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Practice-led Commissioning:

Harnessing the power of the primary care frontline

Richard Lewis

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This paper aims to shape discussion about practice-led commissioning. It asks what this kind of commissioning is intended to achieve and what it really means in the new health care context. It explores the lessons of GP fundholding, total purchasing, and locality/GP commissioning pilots, and suggests some constraints and risks which might occur as implementation of the new policy progresses.

About the author

Richard Lewis is Visiting Fellow in Health Policy at the King's Fund. He carries out policy analysis and research, with a special interest in decentralisation in health care, managed care in the United States, and primary care. He is also an independent health care consultant and special adviser to the National Patient Safety Agency. He has a background in health service management and spent several years as executive director of a large health authority in South West London.

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Foreword

The NHS, like other health systems internationally, has explored the potential for involving primary care in the commissioning of care. The engagement of primary care clinicians has rightly been seen as a crucial component in the delivery of services that are both responsive to patients' individual needs and affordable.

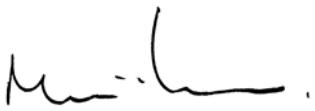
In 1997, the introduction of primary care groups – and later primary care trusts (PCTs) – with primary care clinicians in the driving seat, was seen as perhaps the final stage of a protracted evolution. Primary care groups and trusts were designed to combine the vitality of primary care-led commissioning with the strategic planning of the health authorities that they replaced.

Yet the history of the last seven years suggests that the inclusion of a relatively small number of primary care clinicians within the governing structures of PCTs may not, in itself, always be enough to bring about the change in behaviour that was desired. It is in the commissioning function above all that some PCTs have appeared to struggle, and early enthusiasm for collaboration, among GPs in particular, has appeared to founder. A new approach and impetus is needed to harness the power of primary care in the design and commissioning of services.

This paper by the King's Fund examines the new interest in practice-led commissioning – exploring exactly what it means and how it might be implemented. Richard Lewis, the author, concludes that practice-led commissioning may be well-placed to deliver at least some of the benefits that have been hoped for.

Yet, as the paper makes clear, practice-led commissioning can, and most likely will, mean different things in practice. Primary care teams and PCTs now need to negotiate an approach that is right for them.

It may be tempting to see practice-led commissioning as being in competition with PCT-led commissioning. This paper makes clear that this need not be the case. Indeed, the real engagement of primary care in the commissioning agenda can only serve to strengthen the hand of PCTs. As the providers of care in the future, whether foundation trusts or the private sector, become ever more independent, a powerful commissioning force on behalf of patients and the wider community must surely be welcomed.



Michael Dixon
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Preface

Today's health service faces two great challenges. First how to boost the strength of commissioning, a weakness from the first days of the original internal market, and second how to harness the talents of clinicians in managing and planning health services.

These challenges have never been more compelling. We will soon see a transformation with a revolution that will sweep the health service with patient choice. Hospitals will be paid by results. There will be new emphasis on effective management of chronic disease.

Each one of these initiatives will demand more imagination, greater flair in the management of demand and greater financial risk. It will require new ways of working, which will reduce avoidable admissions and entail much closer work between hospital and community services. We need to develop clear pathways of care, and doctors and nurses need to have greater confidence in the contracts that achieve those ends.

Yet the degree of involvement of clinical staff in the workings of primary care trusts (PCTs) has been disappointing: the expectation that they would be in the driving seat has not been realised. It is therefore not surprising that the idea of giving general practitioners a budget with which to commission care directly has resurfaced.

Of course, in a sense, we have been here before. GP fundholding aroused enormous tension within the NHS, and divided the general practitioner community. As this paper suggests, its impact was mixed. On the one hand, fundholding practices encouraged general practitioners to use their purchasing function to improve the quality of care for their patients. On the other, the transaction costs were high, and differences in access between fundholding and non-fundholding practices developed. Significant benefits were apparent in other forms of commissioning, such as GP commissioning groups.

Since then the policy environment has changed. With the formation of PCTs, and reduced waiting times for elective care, there is much less scope for individual practices to wrest benefits from acute trusts through spot purchases of elective surgery. What is more, while choice of provider for episodic care remains a priority, the management of chronic disease is now recognised as being of at least equal importance and, if it is to be done effectively, will require major changes in the models of care currently deployed in primary care and more integration with hospitals.

In short, the world has moved on and fundholding in its original form is no longer an appropriate model. Yet as Richard Lewis points out in this paper, there is a role for greater financial incentives to encourage general practitioners and their staff to become more involved in commissioning care and managing risk. Whether this takes the form of PCT-directed incentives or practice-led budgets within an agreed Trust strategy would ideally be decided locally.

This is an exciting message. Until now this has been a highly controversial area. Now, for the first time in a long time, primary care is starting to speak with one voice. There is a significant level of agreement between the National Association of Primary Care and the NHS Alliance as to the potential benefits of practice-led commissioning. With the right leadership from the NHS and from the profession, there now is the prospect of effective, innovative commissioning at practice level that drives up quality and gives real choice for patients.

Niall Dickson
Chief Executive
The King's Fund

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Introduction

The Government has announced new arrangements for the reintroduction of practice-led commissioning (Minister of State for Health [John Hutton] 2003). This forms part of a strategy designed to increase the engagement and influence of frontline primary care clinicians in a key primary care trust (PCT) function, thereby facilitating a greater responsiveness of the NHS to the needs of individual patients.

It may also signal a renewed concern to put in place effective means to control an expected upsurge in demand for services as the NHS enters a new era of rapid access and low waiting times for hospital care. This latter point is underlined by a growing sense that many PCTs have struggled with their commissioning role, not only failing to engage with clinicians or the public but also failing to use commissioning as a lever for improvement (Commission for Health Improvement 2004).

As a concept, practice-led commissioning incorporates elements familiar from the past, most particularly GP fundholding (GPFH), total purchasing (TP) – a later variant of the GPFH initiative – and locality/GP commissioning pilots. However, the context in which devolved commissioning will take place looks very different to its initial development between 1991 and 1997.

Primary care trusts, with elected representatives on professional executive committees at their hearts, now provide a potential bridge between NHS bureaucracy and the views and needs of the frontline. Patient choice of provider, once considered the exclusive right of those registered with fundholding practices, is now enshrined in new rights for all patients. Further, the internal market is now giving way to a market where prices are fixed and the potential for individual practices to negotiate favourable prices from hospitals desperate for extra marginal income has gone.

So while it is instructive to look back at previous incarnations of practice-led commissioning in order to anticipate and shape this new initiative, it is important that such lessons are translated into this new context (*see* Table 1).

Table 1: Practice-led commissioning: comparison of historic and current policy environments

Policy environment (1991–1997)	**Current policy environment**
GPFH legally autonomous health care purchasers	Practice-led commissioning exists within broader PCT strategic framework
Disparity in choice of provider between GPFH/TP patients and non-GPFH/TP patients	National minimum standards of choice of provider for all patients
Significant local variability in services	Local variability in services constrained by national standards (national service frameworks, National Institute for Clinical Excellence) and new mechanisms for national inspection and regulation (eg Healthcare Commission)
Price-sensitive purchasing of health care (often at marginal cost)	Standard tariff of NHS prices based on Health Resource Groups

This paper aims to shape discussion about the nature of practice-led commissioning and, in particular, how it might be designed and implemented best to benefit patients in today's environment. It considers a number of questions:

- What does practice-led commissioning really mean in the new health care context and what are the intended benefits?
- What can we learn from GP fundholding, total purchasing and locality/GP commissioning pilots about the likely effects of this new policy?
- How might practice-led commissioning be implemented?
- What constraints, barriers and risks might be faced as implementation progresses?

Practice-led commissioning: what is it and who benefits?

Commissioning is a term used liberally and variably within the NHS. For some, it is simply the process of securing services from providers by contract; for others, it encompasses the planning and design of integrated care pathways. In this paper, commissioning refers to:

- identifying effective and appropriate health service responses to assessed patient needs
- securing national and local health care priorities
- planning the coherent delivery of services
- securing those services through contracts with service providers (or purchasing)
- allocating available resources against competing priorities.

While the whole notion of a conceptual division between commissioning and provision of services suggests a competitive tension between those two functions, in fact, it is entirely possible (even desirable) for commissioners and providers to work in partnership to design services that meet the needs of patients.

Practice-led commissioning involves the devolution of some or all of these commissioning responsibilities from PCTs to primary care practices. Practice-led commissioning might be said to begin once three conditions are met:

- PCTs begin to identify practice-level activity.
- Practices are involved in the design of the services used by their patients.
- Practices face incentives related to their performance against agreed practice-level objectives.

Exactly how practice-led commissioning might be designed is considered further below.

What are the benefits of practice-led commissioning?

Theoretical arguments in support of practice-led commissioning can be broadly divided into three:

Direct patient benefits

Practice-led commissioning is designed to:

- empower primary care teams to construct care packages that reflect the needs of individual patients in a precise and highly responsive way
- offer scope for defining individual preferences in partnership with patients, together with the power to express those preferences through the commissioning process
- provide incentives that may shift the emphasis from treatment to disease prevention and health promotion.

This contrasts with PCT-led commissioning, where decisions on care purchasing reflect (at best) the average requirements of patients rather than the needs of individuals (although it is recognised that the choice agenda may provide greater sensitivity in due course).

Efficiency benefits

Practice-led commissioning provides a new structure within which care can be managed proactively at the level at which patients generally enter the health care system. Managed care means the construction of coherent care packages for individual patients that take into account the need for multi-specialty and multi-disciplinary interventions, the relative priority that should be given to one individual's care compared to other individuals, and whether or not all care demands should be met (with reference to evidence of clinical- and cost-effectiveness).

Practice-led commissioning provides incentives for clinicians to take responsibility for care management and may avoid the need for reliance on less sensitive mechanisms to control demand further downstream (such as tight control of access to waiting lists at hospital). Crucially, practice-led commissioning provides incentives for GPs and others to manage financial risk and reduce clinically avoidable demands for NHS care.

Further, by bringing together service provision and commissioning, the boundary between primary and specialist care could become more permeable as primary care teams chose between the direct provision of services (possibly through extending the skill-mix within the team) and the commissioning of others.

Political benefits

Practice-led commissioning represents a devolution of power from corporate PCTs to constituent practices, and has the potential to offer rewards to participants. Looked at in this way it might represent a strategy to increase the sense of engagement of GPs and other primary care staff with the work of the PCT and, crucially, their level of influence over the exercise of PCT functions. To the extent that PCT legitimacy is founded on its ability to engage local primary care professionals and put them in the driving seat, practice-led commissioning may also act as a tool to increase the legitimacy of PCTs in the context of apparently waning engagement among GPs (Regen 2002, NHS Alliance 2003) and a perceived lack of influence (unpublished survey, OPSR/Department of Health/NAPC 2003). However, such engagement may also serve to increase the wider accountability of primary care clinicians, at least in regard to their responsibilities as gatekeepers to NHS care.

How practice-led commissioning might look

Practice-led commissioning refers to the devolution of commissioning responsibilities from PCTs to primary care practices. Under such an initiative, primary care practices (that may be run by a partnership of GPs and/or other health professionals or a PCT itself) would be assigned responsibilities for commissioning services. While practices may have the right to request their participation in such an initiative, the power to grant such a request remains with the PCT. Unlike GP fundholding (GPFH), practices meeting qualifying criteria cannot expect an automatic and legal right to adopt practice-led commissioning status (Department of Health presentation 2004). Formal guidance is expected shortly.

PCTs and practices face a number of options as to how such responsibilities might be exercised. These can be considered from three important perspectives: the degree of collectiveness of decision-making; the range of services to be commissioned at practice level; and the balance between budget-holding and other financial incentives.

Degree of collectivity

Practice-led commissioning can be structured with the individual practice as the prime focus, with groups of practices operating semi-corporately within associations (but retaining bottom-line accountability as individual practices) or as multi-practice corporate entities (taking full collective accountability for commissioning decisions).

While it is tempting to view these options as inextricably linked to issues of scale, and to assume that multi-practice options inevitably represent larger populations of GPs and patients, this may be misleading. For example, it is entirely likely that some large single-practice commissioners will serve greater patient populations than many multi-practice organisations.

A further aspect of collectivity is the relationship between the commissioning activities of individual practices and those of PCTs. It is a fundamental characteristic of practice-led commissioning that real decision-making power is delegated from PCT to practice level (whether as individual practices or groups of practices). However, the degree to which practice decisions are bounded by broader PCT concerns could be variable.

At one extreme, practices may have limited elbow-room to manoeuvre, simply offering advice to PCTs from their particular perspective. At the other extreme, practices may enjoy full autonomy – provided they act within the law. A mid-point might be the autonomy of practices to commission within strategic boundaries established by the PCT.

It is also entirely possible, and arguably desirable, for the purchasing of services to be divorced from other elements of commissioning. Therefore, PCTs could act as purchasing agents for practices (setting and monitoring contracts), reducing transaction costs and making good use of scarce skills. Keeping the purchasing function at PCT level is consistent with the range of options of practice-level commissioning, even where practices enjoy significant autonomy in the planning and prioritising of services.

Scope of services to be commissioned

The scope of practice-led commissioning is similarly flexible. Options include a focus on elective care, individual diseases (such as chronic diseases), population groups (such as the elderly), or on total care (perhaps excluding highly specialist services). It would seem sensible for practices to focus on those services where the actions of primary care will dictate (at least in part) the patient journey through the NHS.

Spectrum of incentives

The balance between budget-holding and other financial incentives is rather more complex. While the GPFH model was founded on the creation of a practice-level budget managed more or less autonomously, this is not a necessary condition of devolved commissioning.

At its weakest, practice-led commissioning could involve PCTs sharing practice-level hospital utilisation data and relying on peer pressure among primary care professionals to provide performance incentives in the shape of positive or negative personal satisfaction.

However, incentives may be sharpened by applying financial incentives to practices. Payments could be made if practices meet quality standards in relation to their hospital referrals and/or

the actual use of hospital services by their patients, compared to indicative (target) levels. A scheme of this nature is already in operation in North Bradford PCT (*see* Table 2).

Table 2: North Bradford Primary Care Incentive Scheme

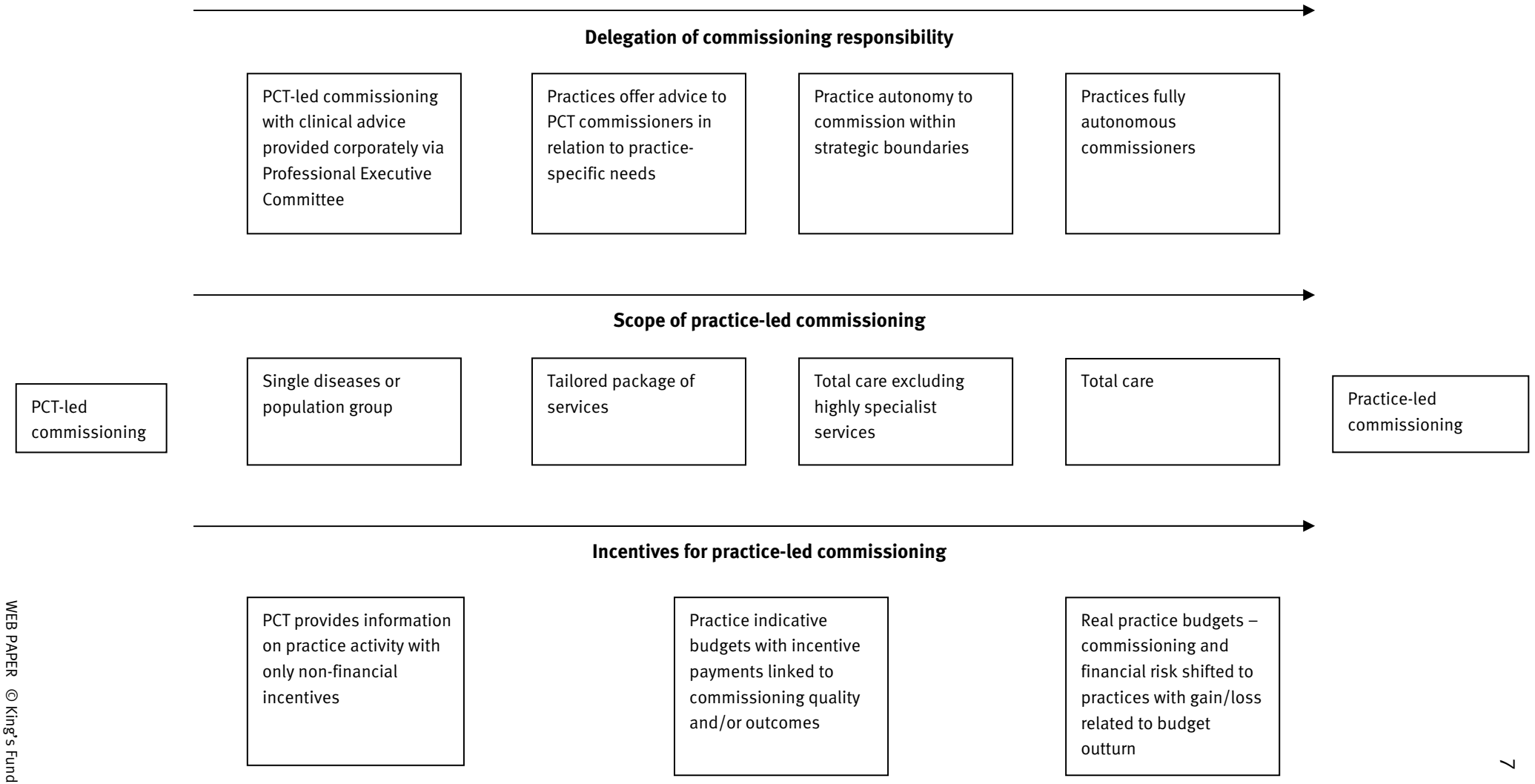
Incentive scheme element		**£ available to practice (based on list size of 10,000)**
Prescribing quality markers	■ Payment is direct to GPs, no conditions on how money is spent.	£12,500 max
Hospital services quality markers		£10,000 max
Financial performance (based on savings made against indicative practice budget for elective hospital services)	■ Linked to quality – if no quality markers achieved then no savings retained. ■ Practice retains 50% of savings made for agreed investment in the practice. ■ Key objective is to encourage practices to achieve value for money and utilise alternative services to manage demand.	£20,000 max
Investment into primary care (maximum possible for a practice of 10,000 patients)		**£42,500 max**

Adapted from presentation by North Bradford PCT, 14 April 2004

However, as indicative practice-based activity levels give way to real practice-level budgets, an important threshold is crossed. Practice-level budgets imply sharper incentives still, with a formal transfer of financial risk from PCT to practice. In this scenario, practices are rewarded not simply according to quality indicators but on actual financial outturn. Importantly, real budgets mean that overspends at practice level could lead to losses being offset against the following year's budget or even result in lost personal income for those in the practice.

Figure 1 illustrates these different dimensions along which practice-led commissioning can be located and designed. To a significant degree these dimensions are independent of one another and practices may agree with PCTs to locate themselves on different parts of each continuum. For example, practices could operate as fully autonomous commissioners with real budgets, yet cover only a very limited range of services. Similarly, practices may be responsible for real budgets for total health services, yet be bounded in their actions by PCT strategic objectives. How these choices might be made is considered further on p 12, Ways of implementing practice-led commissioning.

Figure 1: Dimensions of practice-led commissioning



What can we learn from previous schemes?

In implementing practice-led commissioning in 2004, it is instructive to look back at earlier examples of the phenomenon. This can inform the design and implementation of the initiative today.

Between 1991 and 1998, three key variants of practice-led commissioning were developed:

- **GP fundholding (GPFH)** GPFH practices were allocated a cash-limited budget that covered elective surgery, diagnostic tests and investigations, outpatient referrals, community health services and prescribing. GPFH practices were responsible for purchasing services directly from providers (although some chose to act in concert with other GPFH practices). At first, the scheme was restricted to practices with populations of more than 11,000; however, this limit was reduced subsequently to 5,000. By 1996, more than half of practices in England were fundholding (Mays 1999) and the scheme was formally discontinued in 1999.

- **Total purchasing (TP) pilots** These were established to extend the principles of GPFH purchasing by incorporating emergency and other non-elective services into a practice-led commissioning approach. TP practices operated as sub-committees of health authorities with budgetary responsibilities formally delegated to them. These pilots typically increased the size of commissioning organisation. Of the 53 first-wave TP pilots, 64 per cent involved more than one practice in a collaborative venture. The mean population of TP pilots was 31,000 (ranging from 8,100 to 84,700 [Wyke *et al* 2003]). Two waves of TP pilots were established.

- **Locality/GP commissioning pilots** Groups of practices emerged in the mid-1990s with the objective of exercising collective influence over the commissioning of care within defined localities. In 1997, the new Labour Government formalised this approach by establishing 40 GP commissioning pilots, which were intended to build on best practice and, in particular, meet the central policy aim of greater fairness (NHS Executive 1997).

  These 40 pilots incorporated both GPFH practices and non-GPFH practices and varied in size considerably (serving between 38,000 and 564,000 people). The pilots had a variable responsibility for actively commissioning hospital and community health systems – some commissioned all or selective care services with explicit budgetary responsibilities; others were assigned only indicative budgets or undertook an advisory role only in relation to health authority commissioners (Regen *et al* 1999).

The lessons of GP fundholding

Fundholders generated many headlines during the 1990s, polarising opinion as to their effect on the NHS. While this significant policy departure was not accompanied by a systematic national evaluation, a raft of research soon built up. Systematic reviews of fundholding research in the mid-1990s were equivocal as to the impact of the scheme (Goodwin 1998). However, later research (some of which was not published until well

after the demise of the scheme) has allowed a more confident and positive view of the impact of fundholding.

So what can we deduce about this form of practice-led commissioning?

- **GP fundholders appeared to achieve shorter waits for their patients.** A major study concluded that the waiting times for fundholders' patients for fundholding procedures were 8 per cent shorter than those experienced by the patients of non-fundholders (Propper *et al* 2000). This was particularly the case for specialties such as orthopaedics, ophthalmology and gynaecology, where the longest average waits were concentrated. These findings were consistent with research in West Sussex, where fundholders' patients had significantly shorter waits for treatment (Dowling 1997).

- **GP fundholders appeared to reduce their rates of elective hospital admission compared with non-fundholders**. Early evidence of this phenomenon was inconclusive. However, a later study of admission data over four years of fundholding concluded that fundholders reduced elective admissions by 3.3 per cent although fundholding status had no effect on emergency admissions – not surprisingly, given that the scheme did not include emergency activity (Dusheiko *et al* 2003).

- **GP fundholders held down rises in prescribing costs compared with non-fundholders** (Audit Commission 1995, Coulter 1995). There has been some scepticism as to whether or not this represents a real increase in cost-effectiveness (*see* Goodwin 1998).

- **Transaction costs of fundholding were high.** The Audit Commission found that the staff, equipment and computing costs of fundholding cost £232 million up to the end of 1994/5, significantly more than the audited underspends against budgets of £206 million. Furthermore, these costs were conservative, given that they did not include transaction costs for providers nor the time spent on purchasing by GP fundholders themselves (Audit Commission 1996, Goodwin 1998).

- **Fundholders received a higher than equitable share of resources in some areas.** In NW Thames, per capita funding of non-fundholding patients varied from 59 per cent to 87 per cent of the amount funded per capita on patients in comparable fundholding practices. However, whether this represented a general over-funding nationally is contested (Dixon *et al* 1994).

We might deduce (albeit tentatively given the lack of wholly consistent messages from the research) that fundholders did achieve more rapid treatment of their patients, did act to reduce the level of referrals and did prescribe drugs more cheaply. In many respects the verdict on fundholding has become more positive as the years after its demise increase. However, significant public policy issues were raised. The scheme looked costly (and observers may doubt that the benefits outweighed the costs) and inequitable.

The lessons of total purchasing

The TP initiative provides different lessons to that of GPFH – bringing into play the commissioning of non-elective services. Unlike GPFH, the TP experience was subject to an extensive national evaluation (*see* Wyke *et al* 2003 for summary). So what lessons have emerged?

- While TP pilots were established as comprehensive commissioners, they emerged as selective purchasers, focusing on specific areas of care.

- Upward accountability to health authorities was relatively light and informal and there was little formal downward accountability to patients, mainly because GPs already saw themselves as patients' agents.

- Few TP practices tackled patterns of specialist secondary care (although those that did were mainly successful). However, 69 per cent of TP practices reduced occupied bed days and 13 per cent reduced admissions significantly more than comparable local non-TP practices.

- In maternity care, where notions of patient choice were more prevalent, no significant differences were found in the reported experience or resource use of TP patients compared to patients of similar non-TP practices.

- Budget-setting proved difficult and delays persisted. This had an impact on the ability of TP practices to negotiate changes. A lack of real budgets also meant that GPs had fewer direct personal incentives to manage resources effectively.

- A specific study of risk management by TP practices (Baxter *et al* 2000) found that many pilots did introduce innovations designed to control expenditure (for example, monitoring specialist activity and imposing penalties for under- or over-performing). GPs in TP practices also worked together to control demand by discussing individual cases and agreeing practice protocols.

In summary, the national evaluators found that TP pilots had a 'relatively modest impact' (Wyke *et al* 2003). However, interesting differences emerged between single-practice and multi-practice and between large and small population TP practices. In the first year of operation, smaller TP practices were more likely than larger TP practices to be high achievers (according to self-reported measures). However, by the second year, larger TP practices had caught up.

In terms of risk management, single-practice and smaller TP practices appeared to perform better than multi-practice or larger TP practices (Baxter *et al* 2000). This was related to inter-GP relationships. More multi-practice than single-practice pilots involved only the lead GP in reviewing and discussing expenditure against budget and GPs in multi-practice pilots were twice as likely as single-practice pilots to refer patients for rare and costly conditions without consultation with any other party (such as the health authority or another GP).

The researchers concluded that 'integration of clinical and financial roles is more likely to happen within single-practice than in multi-practice organisations' (Baxter *et al* 2000, p 60). In larger organisations, they suggest, incentives for GPs to gain a free ride (that is, ignore budgetary constraints on their practice) may out weigh incentives upon them to take on the responsibilities of a financial insurer.

The lessons of locality/GP commissioning pilots

The 40 GP commissioning pilots were subject to a national evaluation (*see* Regen *et al* 1999). However, while they were established as two-year pilots, within one year it became clear that the NHS as a whole was to change, and that commissioning pilots would migrate to become primary care groups.

Lessons that can be learned from these pilots include that:

- **This collective model of commissioning did deliver benefits.** The achievements of the GP commissioning pilots were identified in the national evaluation as including: improved collaboration between GPs across practices; the establishment of new corporate management arrangements and structures that overlaid the individual practices; the development of a range of peer review-based approaches to managing the prescribing budget; and the setting up of service review groups or task forces (Smith *et al* 2000).

- **Obstacles to their progress were encountered.** These included: uncertainty about the future, given the imminent move to primary care groups; the level of workload for clinicians involved in leading commissioning activity; problems with health authority support to some groups (including a reluctance to disseminate information and devolve responsibility); and concerns about information management and technology support (Smith *et al* 2000).

- **All 40 pilots held real budgets for prescribing.** Overall, the pilots achieved a significantly lower level of increase in prescribing costs compared to non-pilots (3.9 per cent compared to 5.1 per cent). Three-quarters of the pilots stayed in budget during 1998/9 and the mean budget outturn was an underspend of 2.8 per cent. Pilots had higher rates of generic prescribing compared to similar non-pilot practices. Half the pilots used an incentive scheme and two-thirds made use of pharmacist review at practice level (McLeod *et al* 2000).

- **Some GPs were ambivalent as to how ready they were to assume the health authority's powers and influence.** This was the conclusion of one evaluation of four locality commissioning sites (before and not part of the formal pilot programme of 1998–1999). It was also found that holding commissioning funds directly was seen as an important lever by some GPs, although others saw it as a distraction (Smith and Shapiro 1997).

As with total purchasing, the relatively short period of time in which locality/GP commissioning pilots were active makes it difficult to assess their impact clearly. However, it does appear that corporate structures had begun to be developed and that collective approaches, such as peer review, may have contributed to benefits.

Therefore, in broad terms, the evidence from earlier variants of practice-led commissioning is positive. It suggests that at least some of the theoretical benefits may be achieved in practice. It identifies areas where practice-led commissioning might be expected to offer greatest benefits as well as areas of weakness.

Ways of implementing practice-led commissioning

Practices and PCTs face a potentially bewildering array of choices. The lack of detailed and prescriptive guidance from the Department of Health means that many variants of practice-led commissioning are likely to flourish nationally. This diversity may well prove beneficial; however, it implies that clear decision-making frameworks will need to be negotiated locally.

The prospect of PCTs relinquishing all strategic control over commissioning is both unlikely and unwarranted. After all, PCTs are publicly accountable for national and local health service goals – many to be achieved through the commissioning process – and are well placed to represent both community and other interests. Therefore, PCTs would aim to retain a strategic command of commissioning policy at least. However, beneath this strategic level, PCTs will need to agree the extent to which real decision-making power is devolved and the most appropriate incentives that should be applied. One way of determining such a local approach may be through an analysis of strategic risks and benefits (*see* Table 3).

Strategic risks

The strategic risks faced by local health communities in this case apply mostly to the achievement of key service redesign; in other words, the ability to deliver a complex new model of care that requires multi-institutional co-operation and the planning and delivery of care pathways across sectors.

In this type of case, the unpredictable dynamism of fully-fledged, highly autonomous practice-led commissioning may prove challenging and risky. At the very least in these circumstances, practice-led commissioning might operate best through formal or semi-formal multi-practice organisations.

Where the scheme may be most welcome

Alternatively, this dynamism of autonomous practice-led commissioning may be particularly welcome in service areas where:

- complex re-design is not required (or where the sustainability of major local providers is not likely to be compromised)
- a range of alternative providers exist (in both primary and secondary care)
- services are referral-sensitive: in other words, primary care has significant discretion in the way in which patient care might be managed, such as choosing between hospital referral or extending in-house services
- clear medium-term trade-offs exist between primary care prevention services and treatment (such as chronic diseases).

In these cases, patient benefits may be maximised through high levels of responsiveness to individual needs, clear incentives to promote health, and the opportunities to develop innovative service solutions.

Table 3: Risk/benefit analysis of practice-led commissioning

	Likely outcome (risk/benefit) of practice-led commissioning	Practice-level incentives to be applied
Highly specialised services (eg regional specialties)	■ Few benefits anticipated as practices have little discretion over patient management and few credible alternative provider options.	None
High strategic risk services	■ Autonomous practice-led commissioning may result in poor strategic coherence and failure to achieve major and complex service redesign.	■ Indicative budgets and/or quality indicators linked to referrals. ■ Multi-practice commissioning with real budgets (within clear PCT strategy). ■ PCT to commission additional GMS/PMS services.
Low strategic risk services	■ Autonomous practice-led commissioning may provide dynamic service improvement, particularly where services: ■ are 'referral sensitive' ■ are contestable (range of providers) ■ involve trade-offs between primary care prevention and secondary care treatments (eg chronic disease).	■ Real practice-level budgets with transfer of risk from PCT to practice level. ■ Highly autonomous practice-led commissioning.

Of course, the services that are considered high risk will vary from area to area. Some PCTs may be attempting to redesign chronic care pathways and see the maintenance of control as essential. Others may see chronic disease management as precisely the area where the devolution of commissioning responsibilities to practices will be most effective. Each area will need to negotiate its own path.

Discussion

Should the new initiative for practice-led commissioning be welcomed or treated with suspicion? Broadly it should be welcomed. The devolution of commissioning and service design may contribute to the policy goals of localism (locating as much power as possible as close to patients as possible), the engagement of primary care teams in the active design and management of care pathways, and the loosening of the relatively fixed boundary between primary and secondary care. What's more, evidence from precursors, such as fundholding and total purchasing, suggest that at least some of the theoretical benefits discussed in the earlier section, Practice-led commissioning: what is it and who benefits? on p 3, might be realised.

While there is an inevitable temptation to view new proposals for practice-led commissioning as a return to the past, the context of health policy looks very different in 2004 than it did during the internal market of the 1990s. The standard tariff for health care (a fixed price that is set in advance and charged for care, regardless of the provider), patient choice, and also new systems for on-line booking of appointments for specialist care all look set to transform the environment within which practice-led commissioning will operate.

Further, new structures exist to allow primary care professionals to agree overarching strategies for health care within which commissioning decisions will have to be taken, and new mechanisms exist for national regulation of the scope and standards of NHS care. This new context may defuse some of the historical angst over potential inequities and transaction costs that might re-emerge if some primary care practices are given greater freedom to commission.

Practice-led commissioning may also strengthen the ability of the wider health system to reorganise health care delivery around primary care. The effects of payment by results as it matures are, as yet, unknown. However, it puts in place incentives for hospitals to sustain, or even increase, the range of services managed in a hospital setting – to increase income by maximising the total number of health resource group (HRGs) payments – and to discharge patients quickly into the community to reduce costs per HRG (Lewis and Dixon 2004). (Health resource groups are groupings of treatment episodes similar in resource use and clinical response, to which the standard tariff is applied.) Practice-led commissioning, in contrast, is a potentially powerful new counterbalancing incentive – encouraging primary care to retain or pull back patients into the community.

However, while the general policy thrust may be a good one, the implementation of practice-led commissioning raises complex issues and some important tensions. Several key policy trade-offs underpin the evolution of practice-led commissioning:

- Clear and compelling incentives for primary care practitioners to manage demand and financial risk may conflict with their role as the patient's agent.
- Local freedoms for primary care teams to set their own agenda are in tension with the PCT role to ensure the coherent planning and delivery of services.
- Greater discretion for primary care teams in the use of NHS commissioning resources reduces the degree of formal public accountability exercised through PCTs.

These trade-offs and tensions need to be carefully managed and the right balance achieved between different policy goals.

Getting the incentives right

Both fundholding and total purchasing restricted the personal incentives that applied to GPs – savings from commissioning budgets were to be reinvested in patient care rather than as additional remuneration to team members (of course, in practice, investments, such as those in premises buildings, served to increase services and the personal wealth of GPs simultaneously). Historically, there has been a desire (at the Department of Health at least) to maintain separation between clinical decision-making and the personal rewards for clinicians. This is understandable. However, a policy to dilute the financial incentives for clinicians may reduce the likelihood of the desired benefits being realised – financial incentives are not the sole motivating force, but they are an important one.

Coherent service development

The conundrum for policy-makers is how to free people on the frontline to innovate and use their initiative while at the same time ensuring coherence in the development of wider health services. There is a justified scepticism as to whether sensible micro decisions will inevitably add up to sensible outcomes at the macro level. The strategic coherence provided by PCTs should not be undermined.

PCTs can retain the final say over the actions of practice-led commissioners (or at least set the boundaries within which they will act), ensuring that the latter will have to demonstrate consistency with broader strategic agreements in the local health community. This safeguard should be enough to ensure that sensible strategic plans are not undermined and that collective decisions are supported (decisions that will be informed by the views of practice teams in any case).

However, an application of the strategic trump card that is too heavy-handed will disempower practice-led commissioners and make them question the value of the exercise. PCTs should seek to exercise only light control of delegated commissioning (at least where no major strategic risks are involved).

There may be other barriers to practice-led commissioning, mainly because of mechanisms designed to provide stability for hospitals. Foundation trusts will enjoy three-year (legal) service contracts with PCTs, and the Private Finance Initiative may involve hospitals guaranteeing funding flows to private partners for up to 30 years. The amount of elbow-room for practice-led commissioners to shake up service delivery might, therefore, be questionable, (although ultimately it is hospital managers, not commissioners, who have to satisfy the regulators and private funders).

Scale and effectiveness

How large should practice-led commissioning organisations be? The issue of the appropriate population size for effective local commissioning is an important and contentious one, and issues of scale can be addressed from a number of different perspectives, in particular those of effective risk management and an appropriate skills-base.

Practice-led organisations serving small populations may struggle to manage financial risk and could find it difficult to design effective public health interventions. However, there is little empirical evidence to tell us how small is 'too small'.

Some researchers have suggested that financial risk can be stratified according to the type of service involved. For example, expensive and unpredictable treatments can only be effectively risk-managed at a population level of 250,000; routine emergency care at the level of 50,000; elective care at the level of 10,000–50,000; and community health services at the level of 3,000–10,000 (Mays and Dixon 1996). However, other, empirically-based work suggests that this logic may not hold true in practice. Analysis of smaller TP practices suggests strongly that they were equally, if not more, able to manage financial risk and tended to be better at involving GPs in the management of commissioning budgets (Baxter *et al* 2000). Indeed, relatively few of the first wave of TP practices reported overspending their budgets due to rare and costly problems, and no significant differences were found in overspending between large and small TP practices.

Drawing on the lessons from research, an automatic assumption that larger practice-led groupings are the structure of choice should be avoided, at least on grounds of effective risk management. However, risk-management techniques themselves should be promoted (evidence suggests that this is an area of potential weakness in primary care). Such techniques go beyond issues of population size. For example, practice-led commissioning organisations might protect themselves by managing risk through longer-term contracts or by managing budgets over more than one financial year, rather than by increasing the number of patients covered.

PCTs also have a role in supporting practice-led commissioning organisations and not just through financial risk-sharing organisations. For example, PCT-led risk stratification – identification of individuals at high risk of intensive, and expensive, health care – together with centrally managed case management schemes, might reduce the exposure of practice-led commissioners. It is instructive that managed care organisations in the United States have moved away from the delegation of full, managed care responsibilities to small multi-specialty group practices in light of the difficulties experienced in carrying out this role at local level (Group Health Co-operative, Seattle, personal communication, 2003).

From the perspective of the required skill-base, scale is also an important issue. Effective commissioning is underpinned by a number of distinct skills, including the ability to apply clinical and cost-effectiveness evidence, discriminate between providers on grounds of quality, and understand and reflect the needs and desires of patients from all types of community.

It might reasonably be argued that some of these skills will be maximised through the devolution of commissioning responsibility to the lowest possible level, such as the practice or consulting room. The individual clinician may indeed be expert at judging the needs of individual patients and in building up day-to-day empirical evidence on the quality of providers. However, other skills, such as the assessment of and acting on clinical and cost-effectiveness evidence, may be more specialised and better achieved at a larger organisational level. At the very least, practice-led commissioning is likely to require an increase in support infrastructure, with implications for cost and skill development.

Choice

A defining feature of current public sector reform is that of patient choice of service provider. Practice-led commissioning is broadly consistent with this aim – providing primary care professionals with the power to commission care in accordance with the wishes of individual patients. However, practices will be limited in their commissioning agility by the overarching agreements required by PCTs. Moreover, patients themselves can expect more choice, both at the point of referral and in selecting where they will receive their primary care (Department of Health 2003a, 2003b).

The implications of this is that practice budget-holders will face increased expectations among patients and may find themselves accountable for the care management decisions of other primary care providers. Alternatively, budgets may be adjusted to take account of a multitude of access points to NHS primary care; however, they are likely to be complex to calculate.

Furthermore, financial incentives may reward practices for extending services available in-house (possibly through investments that may put them financially at risk). Patients may be directed to, or feel obliged to attend, practice-based services rather than alternatives at local hospitals or elsewhere. In this context, the extent to which patients are able to make explicit choices may become obscure and will depend, in part, on the willingness and ability of primary care practitioners to articulate these choices. Certainly, during the 1990s, the use of GP fundholder-owned private limited companies, which provided services that had been commissioned by using the fundholding budget, caused concern, leading to regulation and eventual termination.

Accountability

Where should accountability lie and how should it be exercised? Increasingly, the Government is stressing the need for multiple sources of accountability, including mutual membership of local health resources through foundation trusts as well as more traditional accountability through public boards such as those of PCTs.

As commissioning responsibility is devolved to practices, with associated incentives for care to be transferred from hospital to primary care, a question arises as to the appropriate form of accountability. The TP experience found that practice-led commissioning forged few, if any, new accountability relationships with the local community. In this era of community engagement, this may not be good enough.

PCTs are rightly held to account for their performance. If the commissioning function is to be delegated, then so too should accountability. This means that service and public health goals need to be formally agreed with practice-led commissioners as an integral part of the delegation process. This resembles the relationships developed by United States managed care organisations, with local agents responsible for comprehensive care. Lastly, effective means will need to be found to ensure that practices do not cherry-pick their patients to minimise financial risks.

Conclusions

The perception among general practitioners is of a lack of influence over the work of PCTs (OPSR/Department of Health/NAPC 2003). This presents a major policy challenge. Not only the legitimacy of PCTs, but also their strength, relies on their ability to harness the power of primary care and bring it to bear on the design and management of NHS care. PCTs have been dealt a difficult hand, with many expectations laid at their door and little time to develop their capacity.

Practice-led commissioning may offer a new dynamic weapon in their armoury. Rather than dissipate PCT influence, it may increase it, providing that local schemes for practice-led commissioning are developed in a spirit of partnership rather than as a symbol of eventual divorce.

However, as this paper has tried to demonstrate, practice-led commissioning is about far more than practice budgeting. Indeed, the significant involvement of practices in the commissioning process might be achieved in some circumstances without 'real' budgets at all. But practice-led commissioning will need to demonstrate that it adds value in an era of patient choice. After all, critics of the scheme might claim that it is redundant and that it is patients who should design and effectively commission their own care.

However, it is precisely here that practice-led commissioning may offer the NHS big advantages. As waiting times for elective care are reduced, new means will be required to ensure that resources (still scarce, notwithstanding recent record increases in NHS funding) are used well. A poor consequence indeed of shortened waiting times would be a rapid increase in demand, a significant lowering of referral thresholds to include patients with a poor likelihood of benefit and the eventual return of waiting lists at the hospital front door.

Further, by empowering practices to undertake commissioning in its fullest sense (*see* the section, What are the benefits of practice-led commissioning? on p 3), new alliances between primary and secondary care may be forged that are able to offer the sophisticated care packages needed by the increasing number of patients with complex and often multiple chronic diseases.

Practice-led commissioning may well prompt the design of new types of integrated organisation, based in the community, but with new components that, up until now, have been more familiar in hospital settings. With the NHS Modernisation Board discussing targets for reductions in unplanned admissions of up to 20 per cent, new and radical options will be needed.

Yet there are dilemmas and trade-offs inherent to this policy: in particular, the balance between the needs of primary care clinicians to feel free to innovate and be entrepreneurial, and that of PCTs to plan care systematically and to improve equity of access to services among their patients. These trade-offs are not easy to resolve and the solution may look different across the country.

So what should happen next? PCTs and practices need to develop initiatives that sit comfortably with their local context and the aspirations of their local stakeholders. This may include schemes based on real practice budgets or on the development of innovative incentive schemes, with great autonomy for individual practices or the growth of locality-based practice associations.

More likely, PCTs will develop a mixed approach and will be able to pilot different approaches within their own patch. In the absence of a single model sponsored by the Department of Health, an organic growth in this new phenomenon can be expected. While this will not be captured by an overarching evaluation, it is important that the relative merits of the different approaches are assessed and shared.

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