multi-practice projects which consist of a number of practices which do not work as a single purchasing unit but act as more or less independent *sites* within the same project. In this last case, the project operates as a federation of autonomous *sites* which generally have control over their own TP budgets, receive separate management allowances and work to their own sets of purchasing objectives. These sites are effectively working as separate projects for most or all of their purchasing and represent a highly decentralised form of TPP. Thus, whilst 53 TPP *projects* were admitted into the 'first wave', they resulted, in practice, in 62 separate TPP *sites* (i.e. separate purchasing entities – see Table 4.1). This distinction is used throughout this report.

Figure 4.1 shows that a high proportion of *sites* contain just a single practice (27 sites or 43.5%) with a spread of practice numbers in multi-practice sites from two to ten practices. Of these sites, two had withdrawn from total purchasing by October 1996 (of which one was a single-practice TPP and one was a large multi-practice TPP). The main reasons stated for the withdrawal of these pilots were the large amount of managerial work required by general practitioners to run the scheme, combined with a perceived lack of progress. This lack of progress was regarded as caused by a lack of information to inform purchasing decisions and conflict of views, both with the host health authority and internally between the practices involved. A further 17 practices within a number of other sites also opted to withdraw from total purchasing between April and October 1996.

**Table 4.1** 'Pioneer' and 'first wave' TPP numbers and sizes, April 1996

| | *Pioneers* | *'First wave'* |
|---|---|---|
| Number of projects | 4 | 53 |
| Number of single-practice projects | 1 | 16 |
| Number of purchasing sites (as opposed to projects) | 4 | 62 |
| Number of practices | 17 | 191 |
| Number of general practitioners | 105 | 960 |
| Median number of practices per site | - | 2.0 |
| Mean number of practices per site | 4.25 | 3.1 |
| Mean population of projects | 50,450 | 33,327 |
| Median population of projects | - | 28,500 |
| Range of population of projects | 12,000–87,000 | 12,310–84,700 |

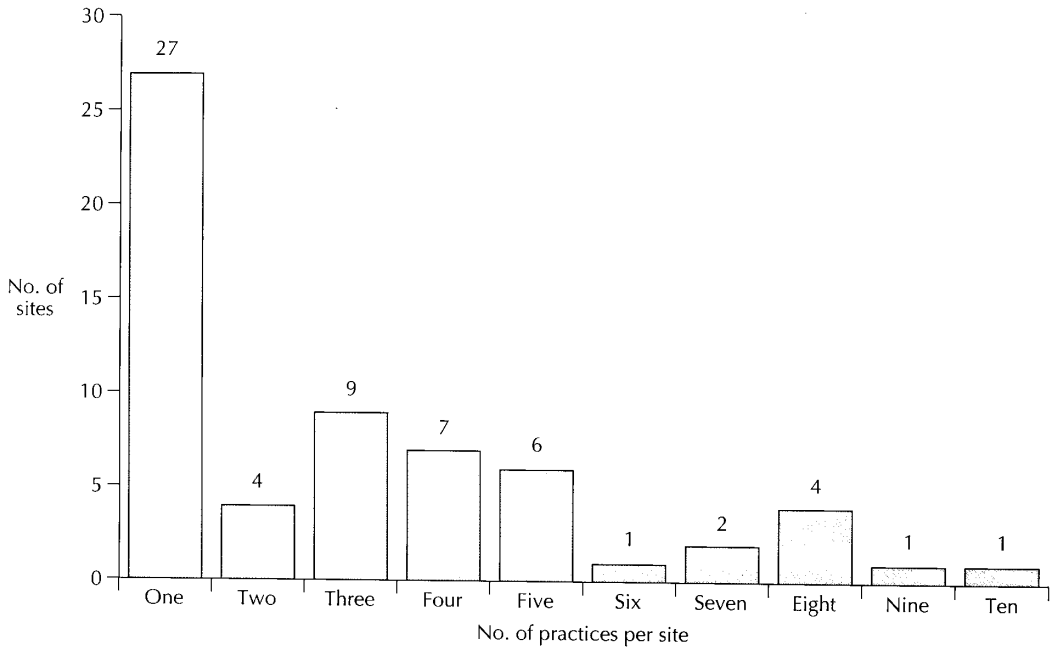


**Figure 4.1** TPP sites by number of practices, April 1996 (n=62)

Only one site had welcomed an additional practice into total purchasing in the period April to October 1996, although many expressed the hope that the scope of their TPP site might be extended to include neighbouring practices in the future.

Two of the TPPs include the formal involvement of general dental practitioners alongside the general practitioners as purchasers of specialist dental services, and one of the TPPs also involves a community pharmacist working together with the general practitioners and the dentist to contribute to service specification and purchasing decisions.

## *Geography of the projects*

The 53 projects were located in each of the eight NHS Regions in England and in five of the Scottish health boards. Despite this apparent wide national distribution, it is clear that most of them lie outside the centres of the major towns and cities and are most often located in suburban and rural areas (see Figure 4.2). This finding is consistent with that of the Audit Commission on the location of fundholding practices (Audit Commission, 1996) and is to be expected, given that eligible practices were supposed to be fundholders.

There are 40 district health authorities and five Scottish health boards which contain TPPs. Five of these have more than one project. It can be seen from Table 4.2 that the average size of the projects varies by Region. The West Midlands, for example, has a high proportion of single-practice TPPs, whilst the North West and North Thames have a high proportion of larger multi-practice TPPs.

Newer pilots are now developing in Wales, Northern Ireland and, in a 'second wave', in England, including some in inner-city areas. Future reports from the national evaluation will discuss these newer TPPs.

Altogether, the 'first wave' national TPPs (i.e. excluding the four 'pioneer' projects) cover a patient population of about 1.75 million which is equivalent to 3.3% of the patient population of England and Scotland. Table 4.3 shows that the regional range of population in TPPs lies between 2% in Anglia and Oxford and 4.5% in Trent. On average, the TPPs cover 5% of their host health authority populations, although the range of coverage in each health authority varies markedly from as low as 2% to as high as 20%.

A number of TPPs cross health authority boundaries. In these cases, the percentage of patient coverage

**Table 4.2** Regional distribution of 'first wave' TPPs, April 1996

| *Region* | *Number of projects* | *Number of authorities with a project* | *Number of practices covered* | *Average number of practices per project* |
|---|---|---|---|---|
| South & West | 6 | 6 | 15 | 2.50 |
| South Thames | 6 | 6 | 26 | 4.33 |
| North Thames | 6 | 3 | 31 | 5.17 |
| Anglia & Oxford | 3 | 3 | 6 | 2.0 |
| West Midlands | 6 | 5 | 11 | 1.83 |
| Trent | 8 | 7 | 24 | 3.0 |
| North West | 7 | 5 | 39 | 5.56 |
| Northern & Yorkshire | 5 | 5 | 19 | 3.80 |
| Scotland | 6 | 5 | 20 | 3.33 |
| **TOTAL** | **53** | **45** | **191** | **3.6** |

**Table 4.3** Number of patients in TPPs by Region

| *Region* | *Projects* | *Sites* | *Number of patients* | *% Region population* |
|---|---|---|---|---|
| South & West | 6 | 13 | 182,951 | 2.8 |
| South Thames | 6 | 6 | 244,834 | 3.6 |
| North Thames | 6 | 6 | 285,501 | 3.9 |
| Anglia & Oxford | 3 | 5 | 94,400 | 2.0 |
| West Midlands | 6 | 6 | 128,527 | 2.4 |
| Trent | 8 | 8 | 213,999 | 4.5 |
| North West | 7 | 7 | 261,576 | 4.1 |
| Northern & Yorkshire | 5 | 5 | 163,948 | 2.4 |
| Scotland | 6 | 6 | 185,249 | 3.6 |
| **TOTALS** | **53** | **62** | **1,760,985** | **3.3** |

is calculated on the patient population of the host health authority (i.e. the health authority that is working with the project). In some of the projects whose practice populations are in more than one health authority, TP only applies to the patients within the health authority which is collaborating with the TPP to the exclusion of those living outside. In one exceptional case, a TPP with patients located in two health authorities has sought a budget from both, although the management of the project is undertaken in conjunction with the health authority which has the majority of the patients.

## *Breakdown by fundholding wave*

Total purchasing has attracted participants from all of the waves of fundholding to date. As Table 4.4 shows, whilst the highest frequency of practices involved in TP are 'first' and 'second wavers' (49 each, totalling 51% of all practices), there are also 23 practices that had no experience of fundholding before becoming involved in a TPP. In these cases, the sites became fundholders in the 'sixth wave' at the same time as becoming total purchasers. However, whilst these practices have been eager to join the total purchasing initiative, most have expressed some reservations about the additional requirement to become fundholders. For example, in one site it was necessary for the local health authority to assign fundholding accounts to practices as a 'legal requirement' in addition to the total purchasing fund. Thus, whilst the practices in the site are technically fundholders, the general practitioners themselves refuse to be known as fundholders and prefer the term 'neighbourhood purchasers'. In another site, it was agreed with Region that some practices could be involved in total purchasing without becoming fundholders, as long as the local health authority represented their fundholding interests. The practices involved in total purchasing, therefore, include a range of practices from experienced fundholders to those with no previous experience of holding a budget, and who are not supporters of the SFH model of general practice-based purchasing.

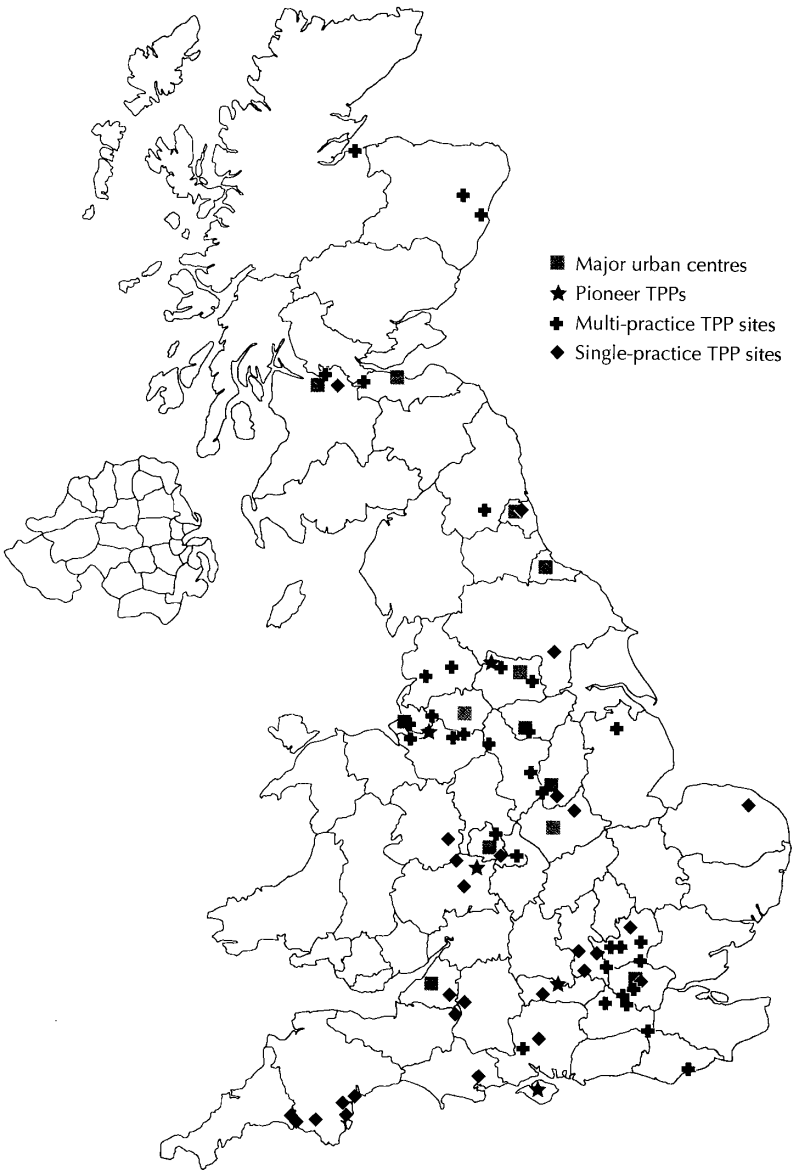


**Figure 4.2** Location of 'pioneer' and 'first wave' TPP sites

**Table 4.4** Breakdown of TPP practices by fundholding wave, April 1996

| | *Wave 1 April '91* | *Wave 2 April '92* | *Wave 3 April '93* | *Wave 4 April '94* | *Wave 5 April '95* | *Wave 6 April '96* | *TOTAL* |
|---|---|---|---|---|---|---|---|
| Single-practice sites | 12 | 7 | 6 | 2 | 0 | 0 | 27 |
| Multi- practice sites | 37 | 42 | 30 | 25 | 7 | 23 | 164 |
| **TOTAL** | **49** | **49** | **36** | **28** | **7** | **23** | **191** |

# 5. Organisation and management of the total purchasing pilot projects

The examination of the organisation and management arrangements for total purchasing is important for a number of reasons: firstly, to be able to determine what style of organisation and management is associated with the more successful TPPs; and secondly, since total purchasing introduces a further sphere of management to the NHS, to address concerns about the additional administrative costs and complexity which may be generated by the set-up and operation of the scheme. The ability to determine what style of organisation works best and is most cost-effective in different situations is an important consideration for the future of total purchasing. This section describes the development of organisational and management arrangements up to April 1996. No doubt further changes have continued to occur.

The TPPs represent another new way of bringing hitherto separate general practices together. They have developed varied organisational frameworks characterised by both formal and informal arrangements for decision-making. This variety in the organisational set-up of the projects reflects the fact that no template for their introduction was imposed. Rather, each TPP has developed very personal organisational and management arrangements in conjunction with its host health authority. These have been influenced by a variety of local factors, including: project size; the previous relationship between the practices and the host health authority; the nature of the local provider market; and the temperament and management style of the individuals involved. Consequently, arrangements for total purchasing are characterised by flexibility and, unsurprisingly, this has led to a wide variety of organisational arrangements.

## *The formal organisational structure of TPPs*

Despite the wide variety of organisational development within TPPs, it is possible to distinguish between those projects which have developed complex arrangements and those with less complex formal organisational structures. This continuum is best thought of by reference to the hypothetical structure for a TPP shown in Figure 5.1. This hierarchical structure shows the fullest formal organisational arrangements which any one TPP could develop, based on observations of the different ways in which TPPs have organised themselves in practice.

Within this hypothetical TPP, the top of the management hierarchy is the *Health Authority Board*, since TPPs are technically part of the health authority because the resources they use to purchase still belong to the health authority. The Health Authority Board is attended purely by health authority staff, discusses health authority policy towards the TPP and gives strategic direction to the project. Typically, the Health Authority Board consists of the chief executive and executive directors such as the directors of finance, contracting and public health.

On the second level of the hypothetical hierarchy lies the *Project Board*. The Project Board acts as the steering group to the TPP and is most likely to be a formal sub-committee of the health authority, although other arrangements were in place in the preparatory year to give the TPP official status.

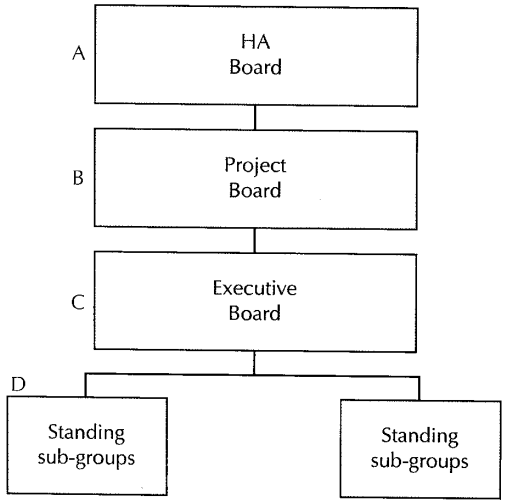


**Figure 5.1** Formal organisational structure of a hypothetical TPP

The Project Board gives strategic guidance to the Executive Board and often holds full delegated power over the project on behalf of the health authority. The Project Board tends to be a mixed group of health authority and TPP practice level personnel. It is most likely to comprise the TP manager (if such a person has been appointed), lead general practitioner(s) and selected directors or senior managers from the health authority. In some cases, membership may be extended to include representatives from the Region, local providers, social services and other interested parties such as community health councils. The latter group would not normally hold any voting rights on project decisions.

Typically, at the third level of the hierarchy, is the *Executive Board*. The Executive Board can be described as the day-to-day 'decision-making' group of the project, since it develops and proposes the objectives and purchasing intentions of the project to the Project Board and is then responsible for their implementation. The Executive Board members are usually the local staff most closely identified with and involved in the TPP. The Executive Board is most likely to comprise the TP manager and/or fundholding managers of the individual participating practices and lead general practitioners from all practices involved in the TPP. It is possible that lower level health authority managers will also be on the Executive Board with specific responsibility for areas such as finance, information, contracting and needs assessment.

It is important to note that the functions of the Project Board and Executive Board are sometimes combined into a single decision-making body. This is particularly true of single-practice projects.

At the final level of the hypothetical hierarchy are *sub-groups*. These can be both standing groups with specific roles, such as dealing with information issues, contracting, finance, clinical priorities, etc., or ad hoc groups which disband when their task is accomplished. Groups also vary in their degree of formality (e.g. how they report to the rest of the TPP). The membership of sub-groups varies widely but often comprises lead general practitioners with a special interest (e.g. in a service area), the site manager and a health authority manager seconded to help the project in that specific area. In some TPPs, health authority managers may form a sub-group without input from staff in the TPP (e.g. to develop a budget-setting method). The overall role of the sub-groups is to feed information and proposals back to the Executive Board for discussion and ratification.

## *Structure of TPPs*

Due to the variation in their design and composition, the formal organisational structures of the TPPs do not fit neatly into organisational 'types'. For example, the staff composition of the various Boards within the hierarchy differs markedly between TPPs which are otherwise similar in terms of formal structure. Likewise, some TPPs which appear to have simple, 'lean' structures may have a high degree of informal input from TP, health authority and other staff. Moreover, total purchasers have been constantly forming and reforming their organisations as they have progressed; sub-groups have been formed and others abolished; levels of management added and removed. However, it is possible to characterise the TPP sites in a simple way through the following three-fold classification of organisational complexity:

*1. Complex*
This is the most elaborate model in which the full hierarchy sketched in Figure 5.1 exists, and formal, standing sub-groups have been developed. There is also a degree of participation from external stakeholders such as Regions or providers. Twenty-five sites can be termed 'complex'.

*2. Intermediate*
The hierarchy may exist but with the merger in some cases of the Executive Board and the Project Board. Some formal sub-groups have developed, but there is a low degree of participation from external stakeholders. Eighteen sites can be termed 'intermediate'.

*3. Simple*
This is the least elaborate model in which the Executive and Project Boards are merged in all cases. There are few or no formal sub-groups beyond this single board and there are few or no staff from outside the TPP involved in its management. Nineteen sites can be regarded as in the simple category.

## Exhibit 5.1 **An example of a complex TPP organisation**

The TPP comprises five practices and covers an estimated population of 58,000 people.

***Project board***

The TPP is a legal sub-committee of the health authority and is administered by a project board. The Board consists of equal numbers of representatives of the members of the practices and health authority executive staff and is chaired by the non-executive director. The Board's responsibility is for supervising, monitoring and determining budgets for the project. It is also a forum where the health authority and the TPP exchange views on strategic problems and issues relating to purchasing and services. Additionally, represented on the Project Board are the community health council, the GP commissioning executive and the local medical committee.

***Project executive***

The Project Board has devolved the TPP budget to the Project Executive which is the main managing committee for the TPP which is chaired by the lead GP. The Project Executive comprises representatives from each of the member practices including equal numbers of managers and doctors. The Executive meets monthly and is responsible for purchasing services. It has responsibilities for producing regular monitoring reports in terms of activity and cost to be forwarded on to the Project Board for consideration.

***Sub-committees***

The Project Executive is supported by sub-committees which include information technology, data collection and finance. There are additionally three clinical working groups covering the areas of acute services, community services and mental health services. These working groups look at the clinical needs of the project population and determine the clinical specifications to be sought from providers through purchasing. They also act as the relevant forum where clinical best practice and audit results are examined.

Each of the managers and the project co-ordinator have been allocated specific providers to work with, and dedicated negotiating teams with delegated authority from the Project Executive have been set up in order to negotiate contracts.

**Table 5.1** Organisational complexity of TPP sites by number of practices in the TPP

| *Practices in TPP* | *Simple* | *Intermediate* | *Complex* |
|---|---|---|---|
| 1 | 15 | 3 | 9 |
| 2 | 2 | 1 | 1 |
| 3 | 1 | 6 | 2 |
| 4 | 1 | 4 | 2 |
| 5 | - | 2 | 4 |
| 6 | - | 1 | - |
| 7 | - | 1 | 1 |
| 8 | - | - | 4 |
| 9 | - | - | 1 |
| 10 | - | - | 1 |

As one might expect, there is an association between the size of the TPP and its organisational complexity. Table 5.1 shows that single-practice projects tend to have more informal and simpler organisational arrangements than multi-practice projects. The only exception to this general observation are the nine single-practice sites which are all involved in multi-practice projects. In these cases, whilst the sites within the project are working independently, they are linked to the same project board. For example, in a project that consists of four single-practice sites, each of these sites has developed its own Executive Board (the day-to-day decision-making body of the site), but they share the same Project Board with the other four. The Project Board, therefore, acts as the steering group to the four sites of the project. These projects are normally the most complex of all the TPP organisations.

## Exhibit 5.2 **An example of a simple TPP organisation**

The TPP comprises a single practice covering about 12,000 people

***Management Arrangements***

- Management arrangements are simple and focused, giving the practice the flexibility to manage the budget with the minimum of bureaucracy while ensuring that the health authority is able to account for the use of its funds. The primary care development manager (fundholding) services the project team.

***Project Team***

- The project team oversees the management of the total fund. The practice fundholding manager manages the pilot on behalf of the practice.
- The project team consists of the general practitioner representatives from the practice, the fundholding manager, the commission directors of finance and development and support staff, and a consultant in public health. Additional members may be co-opted to the project team as necessary.
- The project team is accountable to the health authority and reports on a regular basis.

All policies for various elements of the management of the scheme developed and agreed by the project team. The practice and the health authority then work to these policies. They include: the calculation of the budget; the use of over- and under-spends; virement between the total fund and the fundholding budget; protocols for significant variations in contracts; financial planning and reporting; and invoicing and payment.

Whilst the organisational complexity of the different projects may be useful to explain the future size of transaction costs and the ability of sites to make effective decisions, the typology is crude at this stage. The ability of sites to bring about desired changes through their purchasing may well depend on a wide range of other factors, some highly specific to the local context and features of the TPP. For example, factors such as fundholding history, nature of relations with outside organisations, nature of relations between practices in the TPP and the abilities of key individuals to run the TPP may influence the achievements of the TPP at least as powerfully as the formal organisational structure.

## *Management arrangements*

The examination of organisational structure above attempted to assess the degree of complexity in the TPP sites. This section examines how management decisions are made and, in particular, attempts to determine which individuals exert major control over the destiny of the project.

Although every TPP is technically a sub-committee of the health authority, which suggests that the health authority retains formal control over each project, in practice, there is wide variety in the extent to which the priorities, objectives and management of the project are determined by the formal sub-committee status of the TPP. There appears to be a continuum which runs from top-down, health authority-led projects to bottom-up, general practitioner 'controlled' projects. Equal partnership between health authority and general practitioners appears to lie somewhere in the middle. The extent to which the health authority retains control over the project, therefore, appears to be a matter of degree, although all TPPs include a strong element of health authority–general practitioner collaboration.

Since the extent to which the TPP is run as a top-down venture, a partnership, or a bottom-up venture varies, it would appear important to know in the longer run which style of management is most appropriate and effective. The projects, therefore, have been categorised to reflect this. The project manager is likely to play a crucial role in running the projects. Whilst some project managers have been seconded from the host health authority to help run TPPs – hence giving the health authority, at least in principle, a strong hand in the running of the project – in many other cases, the manager has been employed by the TPP independently, often expressly because the TPP does not wish to have such a strong health authority input. It seems plausible, at this

stage, to hypothesise that the TPPs with their own project manager will operate more autonomously than those which rely on an existing member of health authority staff. The level of autonomy may, in turn, be associated with the relative success of the TPP in bringing about beneficial changes in services. However, TPP managers employed by the health authority can bring benefits to the project, provided that they can cope with the ambiguity inherent in their role and the potential conflicts of interest. For example, they may enable the general practitioners to find their way around the health authority bureaucracy better than an 'outsider' manager. On the other hand, they may find themselves in awkward situations where the actions of the TPP are claimed to be disadvantaging the rest of the health authority's population.

In categorising management arrangements, the following three questions have been used so far to derive variables in the analyses from the evaluation:

1. Is the project a multi-practice or single-practice TPP?

2. Is there a specialist project manager (one employed exclusively to deal with total purchasing issues) and, if so, is this person an employee of the TPP or the health authority?

3. Does the health authority provide a specific person for the TPP to work with, thereby providing a clear liaison role or point of contact, or is there no specific contact at the health authority?

By examining the management arrangements of the TPPs provided during the interviews undertaken with the projects between October 1995 and January 1996, the following managerial types were derived (see Table 5.2):

*1. Extended practice management – single-practice sites*
The most common management type occurs in single-handed TPPs where no dedicated TP manager exists to run the project. The management of the site is usually undertaken by the existing fundholding or practice manager in addition to his/her existing duties (and most often not resourced further) with a lead liaison officer within the health authority acting as co-ordinator of the project. There are 21 single-practice sites which have attempted to extend the roles of their existing staff and have not recruited a dedicated TP manager.

In one site, there appeared to be no one person from the health authority acting as a lead contact with the project. The health authority regarded the site as relatively unimportant because of its small size and hence the site enjoyed a high degree of autonomy, if a low degree of advice and support, from the health authority.

*2. Extended practice management – multi-practice sites*
There are three cases of multi-practice sites which have no site manager to co-ordinate TP. In these cases, the Project Board takes the form of a co-operative with all the general practitioners and fundholding managers from each practice taking part in collective decision-making. In most cases a non-voting chair runs the meeting who is usually a non-executive director of the health authority.

*3. Specialist TPP project management – single-practice sites*
There are five cases of single-practice sites which have employed a specialist site manager. Of these, three have employed a specialist site manager who is not a health authority employee. One single-practice TPP has a member of health authority staff specifically employed to act as TPP manager. This project *may*, therefore, be regarded as potentially highly controlled by the health authority (although this cannot be guaranteed). One site has a specialist TPP manager employed by the site with little management input by the health authority. This site would appear to have a highly autonomous management role.

*4. Specialist TPP project management – multi-practice sites*
The most common form of management for multi-site projects has been the employment of a specific manager to co-ordinate TP. Of the 28 projects which have followed this route, 18 employed a manager independently of the health authority, whilst six projects had a specific manager employed or seconded from the health authority. It may be considered that the management arrangements in the former model allow for potentially greater autonomy in decision-making than in the latter.

**Table 5.2** Management arrangements by type of TPP site (n = 62)

| | *Single-practice sites* | *Multi-practice sites* |
|---|---|---|
| Extended practice management | 21 | 3 |
| Specialist TP manager | 6 | 32 |

**Table 5.3** Participants on the executive boards of projects, April 1996

| *Participant* | *Number of projects including participant* | *Number of projects excluding participant* |
|---|---|---|
| General practitioner | 51 | 2 |
| Fundholding manager | 35 | 18 |
| Health authority representative | 33 | 20 |
| Dedicated TP manager | 33 | 20 |
| Public health representative | 9 | 44 |
| Provider representative | 7 | 46 |
| Social services representative | 2 | 51 |
| Community health council representative | 2 | 51 |
| Other representative (local medical committee, local authority councillor, GP commissioning group, etc.) | 20 | 33 |

Four sites had both a TPP-employed and a health authority-seconded manager working as a team, which suggests a partnership structure.

The importance of studying the organisational and management arrangements of the TPPs lies in their likely influence on the effectiveness of the total purchasing process and on the transaction costs associated with different organisational arrangements. This brief, preliminary analysis of the organisation, and management of TPPs suggests that a very wide variety of structures and management styles has developed, directly related to the individual characteristics of each project. Moreover, these organisational structures appear to be evolving and it is highly probable that most projects will have developed new organisational and management arrangements by the end of their first year of purchasing.

One potential influence on the ability of TPPs to succeed is the degree to which external organisations are involved with projects during the decision-making process. On the whole, the level of participation from representatives of external organisations was low in the preliminary year. As Table 5.3 shows, projects which had officially included representatives from public health, providers, social services and CHCs on their decision-making boards by April 1996 were very much in the minority. However, anecdotal evidence suggests that the level of representation from interest groups has increased rapidly during the first purchasing year.

# 6. Financing the total purchasing pilot projects

## *Budgets of the total purchasing pilot projects*

When the first set of visits to the 53 'first wave' TPPs was undertaken in the autumn and winter of 1995/96, few of the projects had any clear idea of how their budgets would be set or their likely level. Subsequent monthly information from TPP general practitioners made it clear that budget setting was becoming a particularly difficult issue for 1996/97. In large part, this was because health authorities themselves faced difficulties in agreeing their own budgets for the financial year 1996/97, owing to the relatively tight financial settlement agreed between the Treasury and the Department of Health. For these reasons, detailed data on budget setting were collected from the projects in June 1996 when a short postal questionnaire was sent to the 'lead' general practitioners (n = 62) and health authority leads (n = 30) at each of the TPP *sites*. After reminders, non-responders were followed up in August 1996.

Forty out of 62 (65%) general practitioners had replied by the end of August. At that time, only 65% (26/40) of those sites had received an agreed budget. In the remaining 35% of sites, the budget had still not been set for the financial year, which was already four months old. Forty-two percent of sites had not officially known about their precise budget until after June 1996 and only 26% stated that their budget had been made known before the beginning of the relevant financial year in April. By August, 26/30 (86%) of health authorities with TPPs reported that they had offered allocations to their TPPs and 24/30 (80%) of health authorities had agreed allocations with their TPPs. Ten authorities believed that delays in budget setting were likely to have limited what their TPP was aiming to achieve in 1996–97.

Thirty per cent of authorities with TPPs (9/30) were using a purely historical basis for setting budgets, while the remaining 70% (21/30) included some element of capitation in the calculation. Of these, 4/30 (13%) used capitation alone, while 17/30 (57%) calculated the allocation using a mixture of capitation and historical expenditure elements.

Out of the 21 authorities where some element of capitation was used, two used crude population with no weighting for population needs and the rest weighted the population in various ways. The commonest pattern was to use the national health authority capitation formula for HCHS (the 'York formula' in England (Carr-Hill *et al*, 1994) and the 'SHARE formula' in Scotland (Scottish Home and Health Department, 1977)) and to take account of the local prices paid for services by the TPPs.

General practitioners were also asked whether, in their opinion, the method of budget setting was fair. The majority were content that the method used was fair (54%), with 34% believing that the method was unfair. In the sites reporting a perception that the budget was 'unfair', there was a suggestion in some of the comments made by the general practitioners that some health authorities were favouring the allocation method (historic budget or capitation) which produced the lower total. In principle, general practitioners appeared to think that capitation was fairer than a historic budget and less prone to interference and to the weaknesses of a reliance on past utilisation data.

The financial climate facing the NHS in 1996/97, the delay in setting budgets and the fact that an appreciable minority of general practitioners believed that the method chosen was unfair were, unsurprisingly, associated with a very strong view that the budget setting process had been difficult. Altogether, 83% of general practitioners reported that budget setting had been very or somewhat difficult in the first year of TP. Aside from the external factors making budget setting difficult, there was a widespread problem in obtaining accurate data on each site's past use of services and the costs of that use. All the health authorities which reported delays in determining the TPP allocations (19/30) attributed these delays to the problem of estimating past and current expenditures. These data were required to set the baselines used in the process of developing a funding method and would also be used by the TPP when negotiating a final allocation. Some sites found it difficult to check the calculations made on their behalf by the health authority.

The calculations were made more complex by the fact that the TPP and the health authority had to agree the service inclusions and exclusions on which the budget was to be based, since TPPs were not purchasing the same range of services as the health authority (see section 7, below). Ten out of 30 authorities, however, reported that delays in setting budgets were caused neither by data problems nor by technical problems in agreeing the formula. Instead, the cause was simply that capitation produced results which were so different from actual spending that they were unacceptable either to the health authority or the TPP. In eight out of ten authorities, the results were unacceptable to the authority because they would have led to a large rise in the TPPs' share of local spending.

In general, the process of agreeing a method for setting the TPP budget and for finalising the precise sum involved, risked casting the TPP and the health authority in opposition to one another, despite the fact that technically the TPP might be regarded as a project established by and within the health authority. A good, open relationship between the TPP and the health authority appeared to mitigate the worst effects of budgetary disputes.

'Lead' general practitioners at each site were asked, 'What is the total budget for all the extra services which are included in total purchasing (this includes services which have been 'blocked back' to the health authority)? (see section 7 for a discussion of 'blocking back'). The reported budgets for each TPP site, when divided by each site's total population, with no adjustments for the age of the population or other needs, produced a wide range of per capita spending. The site with the highest per capita budget appeared to have six times the resources of the site with the lowest per capita budget. However, extreme care should be taken in interpreting this range. Some of the variation in per capita budgets will be artefactual since there is scope for errors in both the numerator (the budget) and the denominator (the population). There are likely to be inconsistencies between sites in the expenditures which are, or are not, included in the reported budget for TP. Where sites have populations drawn from more than one health authority, generally only one authority's patients are funded for TP. Dividing the spending of these sites by their *total* population will underestimate their level of funding.

Deriving better estimates of the true variations in TP spending will be an important part of the national evaluation in future. It is likely that better estimates will still show very significant variations in per capita budgets even when the definitions of expenditures are consistent, the relevant populations are included and allowance has been made for relative needs. This is because of differences in the ways in which budgets have been set between sites. Establishing the variation in current levels of TPP funding and how this compares with the past may be important in explaining the relative success of different TPPs in the future. Sites with higher levels of per capita resources or significant increases over previous levels are likely, all other things being equal, to be better placed to make changes through TP than other sites.

TP can be regarded as situated between conventional fundholding in which the practice(s) control their own budgets, and general practitioner commissioning in which the practices involved obtain their influence by their close involvement in the commissioning process without holding their own funds. The short questionnaire to 'lead' general practitioners included a question on whether the site was able to keep any 'savings' or surplus from the TP budget to reinvest in the project, because the reported existence of opportunities to use 'savings' may indicate those sites which have been given a higher degree of budgetary autonomy by the parent health authority and may, in turn, distinguish sites where financial incentives are used to generate the impetus to change, as against those where influence and the rewards of participation for the general practitioners are generated in other ways. Forty-eight per cent of general practitioners reported that they were able to retain 'savings' to reinvest in their project, whereas 23% reported that they were unable to do so. Thirty per cent reported that there were arrangements other than a straightforward notion of 'savings' (and, presumably, equally of overspends). The 'other' arrangements included four main options: to carry forward underspends (and overspends, presumably) to the next financial year; for the authority and the TPP to agree jointly on the use of 'savings' (and the implications of overspends, presumably); for the TPP to adjust its spending during the year to avoid 'savings' (and overspends); and, to avoid any prior agreement on

the use of 'savings' (and overspends), but to negotiate their use (or financing) if they arose.

In the group of sites which believed that they had the ability to retain 'savings' to spend on services for the population of the site, most sites seemed to have negotiated an arrangement in which the use of any surplus would be subject to a range of constraints. Examples were ceilings on the size of retainable 'savings' amounting to 1% to 2% of the total budget, or financial ceilings, regardless of the proportion of the actual 'savings'. In other sites, it was believed that the opportunity to use 'savings' was only theoretical since budgets had been set in such a way that any 'savings' would be extremely unlikely. It appeared, from what general practitioners reported, that the 'savings' were intended to be used for patient care only and not for improvement of general practitioners' premises. This is plainly in line with the legal status of TP in which the resources remain the property of the relevant health authority to be used by HCHS.

While the experience of budget setting varied across sites, it has often been difficult. Indeed, agreeing the method and agreeing final allocations have put more strain on the relationships between the TPPs and their parent health authorities than anything else reported in the preparatory year (1995/96). At its bleakest, one lead general practitioner described the process as, 'a recipe for disaster, failure and disillusionment'! Another highlighted problems caused by the position of the TPP as a sub-committee of the health authority which meant that it was very difficult for a TPP to be independent. The consequences were described as 'the health authority won't 'let go' of their budget easily and have been very difficult to deal with. The TPP needed to have regional/NHSE support for budget setting like for fundholding but [this] wasn't forthcoming.'

On the other hand, some authorities managed this difficult process with openness and skill so that the general practitioners understood the difficulties and had confidence in the way in which their allocation was decided. Thus one lead general practitioner observed, 'The good rapport that we have with officers and directors at the authority has enabled us to pick our way through these complexities'.

The NHSE Regional Offices in the North West, North Thames, South and West and West Midlands have organised workshops for TPPs in England, Scotland and Wales in autumn 1996 on budget setting designed to help general practitioners, health authority staff and providers. The focus has been on learning from each others' experiences of the process so that budget setting for 1997–98 may become easier rather than pretending that a magic formula exists. Findings from the national evaluation have been used to inform the contents of these workshops.

## *Management costs*

Each TPP has had to negotiate a management budget with its local health authority to help with the set-up and running costs of total purchasing. This money has been used by the projects for many different purposes. The most common use has been to purchase the services of a project and/or site manager and other administrative staff such as data clerks, secretaries and information officers. In some cases, the money has been used to purchase general practitioner locum time and other practice-based staff to enhance the primary care role of the practices. For example, in one site, a community psychiatric nurse (CPN) and a nurse-practitioner have been hired using funds earmarked for set-up management costs. In addition to staffing, other direct costs have included the development of new, computerised information systems, collection of information on the past and current pattern of activity, equipment and sundry other management costs.

These direct costs have been financed in two ways. First, each English project was entitled to receive a one-off payment of £20,000 from their Region towards set-up and management arrangements in the preparatory year (1995/96). In reality, some of the larger projects received as much as £50,000 from their Region. Second, this payment has been supplemented by a negotiated sum from the local health authority. In Scotland, this money has come from the Scottish Office Department of Health which has funded not only the TPPs' set-up and running costs for year one, but also some TP running costs incurred by the health boards. The range of Scottish Office allocation to TPPs has been £50,000 to £132,000.

The level of this budget has been a matter for negotiation between the TPPs and the health authority in England and ranged from nothing to £40,000 in single-practice sites and from £20,000 to £300,000 in multi-practice sites in 1995/96. In the case of multi-'site' projects, this could mean £20,000 per 'site'. The total direct costs (i.e. those directly attributable to TPP management at health authority or practice level, excluding costs borne by providers or 'hidden' or indirect costs such as the costs of general practitioners' time not accounted for by locum payments) of managing total purchasing in the preparatory year amounted to approximately £5 million.

There have been a number of different methods by which this money has been allocated. For example, a distinction has often been made between set-up costs for the first year and running costs for future years. Consequently, the level of payment to TPPs given above is likely to be substantially inflated for the initial year particularly if information technology has had to be purchased. However, it has not been possible in many TPPs straightforwardly to separate the start-up costs from the likely recurrent costs of running the projects. Moreover, whilst in some cases the local health authority has given an actual cash sum for the sites to use, others have allocated a management budget from which the site can claim reimbursement. Some of the money earmarked, therefore, may not yet have been spent. Thus strictly, the sums reported in this section are *budgets* rather than actual costs incurred. In addition, some of the budgets have included unused fundholder savings belonging to the practices. Thus it is plausible that the level of direct management costs will be substantially lower in 1996/97 and beyond.

In order to ascertain whether the organisation of the sites was related to the size of the management budget, the per capita management budgets were compared using the clarification of complexity used in the previous section. As Table 6.1 reveals, the level of organisational complexity appears to relate to the level of the per capita budget. Thus, in the simple sites, the average direct management budget was £2.33 per patient, whilst in the complex sites the figure was £3.81 per patient. One possible explanation for this differential is that the larger, more complex sites have most often invested in site managers and new information technology systems to help facilitate total purchasing. However, within the general trend, there is a wide variation in the per capita budget. For example, multi-practice sites with complex organisational structures that have employed site managers have a range of budgets from 44p to £6.15 per capita.

Despite the variation in per capita management budgets, it is generally the case that sites which have invested in site managers and information technology have incurred higher than average direct costs. It is also the case that, in multi-practice sites, those with the largest patient populations appear to have the lowest per capita management costs. For example, sites with two to five practices have an average per capita management budget of £3.31 compared to only £2.34 for those with more than five practices. However, all calculations of management costs per capita should be regarded with caution for the same reason as per capita allocations for services (see above), since there are problems in knowing the population denominator precisely in TPPs with patients from more than one authority. Further work will be undertaken on this issue in the future.

The figures presented here provide a rough indication of the direct costs associated with total purchasing in the preparatory year (1995/96). These direct costs are likely to be reduced in future years since many of them are associated with one-off set-up costs. A focus for the evaluation in the future will be an assessment of direct costs compared to the consequences of TP, since the greater costs associated with setting up highly complex sites may result in greater purchasing activity and greater benefits to patients. The wide range of expenditure on management should be interpreted with care. In part, lower costs may be associated with the extent to which TPP management activities are being undertaken by existing staff whose jobs include a range of responsibilities other than TP. However, the disparities are also likely to relate to the uncertainty facing all TPPs, at the outset, as to precisely what type and scale of managerial, information and accounting infrastructure was necessary to run a successful TPP. This remains an open question at this stage in the evolution of TP.

**Table 6.1** Budgeted direct management costs of TPP sites and level of organisational complexity

| *Organisational complexity* | *Average direct management costs per capita* | *Range* |
|---|---|---|
| Simple | £2.33 | £0.73 to £5.39 |
| Intermediate | £2.88 | £0.26 to £8.05 |
| Complex | £3.81 | £0.44 to £6.15 |
| All sites | £3.00 | £0.26 to £8.05 |

# 7. Main objectives and purchasing intentions of the TPP sites, 1996–97

## *Approaches to purchasing*

During the interviews with general practitioners and site managers that took place in late 1995 and early 1996, the sites were asked to name their four main purchasing objectives/intentions for the 1996/7 contracting year – the year that most 'first wave' TPPs would be 'going live'. However, not all sites could, at that stage, describe four main changes. The data generated for analysis also proved problematic to analyse. There were sites which had more than four major purchasing intentions, but the nature and extent of these intentions varied considerably. Since the interviews were undertaken, most sites have tended to reduce the level of their ambition in the purchasing of services for 1996–97, following a realisation that the workload and data collection required would be too onerous for all objectives to be pursued at once. For example, on return to those sites which had identified community/continuing care as a priority late in 1995, the evaluation team found in summer 1996 that less than half had any detailed plans for changes to services and/or contracts in this area for the first purchasing year. From this, it would appear that project teams were making a realistic appraisal of what was likely to be feasible, preferring to increase the probability of making important changes across a more restricted range of services than to fail to bring about change by striving to be comprehensive.

There was further variation in the expressed purchasing priorities depending on the different interviewees within the same sites which was made more problematic by variability in the purchasing intentions documents produced. In examining the '*main purchasing intentions*' of each site, therefore, a judgement has been made from the interviews and documents in order to derive their priorities as they stood at the end of the preparatory year. Furthermore, since these accounts and documents were statements of *intention*, the following analysis should be seen as a guide to the main ideas of the sites rather than as a definitive list of what the sites are actually purchasing in 1996/97.

Most TPPs did not intend to purchase the full range of the services potentially available to them. Instead, as suggested previously, total purchasing could be renamed 'selective purchasing', since it is clear that most sites have selected certain areas that they wish to influence using the total purchasing budget. In many cases, TPP sites intended to purchase services in subsequent years which they were not considering in 1996/97, but this is by no means the case for all TPPs.

There appear to be four main approaches to the purchasing of services that fall under the total purchasing budget:

*1. Exclusion*

In this case, the TPP does not hold a part of the budget for certain services which it considers inappropriate to buy. This is particularly true of services which require specialist treatments and where there may be a great deal of financial risk involved. Exclusions also include services for people with HIV/AIDS where resources are ringfenced and cannot be used alternatively and genito-urinary medicine services where patients cannot be identified for reasons of confidentiality and thus practices' use cannot be calculated.

*2. Blocking-back*

In this case, the TPP holds the nominal budget for the service but 'blocks-back' all contracting responsibilities to the health authority. The sites do this for a number of reasons: either they are happy with the service that is being provided; or the service is not an area of special interest to the TPP at the present time; or it is felt to be inappropriate to interfere with the current purchasing of the service as this may cause destabilisation of provision. Sometimes, services which are 'blocked back' are also services with high levels of financial risk. 'Blocking-back' does not necessarily indicate that the site is uninterested in influencing the service or in purchasing it directly in future. The majority of services will be 'blocked-back' to the health authority in 1996/97.

**Table 7.1** A comparison of the numbers of specific purchasing intentions between single-practice and multi-practice TPP sites for the contracting year 1996–97

| *Number of specific purchasing intentions* | *Single-practice sites* | *Multi-practice sites* | *Total* |
|---|---|---|---|
| 0 | 4 | 2 | 6 |
| 1 | 3 | 5 | 8 |
| 2 | 9 | 7 | 16 |
| 3 | 8 | 12 | 20 |
| 4 or more | 3 | 9 | 12 |

*3. Co-purchasing*
Co-purchasing usually involves the TPP working closely with the health authority over changes to services and contracts, but falls short of true TPP purchasing since the final contract is negotiated by the health authority rather than the TPP. The co-purchasing method, therefore, is similar to general practitioner commissioning (Black, Birchall and Trimble, 1994).

*4. TPP purchasing*
Where the TPP holds a delegated nominal budget for a service from the health authority and forms contracts to purchase the service largely independently of the health authority. However, the health authority has ultimately to agree to honour the contract, since the TPP's resources remain the responsibility of the authority.

## *Purchasing intentions*

There is a wide variety in the level of ambition with which different sites are approaching the purchasing of services. Most sites have concentrated on services in which they have a special interest or which are the focus of local concern. Indeed, one possible model of TPP action is to act as the 'vanguard' for the health authority in which the TPP targets a small number of service areas and makes changes which are built on by the health authority. The TPP then moves on to new areas for change. Some sites have been far more ambitious, while others have not put forward any plans to purchase a specific service in 1996/97. One criterion for the success of total purchasers might be seen as the extent to which they have been able to fulfil their own purchasing objectives regardless of their level of ambition. This will be studied in due course.

As Table 7.1 shows, most TPPs have had limited ambitions for 1996/97, restricting their focus to those service areas in which they have a special interest, and/or where good information exists to inform their purchasing decisions. Six sites have decided not to purchase anything in their first year, but spend a further year refining the management of their projects and/or collect further information before deciding what future changes may be appropriate. Only twelve sites have suggested they would want to directly purchase (i.e. 'TP purchasing' as set out above) four or more services in year one.

The ambition of TPPs also seems to be associated with their size. Single-practice sites have been generally less ambitious than their multi-practice colleagues. Sixty per cent of single-practice sites, for example, intended to purchase in only one or two services areas. On the other hand, 60% of multi-practice sites claimed that they intended to purchase three or more services. In addition, the smaller sites tended to have local goals and very specific small-scale changes in mind whilst the larger TPPs tended to have far more ambitious plans. This difference in ambition may be related to many factors including the relative purchasing power of the TPPs and the numbers of managerial staff within the sites. Thus, smaller TPPs are far less likely to have grand designs and are far more likely to purchase selectively.

The fact that most of the TPPs expressed modest purchasing ambitions for their first year of purchasing is not surprising, nor is it necessarily a criticism. In general, TPPs have adopted a practical approach in which they have concentrated on a few service areas where the need for change was clear to them; where there was information available to guide them; where the GPs and site managers could cope with the work; and where the probability of success was high. The Audit Commission's study of SFH showed a very similar picture of selective purchasing in the field of elective care with practices focusing their energies on making changes in a small number of

**Table 7.2** Priority service areas for purchasing by the TPP sites, 1996–97

| *Service area* | *No. of sites* |
|---|---|
| Emergency admissions and accident and emergency attendances | 33 |
| Community/continuing care | 32 |
| Mental health care | 29 |
| Maternity care | 28 |
| Care of the elderly | 14 |
| Early discharge/reduced length of stay in acute medical and surgical beds | 12 |
| Other accident and emergency (e.g. ambulances, data gathering) | 12 |
| Oncology | 5 |
| Palliative & terminal care | 3 |
| Cardiology | 2 |
| Other priority service areas | 9 |

**Table 7.3** Non-service specific priorities for the TPP sites, 1996–97

| *Priority* | *No. of sites* |
|---|---|
| Shift of services from secondary to primary care | 15 |
| Protection or enhancement of local hospital | 7 |
| Information gathering and monitoring of services to inform future purchasing | 6 |
| Needs assessment to inform purchasing in future | 3 |
| Better patient transport; health promotion; contract currency change; evidence-based protocols; control use of resources; better dialogue with providers; increase prescribing to prevent illness | 1 each |

service areas (Audit Commission, 1996). It is at least plausible that a TPP which sets out its intentions realistically is more likely to achieve them than a TPP which attempts to bring about strategic change across the board in a few years. However, it has to be realised that such an approach inevitably leaves the health authority with the overall responsibility for meeting the health needs of the population within a fixed budget.

An additional factor shaping TPP purchasing intentions was the fact that good activity, quality and cost information was not automatically available in the areas of service covered by TP. Thus a noticeable amount of effort in 1996/97 was spent on collecting better data to inform purchasing in future years (see below).

## *Analysis of purchasing intentions by service area*

Tables 7.2 and 7.3 show the frequency with which broad service areas were included in the purchasing intentions of the 53 'first wave' projects. The list has been compiled from the four most important objectives identified by each site (ie. purchasing entity, see above, section 4) and has been subdivided, as far as possible, into service-specific and non-service-specific priorities (i.e. mechanisms of change) for the TPP sites in the first year. Some TPPs did not have more than four areas, and in other cases, one purchasing objective impinged on two service areas. For example, whilst twelve sites wished to reduce length of stay in hospitals, the same twelve sites linked this objective to purchasing services for respite care in local community hospitals or in nursing homes. Moreover, there is also likely to be irreducible overlap between some of the categories, such as between 'emergency admissions' and 'elderly care' depending on how the site expressed its purchasing intentions. Since sites were free to describe as many intentions as they wished, the frequency with which service areas were mentioned has not been summed in Table 7.2 or any other of the similar tables in this section. Thus the data in Tables 7.2 and 7.3 should be regarded as indicative rather than definitive representations of the purchasing intentions of the TPPs.

The frequency count of purchasing intentions reveals that the most popular areas for change have been emergency admissions and A&E attendances, community/continuing care, mental health care and maternity care. However, a wide variety of other

**Table 7.4** TPP priorities in influencing accident and emergency services/emergency admissions

| *Service area* | *No. of sites* | *Mechanism for change* | *No. of sites* |
|---|---|---|---|
| Reducing emergency admissions and accident and emergency attendances | 33 | Local minor injuries clinic | 9 |
| | | Practice-based nurse practitioner | 6 |
| | | Rationalisation of admissions by provider | 5 |
| | | Promotion of community hospital facilities | 5 |
| | | General practitioner-led emergency assessment facility | 4 |
| | | Better patient education on use of accident and emergency department | 1 |
| | | No mechanism mentioned | 3 |
| Promoting early discharge from acute beds | 12 | Changing contract currency with provider | 8 |
| | | Use of discharge liaison nurse | 5 |
| Accident and emergency | 12 | Information gathering and monitoring | 7 |
| | | Ambulance service | 2 |
| | | Reduce waiting times through contract; integrate protocols between providers for better continuity of care; better documentation from accident and emergency department | 1 each |

services have been highlighted as priorities and these are detailed below together with the different mechanisms of change employed.

## Accident and emergency/emergency admissions

Forty-three sites expressed an interest in helping to reshape the way accident and emergency services were provided for their patients. Of these, 18 sites employed more than one method, or mechanism, for doing so. As Table 7.4 reveals, the most popular target for change was the reduction of inappropriate emergency admissions and attendances at the accident and emergency department (33 sites), while twelve sites wanted to promote early discharge from acute hospital beds.

The different pilots have formulated a number of different mechanisms for influencing accident and emergency department use and emergency admissions. The most popular mechanism has been to offer more treatment facilities locally as an alternative to the hospital accident and emergency department. This was to be achieved through the creation of local facilities, such as a minor injuries clinic, or by extending the services available to patients within practices. The second method of reducing inappropriate accident and emergency attendances has been to develop better methods of assessing patients' injuries. In many cases this has involved a protocol with the accident and emergency provider to refer patients with non-urgent injuries back to their general practitioner.

The promotion of early discharge from acute medical and surgical beds was to be achieved using two main mechanisms. First, contract currencies with providers would be changed to promote early discharge by making longer stays in hospital less financially rewarding. The stipulated method has varied but has generally involved contracts based on either a sliding scale of daily charges depending on treatment costs or expected episode costs such as those derived from Healthcare Resource Groups (HRGs). The second approach was to employ a discharge liaison nurse who would enter hospitals, assess the condition of patients and discharge those patients whose treatment could be continued appropriately in the community.

## Community/continuing care

Thirty-two sites prioritised community and/or continuing care. Of these, twelve sites had more than one mechanism to influence delivery. As Table 7.5 shows, twelve of the sites wanted to facilitate earlier discharge from hospitals by purchasing beds in local community hospitals or nursing homes. These sites were primarily concerned with the problems caused by 'bed-blocking' in their local area.

The other major target for TPPs which wanted to influence community care has been the establishment of links with local authority social services departments. Many benefits were highlighted, from the ability to combine funds for the purchase of more respite care, to the attachment of care managers

## Exhibit 7.1 **An example of purchasing intentions for accident and emergency/emergency admissions**

The intention will be to improve the quality of care delivered in accident and emergency departments, in particular by cutting down waiting times for treatment. It is envisaged that this can be achieved by:

- a telephone triage system, designed to direct patients towards the site of optimum care in the event of accident or sudden illness
- increasing the availability of nurse-practitioner-led Minor Injury Treatment Units (MITUs) throughout the district
- improving the communication between A&E departments, MITUs, ambulance control centres and general practices

It is intended that the burden of minor and primary-care attendees on A&E departments will be reduced, leaving casualty department medical staff freer to care for the more seriously ill or injured.

## Exhibit 7.2 **An example of purchasing intentions for community/continuing care**

- A major goal of the project in 1996–7 will be to more effectively bridge the gap between acute and community services. The employment of care co-ordinators will benefit the community services component of total purchasing by providing timely access of TPP patients to continuing care, care in the home and other community services
- The project intends to co-purchase non-emergency transport services with the health authority and intends to monitor the quality of transport services. The project will consider mechanisms for increasing availability of Dial-a-Ride, ambulance and other transport services
- The project intends to increase appropriate utilisation of continuing care beds by TPP patients. Additional beds will be purchased at the local community care centre if possible.
- It is the intention of the project to purchase the services of qualified nurses in order to address the issue of patients in need of a variety of different types of services as a condition of or upon discharge from acute providers. These services may be purchased either through the direct hire and placement of care co-ordinators or through funding of staff employed by providers.

from social services to work alongside the TPP as part of the development towards a more integrated primary health and social care team.

### Mental health care

Twenty-nine sites expressed an interest in tackling some form of mental health service beyond those in SFH. Four sites had more than one mechanism in mind. The priorities in this area are summarised in Table 7.6.

The most popular method of influencing mental health provision was the development of local community mental health teams (CMHTs). The development of the CMHTs generally involved the addition to local practices of mental health care experts including CPNs, practice-based counsellors and psychiatrists working on a sessional basis. Thus, the sites wanted to provide more services and develop better access to and better care for local people with mental health problems. Of the 21 sites intending to make changes of this type, nine intended to employ a CPN *only* whilst a further twelve sites highlighted other personnel and service improvements which they wanted to put in place to develop a more comprehensive CMHT.

Twelve sites sought to influence the care provided by their mental health provider. Of these, four wanted the provider to improve the flow of information to the TPP on the services provided to their patients; three wanted to develop their own mental health care units within local community

**Table 7.5** TPP priorities in influencing community/continuing care

| *Service area* | *No. of sites* | *Mechanism for change* | *No of sites* |
|---|---|---|---|
| Promoting early discharge | 12 | Purchasing beds in local community hospitals and nursing homes (intermediate care) | 9 |
| | | Discharge liaison nurse | 3 |
| Establishing links with social services | 23 | Joint commissioning of respite care to develop nursing homes and purchase more continuing care places | 7 |
| | | Attachment of care manager to TPP | 6 |
| | | Employment of community health nurse | 6 |
| | | Promotion of hospital-at-home service | 4 |
| Other priorities | 6 | Purchase more beds for rehabilitation services (separately from social services) | 2 |
| | | More practice-based services; better integration with providers; develop day hospital; develop 'care-co-ordination' package for discharged patients | 1 each |

## Exhibit 7.3 **An example of purchasing intentions for mental health care**

- The project will be working to align mental health activity around general practices and contracts with providers will be structured to enable this to take place
- Mental health providers will be required to provide activity information by patient and general practitioner. Contracts may be structured so the TPP only pays for activity that can be attributed to its patients. Providers will be required to make activity information available in a format acceptable to the project, via computer links into the project database
- The TPP will move away from contracting for services on the basis of inputs and will seek to move to contracting for specific outputs. A range of care outcomes and care packages will be introduced on a trial basis
- Dependent on the ability of the TPP to achieve these objectives, the project may consider contracting with alternative providers or providing services directly. This could result in significantly reduced activity for some providers

**Table 7.6** TPP priorities in influencing mental health care

| *Service area* | *No. of sites* | *Mechanism for change* | *No. of sites* |
|---|---|---|---|
| Creation of a local community mental health team | 21 | Employment of a wide range of personnel including CPNs, psychiatrists, counsellors, etc. | 12 |
| | | Employment of a CPN only | 9 |
| Improved service provision by providers | 12 | Improve quality of information on patients receiving mental health services | 4 |
| | | Develop specialised mental health unit within local community hospitals | 3 |
| | | Freedom to refer to chosen provider/consultant | 2 |
| | | Shift contract to alternative provider | 2 |
| | | Purchase consultant psychiatrist for local provider | 1 |
| Other priorities | 2 | Create a unified specification for mental health services for all the practices of the TPP; no mechanism | 1 each |

hospitals; two wanted to be able to gain a freedom of referral for their patients to the consultant of their choice; and two wanted to shift contracts to a different provider where care was considered to be more appropriate. In the last case, one site was intending to shift the contract to a private provider.

## Exhibit 7.4 **An example of purchasing intentions for maternity services**

It is hoped where possible to follow the recommendations of *Changing Childbirth* and extend choice to individual patients. To achieve this, the TPP intends to:

- extend and improve provision of community midwifery services, thereby reducing dependence on high-tech maternity units
- develop practice-based, comprehensive, antenatal and postnatal services, including ultrasound
- offer those patients requiring hospital-based services (in particular deliveries) the opportunity of visiting competing provider maternity units before choosing where to be delivered.

**Table 7.7** TPP priorities in influencing maternity care

| *Service area* | *No. of sites* | *Mechanism for change* | *No. of sites* |
|---|---|---|---|
| Implementing *Changing Childbirth* | 24 | Attached midwives and personal care to improve flexibility and continuity of care | 24 |
| Improved service provision by providers | 5 | Change contract currency with provider | 3 |
| | | Develop maternity unit at local hospital | 1 |
| | | Develop common protocols between main providers | 1 |
| Practice-based provision | 2 | Develop practice-based maternity services | 2 |

### Maternity care

Twenty-eight sites intended to influence maternity care. Four of these sites wanted to use more than one mechanism for doing so. In most cases, change in the provision of maternity services was to be brought about using the recommendations of the *Changing Childbirth* initiative (Expert Maternity Group, 1993). Thus, mechanisms for change included the development of attached midwives to practices, personal care rather than team care and the flexible use of community midwives to promote a better continuity of midwifery care for TPP patients. Other goals included changing the contract currency with the main provider to reduce overbilling and facilitate early discharge of patients. In two sites, for example, it was intended that the contract for maternity care be split into three stages – antenatal, delivery and postnatal, whilst in another case the plan was to change the contract currency from bed days to number of deliveries. In summary, the intended changes to maternity care by the TPPs aimed to improve continuity of care and reduce the cost of the service.

## *Other service priorities*

A number of other services were highlighted as priorities by the TPPs. These are listed in Table 7.8 overleaf.

### Elderly care

Fourteen sites specifically mentioned care of the elderly as a priority for their site. In classifying these priorities under 'care of the elderly' rather than 'community and/or continuing care' or 'emergency admissions', a judgement was made about the prime focus of the initiatives described. However, it is apparent that some of the priorities overlap with areas discussed above. Eight sites specifically wanted to create more beds for the rehabilitation of elderly patients and to help promote early discharge of elderly patients (rather than other types of patient) from hospital. This involved a number of mechanisms including the greater use of general practitioner beds; the creation of a cottage hospital for nursing/respite care of the elderly; and a specific discharge nurse for elderly patients.

**Table 7.8** TPP priorities in relation to other specific services

| *Service area* | *No. of sites* | *Mechanism for change* | *No. of sites* |
|---|---|---|---|
| Elderly care | 14 | Rehabilitation beds in the community | 8 |
| | | Day care services; practice-based elderly care services; care at home; better transport facilities; practice-based elderly physician; contract currency change | 1 each |
| Oncology | 5 | Change of protocol with main provider | 3 |
| | | Freedom of referral; practice-based support nurse | 1 each |
| Cardiology | 2 | One-stop clinic staffed by cardiologist | 1 |
| | | Freedom of referral to preferred consultant | 1 |
| Palliative care | 2 | Promotion of care at home | 1 |
| | | More general practitioner beds | 1 |
| Terminal care | 1 | Creation of a pain clinic | 1 |
| Diabetes | 1 | Common service specification by main providers | 1 |
| Leg ulcers | 1 | Creation of practice-based clinic | 1 |
| Ophthalmology | 1 | Better access to specialist care | 1 |
| Teenage pregnancy | 1 | Education service at local schools | 1 |
| Epilepsy | 1 | Specialist care ward at local hospital | 1 |
| Stroke | 1 | Specialist care ward at local hospital | 1 |
| Hip replacements | 1 | Vire money from TP funds to SFH to reduce waiting times | 1 |
| Cataracts | 1 | Vire money from TP funds to SFH to reduce waiting times | 1 |

Elderly care services were also a focus for change in six other sites. In these sites, the methods of influence were wide-ranging, including the provision of more day care services; more practice-based management of elderly patients; the creation of a local task force for better care of the elderly at home; improving access to surgery by better transport facilities for elderly patients; employing a practice-based consultant physician for elderly people; and changing the contract currency for elderly care from block to cost-and-volume.

## Palliative and terminal care

Two sites made palliative care a priority and one site highlighted terminal care. In the former category, the sites wanted to achieve more care at home and facilitate the better use of general practitioner beds. In the latter case, the site was going to employ its own specialist nurse for the care of terminally ill patients and create a pain clinic.

## Oncology

Five sites described oncology as a priority for change through becoming total purchasers. Of these, two specifically wanted to improve the provision of breast cancer services. The mechanisms to be used to influence oncology services included changing protocols with providers to improve access to, and quality of, care; gaining referral freedom to a preferred consultant; and employing a practice-based patient support nurse for cancer sufferers.

## Cardiology

Two sites wanted to influence cardiology services. One site wanted freedom of referral to a preferred consultant; the other wanted to establish a one-stop clinic to assess and manage cardiovascular disease. The latter was to be staffed by a consultant cardiologist on a sessional basis.

## *Non-service specific priorities*

A number of non-service-specific priorities were highlighted by the TPP sites for their first year of purchasing. In these cases, no specific service was mentioned and the priority tended to be a general objective of the site, often with a potential to influence a wide range of TPP services. As Table 7.3 shows, a general objective of some of the sites was a shift in services from the secondary to the primary care sector. This was seen as a priority in its own right without the sites necessarily outlining the mechanisms to bring it about or the services which would be affected. The sites most strongly interested in shifting resources and activity from secondary to primary care had an interest in eventually being able to break down the boundaries between currently separate NHS funding streams for General Medical Services (GMS) and HCHS. In some cases, the main priority was to provide more services within local practices (such as physiotherapy) along lines pursued previously by SFH practices and, in one case, there was a general aim that consultants should work in primary care settings rather than be based in hospitals.

Another important non-service-specific priority, highlighted by seven sites, was the protection or enhancement of the local hospital. This priority follows a trend in total purchasing towards enhancing the provision of services to the local community. In one case, the TPP intended to use its funds to help build a new local hospital.

In many cases, the sites wished to improve their level of knowledge of the services they could purchase before making any decisions on purchasing priorities for future years. Thus, sites wanted to gather information, monitor services and undertake needs assessment exercises as a general priority. In other cases, sites highlighted the general mechanisms that they had considered using to influence health care without specifying which services they actually wanted to influence.

## *Services excluded from total purchasing*

In most TPPs, certain services that could potentially be included in total purchasing have been wholly excluded. These generally include high-cost and/or low-volume services and regional specialties, examples of which are shown in Table 7.9. Such services carry potential problems and risks to TPPs since they are diverse and generally very costly.

**Table 7.9** A list of services typically excluded from total purchasing*

- Bone marrow and other major transplant surgery
- Services for amputees and prosthetic limbs
- Treatment of major burns
- Spinal injuries treatment
- Plastic surgery
- Infertility treatment
- High cost drug therapies
- Neuro-rehabilitation and paediatric neuro-disability services
- Haemoglobinopathy services
- Emergency and air ambulance services
- Treatment of eating and psychosexual disorders
- Renal services
- Other high cost ECRs

*In all sites, services for people with HIV/AIDS and genito-urinary medicine (GUM) services are automatically excluded since HIV/AIDS monies are earmarked exclusively for these areas and GUM services are provided confidentially so that individual general practitioners cannot be billed when their patients attend.

They present a high risk to the budget of TPPs and the overall viability of the projects. Moreover, many TPPs have highlighted the lack of sufficient expertise in general practice for understanding such conditions, thus making effective purchasing impossible. Consequently, budgets generally exclude allocations to buy such services, or there is a mechanism by which the funding allocated for such services is automatically returned to the authority.

# 8. Participants' views of total purchasing

The views of the key participants in the development of total purchasing are important, since these are the views of those at the forefront of this new development in primary care-led purchasing. This part of the report examines the pros and cons of total purchasing as expressed by the 'lead' general practitioners in the projects, the representatives of the main providers which are likely to be affected by the TPPs and the staff of the local health authority most involved in the TPPs. The views expressed in these sections were derived from face-to-face interviews undertaken between October 1995 and January 1996. The section ends by examining how the general perceptions of the balance of costs and benefits of total purchasing of all the key participants have changed since then.

## *'Lead' general practitioners' perceptions of the pros and cons of total purchasing*

The 'lead' general practitioners in each of the TPPs were asked to comment, without being prompted, about the main pros and cons of total purchasing. Table 8.1 presents a frequency count of the number of times a specific pro or con was mentioned in the interview summaries prepared by the interviewers. General practitioners' perceptions of total purchasing appear to fall into two categories. First, expectations of what total purchasing will be able to achieve and, second, the general practitioners' actual experiences of setting up total purchasing in the preparatory year.

On the positive side, the emphasis was on the potential advantages of total purchasing expressed in broad terms. Thus, general practitioners highlighted the perception that total purchasing would be a further way of influencing service provision, increasing self-determination and improving and extending services in primary care. Since purchasing decisions were patient-focused, it was also felt that total purchasing would be likely to improve the appropriateness and quality of patient care. Other important pros included a recognition that total purchasing was innovative and, therefore, a new challenge. In addition, nine general practitioners felt that total purchasing was fairer and a more realistic test of general practitioner purchasing than SFH, by which they generally meant that it was fairer to non-TPP practices, since the TPP had to purchase more difficult, unpredictable services such as emergency medical admissions, whereas SFH concentrated on easier elective services.

The pros expressed by general practitioners which related directly to their actual experience of TP issues in the set-up phase (1995–96) were focused on the new links being forged with both providers and health authorities. Eight respondents, for example, felt that a constructive dialogue had developed between the TPP and the main provider in a way that had not happened through fundholding. Moreover, seven of the general practitioners interviewed observed that they had learnt much more about how both the health authority and the providers operated. This greater understanding proved to be an important pro in the set-up stage.

The major negative feature of total purchasing in the preparatory period, as perceived by 44 of the general practitioners interviewed, was the additional workload. This was manifest in the time taken over administrative issues which had an impact both in terms of time away from the surgery and longer working hours. Workload was the major factor affecting the general practitioners' overall enthusiasm for the goals of TP. Indeed, ten general practitioners interviewed said that relations between themselves and other partners in the practice had worsened because of the additional workloads imposed by total purchasing. This perception is not surprising given that the general practitioners were being interviewed in the middle of their preparations for 'going live' in April 1996. It may well be the case that the work required of the leading general practitioners reduces with time as projects consolidate themselves. The other important con to highlight, mentioned by six general practitioners, was the feeling of a lack of progress which has often been blamed, rightly or wrongly, on inertia on the part of the parent health authorities.

The general practitioners' perceptions of the advantages of total purchasing and their enthusiasm in developing it were clearly in conflict with the

**Table 8.1** 'Lead' general practitioners' perceptions of the pros and cons of total purchasing (n = 72)*

| *PROS* | *No.* | *CONS* | *No.* |
|---|---|---|---|
| Influence on service provision | 17 | Time constraints and general practitioner workload | 44 |
| Shift from secondary to primary care | 11 | Worse relations with general practitioner partners | 10 |
| Being at the forefront of innovation | 11 | Lack of progress (HA inertia) | 6 |
| Better/fairer than fundholding | 9 | TP too ambitious for general practitioners – lack of skills | 6 |
| Better quality of care | 8 | Not value-for-money | 4 |
| Better contact with providers/clinicians | 8 | High risk strategy | 4 |
| Better relations with health authority | 7 | Responsibility for rationing | 3 |
| More power – greater self-determination | 7 | Lack of data and information | 3 |
| Flexible use of resources (virement of funds) | 6 | Destabilisation of providers | 2 |
| Better relations with general practitioner partners | 6 | Worse TPP-provider relations | 2 |
| Enjoyable | 5 | More responsibility (not just rationing) | 2 |
| Learning new skills | 3 | TP is a politically motivated scheme | 2 |
| Better understanding of purchasing | 3 | Not fully locality-based | 1 |
| Greater patient involvement | 3 | Lack of freedom from health authority | 1 |
| TPP multi-practice is more cost-effective than single practice SFH | 2 | Conflicting role as provider and purchaser | 1 |
| | | Inability to vire budgets between SFH and TP | 1 |
| Generates better information | 2 | Loss of patient contact because of management role | 1 |
| Ability to share risk through multi-practice TPP | 2 | | |
| Needs-based purchasing | 2 | | |
| Existence of TPP evaluation | 1 | | |
| Ability to control referrals through protocols | 1 | | |

3 general practitioners reported that TP had no cons and 2 general practitioners reported that there were no pros

*The number of respondents refers to the number interviewed who gave an answer to this question. Each respondent could give any number of pros and cons, hence number of pros and cons is greater than the number of respondents

high workload involved and the lack of rapid, early progress experienced in getting pilots under way. One of the contributing factors to the withdrawal from the pilot scheme by some practices and sites has undoubtedly been the high workload involved and the fact that this was not always perceived to be justified by the progress made. Despite such problems, the majority of lead general practitioners remained committed and enthusiastic to total purchasing at the time of interview.

## *Providers' perceptions of the pros and cons of total purchasing*

Representatives from main local providers who would be dealing with the TPPs (mainly business and contracts managers) were also asked to comment, unprompted, on the main pros and cons of total purchasing at the time of the interviews (October 1995 to January 1996). Table 8.2 presents the count of the number of times a specific pro or con was mentioned by the provider representatives. In this analysis, the views of the different types of provider (acute, community and mental health) have been combined to provide an overall picture of the pros and cons of total purchasing.

The providers identified three major pros of total purchasing: that general practitioner-led purchasing would be patient-focused and therefore more appropriate; that the greater purchasing power of TPPs would force the trust to reconsider its future plans for the better; and that total purchasing would open a dialogue with general practitioners that had not existed before.

The major con, identified by 34 respondents, was the high transaction costs associated with dealing with total purchasers in the set-up year. At the time, this greater workload was manifest in dealing with requests for activity and cost information on TP patients who had used trust services. In many cases, the providers have subsequently had to implement new systems to collect this information, at significant cost. Eight respondents felt that it was

**Table 8.2** Providers' perceptions of the pros and cons of total purchasing (n = 81)*

| *PROS* | *No.* | *CONS* | *No.* |
|---|---|---|---|
| Patient-focused/general practitioner-led purchasing | 26 | Transaction costs | 34 |
| Catalyst for change in trusts | 25 | Inequity – better services for TPP practices | 11 |
| Dialogue with general practitioners | 15 | Destabilisation of local services | 11 |
| Emphasis on primary care | 5 | Potential loss of business | 10 |
| Potential gain in business | 3 | Plurality/complexity of purchasers | 10 |
| General practitioners made more accountable | 3 | Lack of strategic focus | 9 |
| Improved generation of data | 2 | No resources given to trust to deal with TPPs | 8 |
| Pilot project – ability to test innovation | 2 | Lack of TPP-provider collaboration | 6 |
| Link with social services | 2 | Another upheaval to NHS | 4 |
| Combination of local change and strategic focus | 2 | General practitioners are poor managers/contractors | 4 |
| Better than fundholding | 2 | 'Cherry picking' (purchasing easiest services) | 2 |
| Better than health authority purchasing | 2 | Concern about lack of clinical knowledge of general practitioners | 2 |
| Flexibility of resource use (vire purchasing between TP and FH budgets) | 2 | Financial risk for practices involved | 1 |
| Ability to target need | 1 | Internal cohesion between general practitioners in TPPs | 1 |
| Better relations between trust and health authority | 1 | Worse TPP-health authority relationship | 1 |
| Equity – TP may avert 'two-tierism' | 1 | Lack of TPP accountability | 1 |
| | | Lack of patient choice | 1 |
| | | Worse TPP-trust relationship | 1 |
| | | Friction between general practitioners and consultants | 1 |
| | | Not locality-based | 1 |

One respondent identified no pros and one no cons to TP

*The number of respondents refers to the number interviewed who gave an answer to this question. Each respondent could give any number of pros and cons, hence number of pros and cons is greater than the number of respondents

unfair that their trusts did not receive any resources to fund TP-associated set-up costs. Many respondents also felt that future costs would be high since total purchasing would increase the number of purchasers that the provider had to negotiate contracts with. One community trust, for example, expected the number of contracts it negotiated with purchasers to increase four-fold by the time the local TPPs 'went live' and that this would have a significant impact on the level of transaction costs.

Equity concerns were raised by eleven respondents. They feared that their trust would, under total purchasing, have no option but to work to contract which might mean that the patients of total purchasers would receive a priority service that was not based on clinical need, but on the TPPs' control over resources. A further eleven respondents feared that total purchasing had the power to destabilise them if the TPP switched contracts. Ten feared loss of business because of TP. Nine respondents felt that total purchasers would lack a strategic focus to their purchasing decisions which could compound these fears.

Overall, providers dealing with total purchasers appeared to take them very seriously since they perceived that the TPPs had far more purchasing power than standard fundholders. Thus, providers highlighted better communication with general practitioners as a pro. Whilst providers appeared to accept the argument that total purchasing would, on the whole, be a good thing since it would take purchasing decisions closer to patients, there appeared to be an underlying uneasiness about the possible consequences of destabilisation, loss of business and greater transaction costs.

**Table 8.3** Health authority staff perceptions of the pros and cons of total purchasing (n=45)*

| *PROS* | *No.* | *CONS* | *No.* |
|---|---|---|---|
| Patient focused/GP-led purchasing | 21 | Workload for health authority | 14 |
| Cultural change – better GP-health authority relations | 11 | Financial costs to health authority/ management costs of TPP | 10 |
| Ability to make changes quickly | 8 | Cultural change problematic | 7 |
| More responsibility for general practitioners | 6 | Lack of GP expertise to run TP | 7 |
| Improved generation of data | 3 | TPP a threat to health authority | 7 |
| Part of the health authority's strategy | 3 | Destabilisation and upheaval of services | 4 |
| A learning-stage for the future | 3 | Inequity/'two-tierism' | 3 |
| Health authority forced to consider purchasing in more detail | 3 | Challenge to health authority supremacy in purchasing | 3 |
| Ability to influence changes in line with national policy | 2 | Workload for providers | 3 |
| Better links with social services | 1 | Workload for GPs | 3 |
| Better links with providers | 1 | Lack of strategic focus | 3 |
| A challenge | 1 | TPP model unsuited to other practices in NHS | 2 |
| Greater involvement of patients | 1 | Selective purchasing | 1 |
| Greater general practitioner role in disease management | 1 | Lack of national objectives for TPP | 1 |
| | | Weak viability of single-practice TPPs | 1 |
| | | Disagreement on use of savings | 1 |

*The number of respondents refers to the number interviewed who gave an answer to this question. Each respondent could give any number of pros and cons, hence number of pros and cons is greater than the number of respondents

## *Health authority staff perceptions of the pros and cons of total purchasing*

Table 8.3 provides an indication of the views of health authority 'leads' who were actively involved with the TPPs. Since these views were collected in the preparatory year, many of the pros and cons are related to expectations of what TPPs might be able to achieve rather than observation of actual changes.

The major pro, identified by 21 health authority leads, was the shift in purchasing to primary care where it was believed it would become patient-focused and, therefore, more appropriate. In addition, eight respondents believed from what they had already seen that TPPs would be able to make practical changes to service provision, whilst a further six felt that TP would make general practitioners far more responsible in their use of resources and in their purchasing decision-making. Conversely, seven respondents felt that general practitioners did not have the skills or expertise to run total purchasing effectively whilst several others feared that the further upheaval to the NHS caused by total purchasing would lead to destabilisation of provision and a lack of strategic purchasing. Despite these contradictions in the responses of health authority leads, the general shift in emphasis towards primary care-led purchasing appears to have been welcomed as a guiding principle for the development of purchasing in the future.

Whilst eleven respondents felt that the cultural differences between general practitioners and the health authority had changed for the better following the creation of the TPPs, seven respondents also felt that such cultural change has been problematic and difficult to achieve. This was related to the problem that another seven health authority respondents raised: namely, that their organisations had felt threatened by the emergence of TPPs as alternative purchasing organisations. This suggests that the trust and partnership between the TPPs and the health authority is rather better developed in some areas than others. The extent to which the cultural differences are resolved and partnerships strengthened may be an important factor in the development and success of the projects in the future.

The major cons identified continue the theme identified from local providers that total purchasing had been both very time-consuming and costly. Fourteen respondents pointed to the extra workload implications of total purchasing, whilst a further ten felt that TPP had imposed significant financial costs, particularly in support of project management, in the first year. Some health authority respondents also

recognised the additional workloads imposed on general practitioners and on providers.

The views of 'lead' general practitioners, their local providers and health authority managers were obviously influenced by the timing of the interview. Many of the pros and cons expressed were personal predictions of what might happen rather than actual experience of total purchasing at the time. As these interviews were undertaken in the set-up phase of total purchasing, it is not surprising that workload and transaction costs issues were raised as major disadvantages to the scheme. The next section examines the perception of a wider range of participants in total purchasing subsequently and assesses the extent to which the perceived balance between costs and benefits has changed over time.

## *Principal participants' general perceptions of the costs and benefits of total purchasing*

Postcards which asked respondents to rate the perceived benefits and costs of TP for one week in each month are sent to seven different people within each project each month, as follows: the lead general practitioner, health authority lead manager, site manager, main acute provider, main community provider, or main combined acute/community provider, social services contact, and a 'non-lead' general practitioner. Respondents rate their perceptions of the overall costs and benefits of TP on two separate ten-point visual analogue scales. With the exception of the 'non-lead' general practitioner, the respondents are those who were interviewed at the TPP site visits, October 1995 – January 1996. The first set of postcards were sent to TPPs in February 1996, and each month since then. Follow-up of non-response has been made by telephone contacts with both site managers and individual non-responders. Non-responses were partly due to personnel changes. Results are presented which summarise responses to the diary cards between February and July 1996, which includes the beginning of 'live' purchasing by the 'first wave' TPPs in April 1996.

Response rates varied between respondents, being highest for TPP managers (62%) and lowest for health authority respondents (43%). TPP managers consistently rated the benefits of TP more highly than other respondents, whilst providers and 'non-lead' general practitioners tended to rate the benefits lower than others. However, TPP managers, health authority, and 'lead' general practitioners also consistently rated the costs of TP highly, presumably reflecting their level of commitment to the project.

Figure 8.1 shows the differences between perceptions of costs and benefits for each type of respondent. It shows that TPP managers consistently rated the benefits of TP higher than the costs (i.e. the mean difference in their cost and benefit ratings was consistently *above* the zero point on the y-axis), whilst providers tended to rate the costs higher than the benefits. 'Lead' general practitioners and health authority lead managers tended to rate the costs and benefits roughly equally.

It would be premature to over-interpret a short run of data from these simple diary cards, especially when the response rates were modest. However, it is worthy of note that the TPP managers who are most directly involved in the projects appeared to be most enthusiastic about the positive balance of benefits over costs. Of course, their future employment depends on TP being a success and they spend all their time actively promoting TP, so one might expect a positive outlook on the benefits it brings.

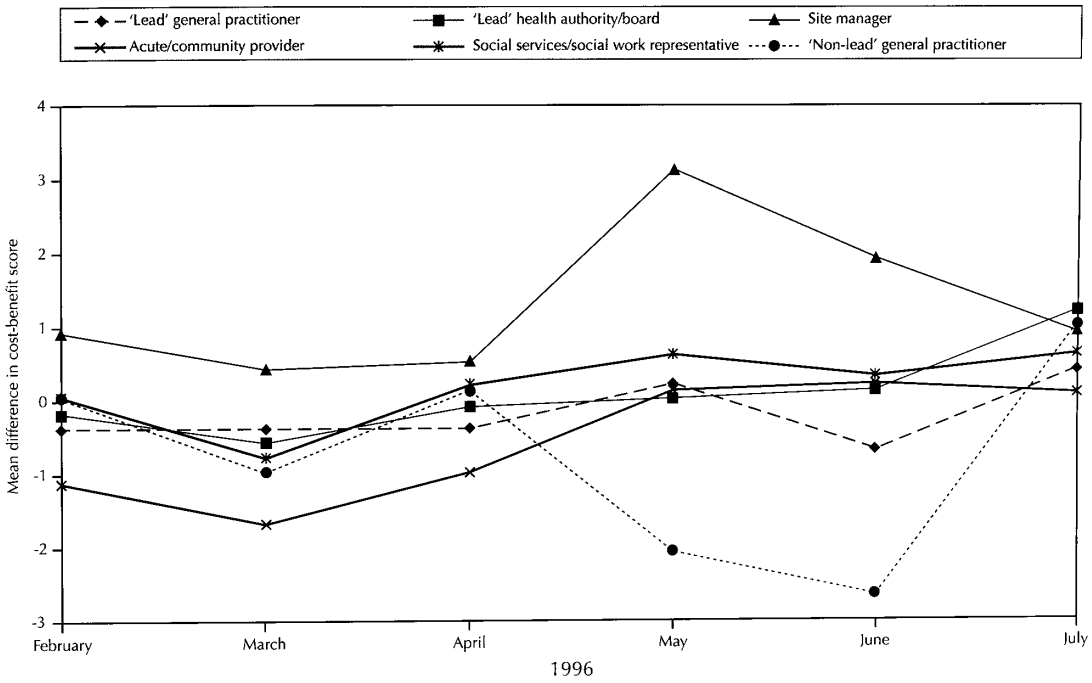


**Figure 8.1** Difference between key participants' perceptions of costs and benefits of total purchasing

# 9. Conclusions – a preliminary assessment of total purchasing in the national pilot projects

The aim of this report has been to describe the national TPPs using data mainly collected in their preparatory year (1995/96), as a precursor to their subsequent evaluation. It is too soon to say how effective the 'first wave' national TPPs will be as purchasers of health care and this report has attempted to avoid reaching premature judgements on the projects. It could be argued that a fair assessment of their contribution to better purchasing can only be made when they have had the opportunity to undertake at least two years of active purchasing. This will not be until April 1998. Clearly, the 'first wave' pilot projects must be allowed to complete at least a full year of purchasing (1996/97) before any consequences can be reported. In addition, the stand-alone evaluations of the first four 'pioneer' TPPs have yet to report, so there is little or no information available on the costs and benefits of TP. It must also be borne in mind that the 'first wave' TPPs are selected volunteer projects. Their experience will, inevitably, be only partially generalisable to the wider general practice population. However, this does not mean that nothing of use has been learned so far. It is now possible to characterise more clearly what TP means in practice and to identify some of the policy and operational issues thrown up by the pilot projects in their early stages, which may also be helpful to the development of the 'second wave' of TPPs.

## *What is 'total purchasing'?*

The extension of SFH, entitled by the NHSE as 'total purchasing', was introduced on a pilot basis without primary legislation. As a result, the budgets of the TPPs have remained legally the responsibility of the local health authority, distinguishing them thereby from SFH budgets. Thus TP has emerged as a hybrid of health authority purchasing (with its leverage over providers based in the size and purchasing power generated by a large population) and of SFH purchasing (with its power based on a view that general practitioners are close to patients' needs and have greater manoeuvrability) (Shapiro, 1994). Figure 9.1 attempts to locate TP within the spectrum of local purchasing which has developed in the NHS since 1991. This report has shown that TP is currently neither 'total' nor exclusively based on 'purchasing' as a means of bringing about improvements in services. There are elements of 'commissioning' in the ways in which TPPs procure some of their services (e.g. co-purchasing with the health authority) and their purchasing is selective.

Since TP has been developed without any national template at local level through negotiation between interested practices and their local health authorities, it is not surprising that the TPPs vary widely in their basic characteristics (e.g. size of population, number of practices involved, organisation, objectives and funding methods). Apart from the fact that the vast majority of 'first wave' TPPs are outside the main conurbations and all were specially selected for TP, most generalisations about the TPPs are fallible and the TPPs themselves are continuously changing. The history of some TPPs, for example, is suggestive of a strong movement into TP on the part of the practices themselves. In other places, the TPPs appear to have been carefully orchestrated by the health authority, which identified suitable practices and encouraged general practitioners to take an interest in purchasing beyond SFH. Finding a typical project is fraught with difficulties. Some projects are implementing the concept of TP in the spirit of the previous SFH initiative, while others are taking the opportunity of TP to develop a model of collective purchasing between practices. The latter is highly reminiscent of the general practitioner commissioning or 'non-fundholding' approaches to general practitioner involvement in health authority purchasing (Black, Burchall and Trimble, 1994).

Thus, within a seemingly single scheme, local experiments are taking place. Some of these experiments are informed by economic models of incentives and behavioural change which stress the importance of budgetary control, the ability to make 'savings' and general practitioner autonomy from the health authority. Others are rooted in models which stress trust and collaboration between

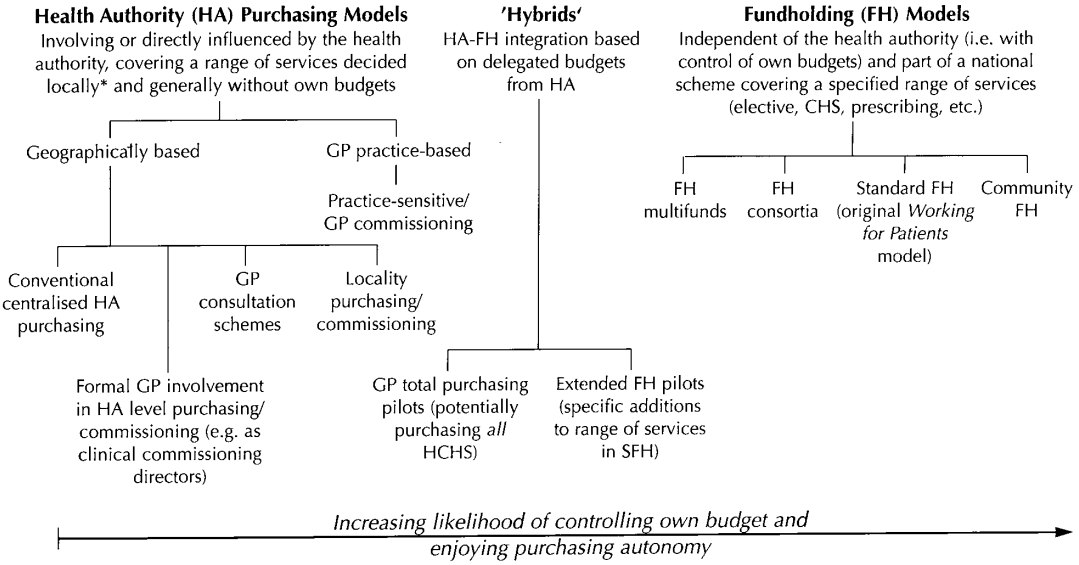


**Figure 9.1** A typology of current purchasing organisations in the NHS

different organisations. For example, it may be that one of the most significant achievements of TP will relate to the opportunity it represents for mutual learning between health authority staff and primary care professionals which may alter the local NHS culture. It will be fascinating to see whether a fundholding or a commissioning approach is the more successful in bringing about beneficial changes in local services and in which sets of circumstances. The only study to have attempted to compare SFH with other ways in which general practitioners have become involved in purchasing or commissioning services for their patients, has concluded that GP commissioning and related approaches tend to serve different purposes from fundholding, but that SFH appears to have the greater impact in achieving micro-efficiency improvements from providers (Glennerster, Cohen and Bovell, 1996). The authors note, however, that, by and large, fundholders have been better supported administratively than non-fundholding schemes. This suggests that, in the case of TP, the relations between the practices and the health authority in the pilot projects will prove highly influential. The results of the current study should, therefore, have major implications for deciding how to build on the current diversity of purchaser organisations at local level in the NHS (Mays and Dixon, 1996).

To add to an already complex scene, the scheme as currently unfolding could more aptly be called 'selective purchasing', at least in the first year of purchasing through TPPs. The participating practices appear to have complete discretion as to which services to purchase actively, which ones to 'co-purchase' with their health authority, which ones to 'block-back' to the health authority and which ones to exclude entirely from any budgetary or purchasing consideration. This allows the TPPs to set purchasing intentions which vary widely in their scope and level of ambition, although the vast majority of the TPPs aim in various ways to shift resources and services from secondary to primary and community settings. In this, they are drawing on the general climate of opinion in the NHS in favour of primary and community-based services and the greater use of a range of intermediate care.

Another area in which the TPPs have displayed their diversity is in their management arrangements and management costs. In general, the more complex TPPs (which are not always the larger ones) tend to have invested more resources in management, particularly in information systems and the people to run them. Again, without a national template for TP, individual projects and health authorities have had to decide locally how much it is appropriate to

invest in bespoke data collection and analysis systems to support TP functions. It remains to be seen whether those TPPs which have adopted a rational approach to purchasing, based on acquiring the necessary data on needs, activity and costs, are enabled to make more effective use of their TP budgets as purchasers than the projects which have improvised with whatever data the health authority and local providers have been able to make available on a disaggregated basis.

## *Issues arising from the early experience of implementing total purchasing*

Although findings are not yet available on whether the TPPs have been able successfully to implement their purchasing priorities, and at what cost, it is possible to identify a number of important issues arising from the early stages of implementing TP:

- Accountability – the TPPs represent new forms of organisation in the NHS, linking general practices with one another and with health authorities in highly variable ways. These new organisations are officially part of the health authority purchasing structure and the resources which they are deploying are the responsibility of the health authority. Yet general practitioners have traditionally operated as independent contractors to the NHS. The means by which they are held to account for their purchasing decisions, either to the health authority or to their patients, will need to be developed. The larger TPPs influence very substantial amounts of funding, but in some TPPs formal accountability to the health authority, where the data in this report were collected, operated through a single director who sat on the Project Board. Accountability arrangements were not a major preoccupation during the preparatory year of TP (1995/96). It remains a matter of opinion as to whether the early arrangements will prove adequate in the future.
- Sustainability – TPPs appeared to be heavily dependent on the creativity and energy of a relatively small number of people during the preparatory period before April 1996, especially the 'lead' general practitioner(s) and to an increasing extent, the project manager(s). The pivotal role of the general practitioners, particularly in setting the purchasing goals of the TPP, raises questions about their ability to cope with work pressures when combined with their clinical roles. The 'lead' general practitioners were consistently concerned about the additional workload of TP. This in turn raises questions about the sustainability of the TPPs and how the general practitioners can be supported to manage these new organisations.
- By October 1996, two out of the original 53 TPPs in place in April 1996 had decided not to go ahead with purchasing in 1996/97. In the same period, 17 practices involved in projects had withdrawn and one new practice had joined the TP scheme. The main reasons seem to have been the high level of work faced by the lead general practitioners combined with a feeling that progress was being made too slowly. A number of interviewees commented that the gains of TP would take longer to achieve than those of SFH. Other reasons for a perceived lack of progress include insufficient information on which to base purchasing decisions, conflicts with the local health authority, absence of health authority support and failure to establish inter-practice working and decision-making arrangements. Attention will need to be given in future to address the mutual expectations of participants in the TPPs of one another and to define what would constitute a reasonable rate of progress.
- Management and transaction costs – there is a general concern that TP may generate a large amount of managerial work for general practitioners and TPP managers. However, local providers reported even greater concern about the additional transaction costs generated by having to deal with another set of purchasing organisations. Unlike TPP practices, which can negotiate arrangements with their local health authority to meet additional management and general practitioner locum costs, providers are not compensated in any way for any additional costs generated by TP.
- Budget setting – most of the TPPs reported major difficulties and a large amount of time spent in trying to agree a budget setting method for their TPP and in negotiating the eventual amount of the TPP budget. This, in turn, inhibited some TPPs from developing their

contracts with providers until well into the first purchasing cycle. This may well lead to a situation in which the first year of TPP purchasing achieves far less than it would otherwise have done.

## *The future of total purchasing*

Despite the fact that the 'first wave' of TPPs have yet to complete their first year of purchasing, it seems likely that TP, like most health policy innovations, will evolve continuously during the period of the current evaluation. There are a number of other tendencies discernible in policy discussions and official statements which may lead to changes in the TPP approach described in this report:

- the current model of TPP, in which TP budgets remain the legal responsibility of the health authority, may change to include an option in which TPPs are entitled to control their own budgets directly as in SFH;
- there appears to be stronger interest in forms of devolved purchasing at local level which involve collaboration between general practices than in single practice models of general practitioner purchasing such as SFH. Fundholders appear to be grouping together increasingly. For example, the discussion document *Primary Care:The future* (NHSE, 1996) suggested that new organisations such as fundholding multi-funds and TPPs offered a possible way to improve standards of care, improve the management of primary care, reduce general practitioners' isolation and increase the level of collaboration between practices. This would thereby enable them to share equipment and specialised staff, widen the range of services in primary care and offer the opportunity for a degree of general practitioner specialisation, all while maintaining the individual link between patient and general practitioner (para 43, p29). These observations appear to reflect the activities of the TPPs;
- there appears to be increasing interest, both at national level and expressed by general practitioners themselves, for integrated budgets. This which would bring together hitherto separate GMS, TP and SFH budgets, thereby allowing the TPPs to use all their resources in a more flexible way. For example, some TPPs wish to extend the range of services which general practitioners themselves and their employed staff can provide to their enrolled patients using HCHS resources from the health authority.

The primary care White Paper of October 1996 is intended to lead to legislation which, among many other things, is likely to permit volunteer TPPs in the future to take responsibility, on contract to the local health authority, for a single, integrated budget which could cover GMS and the whole of HCHS, including the elective care and prescribing currently included in fundholding (Secretaries of State, 1996). The TPPs would be required to ensure that comprehensive health care was available to their enrolled populations and would be able to choose how much of this care to provide with their own staff in their constituent practices and how much to buy in from other providers (e.g. community and acute trusts and the private and voluntary sectors). It is possible, therefore, that a proportion of the current TPPs will opt to take a fully comprehensive budget for which they are legally responsible, independently of the health authority, while other TPPs will stay with the more hybrid model described in this report (see Figure 9.1). This would add a further level of diversity to the already heterogeneous family of TPPs, and poses a further challenge to an already complex evaluation.

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# Appendix 1

## *'First wave' total purchasing pilot projects: the basic facts, April 1996*

| Region | Host health authority | Total purchasing project | Patient pop | % health authority pop | Number of general practitioners |
|---|---|---|---|---|---|
| SOUTH AND WEST | Cornwall | SALTASH* | 11,438 | 2.3 | 6 |
| | South & West Devon | SOUTH & WEST DEVON** | 46,113 | 8.2 | 26 |
| | Southampton & S.W. Hampshire | ROMSEY | 29,000 | 6.3 | 18 |
| | Wiltshire & Bath | TROWBRIDGE, BATH & FROME** | 59,300 | 7.7 | 32 |
| | North & Mid Hampshire | WINCHESTER | 20,000 | 3.3 | 11 |
| | Dorset | DORSET | 17,100 | 2.6 | 11 |
| SOUTH THAMES | East Sussex | BEXHILL | 43,000 | 6.0 | 24 |
| | West Surrey | WEST BYFLEET | 27,949 | 4.4 | 15 |
| | West Sussex | EAST GRINSTEAD | 32,746 | 4.5 | 16 |
| | Merton, Sutton & Wandsworth | SOUTH WEST LONDON | 79,300 | 13.0 | 42 |
| | East Surrey | EASTERN SURREY | 23,007 | 12.1 | 11 |
| | Kingston & Richmond | KINGSTON & RICHMOND | 38,632 | 12.0 | 24 |
| NORTH THAMES | Hertfordshire | HEMEL HEMPSTEAD* | 84,700 | 8.5 | 44 |
| | Hertfordshire | HERTFORD | 35,781 | 3.6 | 22 |
| | Hillingdon | HILLINGDON | 24,710 | 9.8 | 13 |
| | New River | NEW RIVER | 58,000 | 11.0 | 26 |
| | Hertfordshire | ST ALBANS | 70,000 | 7.0 | 35 |
| | Hertfordshire | STEVENAGE | 12,310 | 1.2 | 6 |
| ANGLIA & OXFORD | East Norfolk | ATTLEBOROUGH | 14,400 | 2.2 | 6 |
| | Buckinghamshire | SOUTH BUCKS CONSORTIUM** | 55,000 | 8.6 | 24 |
| | Berkshire | THATCHAM | 25,000 | 3.3 | 12 |
| WEST MIDLANDS | Hereford & Worcester | BEWDLEY | 12,943 | 4.6 | 7 |
| | South Birmingham | BIRMINGHAM | 46,471 | 4.3 | 24 |
| | Shropshire | BRIDGNORTH | 15,024 | 3.6 | 8 |
| | Coventry | COVENTRY | 20,121 | 6.3 | 10 |
| | Solihull | SOLIHULL | 18,944 | 10.0 | 9 |
| | Hereford & Worcester | WORCESTER | 15,024 | 5.1 | 6 |

* Projects which have subsequently withdrawn from total purchasing

** Projects which consist of a number of autonomous sites

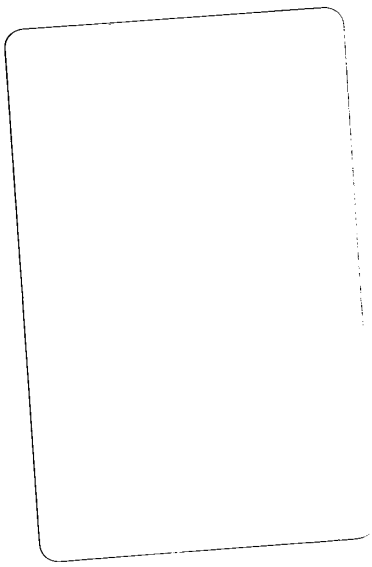
| Region | Host health authority | Total purchasing project | Patient pop | % health authority pop | Number of general practitioners |
|---|---|---|---|---|---|
| TRENT | South Derbyshire | BELPER | 23,000 | 6.9 | 12 |
| | Nottingham | KEYWORTH | 12,000 | 1.9 | 4 |
| | South Derbyshire | LONG EATON | 33,000 | 10.0 | 17 |
| | Leicestershire | MELTON MOWBRAY | 33,000 | 3.5 | 17 |
| | North Derbyshire | HIGH PEAK | 39,113 | 10.5 | 23 |
| | Lincolnshire | NORTH LINCOLNSHIRE | 28,500 | 4.8 | 15 |
| | Rotherham | ROTHERHAM | 14,668 | 5.6 | 7 |
| | Sheffield | SHEFFIELD SOUTH | 30,718 | 5.8 | 21 |
| NORTH WEST | Liverpool | LIVERPOOL | 45,000 | 10.0 | 24 |
| | St Helens and Knowsley | NEWTON & HADDOCK | 45,359 | 10.7 | 21 |
| | East Lancashire | RIBBLESDALE | 30,400 | 6.2 | 18 |
| | South Lancashire (& N. Lancashire) | SOUTH BANK | 19,137 | 5.9 | 9 |
| | South Cheshire | KNUTSFORD | 20,018 | 3.0 | 13 |
| | South Cheshire | WILMSLOW | 35,019 | 5.3 | 19 |
| | South Cheshire | ELLESMERE PORT | 66,643 | 10.0 | 35 |
| NORTHERN & YORKSHIRE | Bradford | BRADFORD | 30,000 | 6.3 | 17 |
| | Wakefield | WAKEFIELD | 51,698 | 16.0 | 32 |
| | North Yorkshire | YORK | 21,250 | 2.9 | 12 |
| | Northumberland | TYNEDALE | 45,000 | 14.5 | 30 |
| | Newcastle & North Tyneside | NEWCASTLE | 16,000 | 3.4 | 7 |
| SCOTLAND | HOST HEALTH BOARD | | | | |
| | Grampian | GRAMPIAN COUNTY PRACTICES | 43,403 | 8.3 | 25 |
| | Grampian | ABERDEEN WEST | 36,590 | 6.8 | 23 |
| | Lanarkshire | LANARKSHIRE | 15,300 | 2.7 | 8 |
| | Highland | HIGHLAND | 13,818 | 6.7 | 10 |
| | Greater Glasgow | GREATER GLASGOW | 26,500 | 3.0 | 19 |
| | Lothian | LOTHIAN | 49,638 | 6.7 | 34 |

# Appendix 2

## *'Pioneer' total purchasing pilot projects: the basic facts, April 1996*

| *Region* | *Host health authority* | *Total purchasing project* | *Patient pop* | *% HA pop* | *Number of GPs* |
|---|---|---|---|---|---|
| Oxford & Anglia | Berkshire | Berkshire Integrated Purchasing Project | 87,000 | 9.6 | 44 |
| West Midlands | North Worcs. | Bromsgrove | 40,000 | 14.5 | 18 |
| North West | North Cheshire | Castlefields (Runcorn) | 12,000 | 3.4 | 7 |
| Northern & Yorkshire | Bradford | Worth Valley | 62,800 | 12.5 | 36 |

# Appendix 2



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ISBN 1-85717-138-1