King's Fund

National Evaluation of Total Purchasing
Pilot Projects
Working Paper

The management challenges for Primary Care Groups

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The Total Purchasing National Evaluation Team (TP-NET)

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

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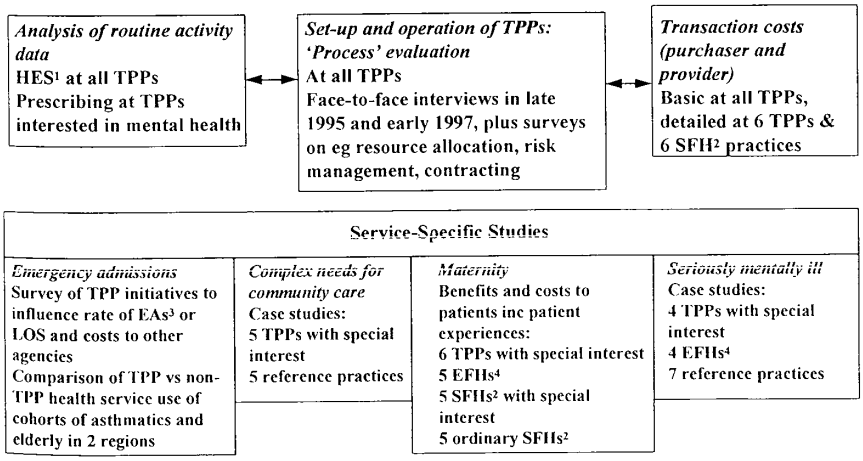
Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

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King's Fund, London
January 1998

National Evaluation of Total Purchasing Pilot Projects
Main Reports and Working Papers

Title and Authors	*ISBN*
Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Working Papers	
The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:	
Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
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A profile of second wave total purchasing pilots: lessons learned from the first wave

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The management challenges for Primary Care Groups

Executive Summary

Considerable management challenges must be faced in order to ensure the successful operation of Primary Care Groups (PCGs). The insights to be gained from those involved in Total Purchasing Pilots (TPPs), arguably the closest existing model to PCGs, are likely to prove valuable in informing the development of PCGs, and we conducted a series of workshops designed to capture some of these insights.

While it is clear that there are substantial challenges to establishing PCGs, there is also a belief that this form of organisation will be beneficial, both to healthcare professionals and to patients. It is important that existing enthusiasm and energy is not dissipated by forcing a tight timetable for implementation.

The TPP evaluation revealed that organisational arrangements were key to the success of the pilots. PCGs are to be larger and more complex than were TPPs, and PCGs face additional challenges in developing corporate identity and common vision. It was generally felt that problems with managing an organisation covering populations of 100,000 or more would be resolved by developing a hierarchical model involving sub-groups within the PCG.

The budget-setting process is likely to prove important to how well PCGs function, and budgets will have to be perceived to be fair in order to engender financial responsibility for referral and prescribing behaviour. However, there was a general failure to face up to the fact that the money might run out and that action might need to be taken to deal with the situation.

There is always a danger that reliance on co-operative working will be undermined by those who do not actively participate. It was felt strongly that such people would be brought on board by encouragement rather than by coercion.

The overall outcome from the workshops is best summed up by the participants' own key messages for ensuring the success of PCGs:

1. It will take time to achieve success;
2. It will take resources to manage successfully;
3. First class information technology is essential.

1 Introduction

Primary Care Groups (PCGs) are designed to overcome the current fragmentation evident in primary care, in which practices participate to varying degrees in the commissioning process and co-ordinated development across practices is difficult to realise. PCGs will give a unified momentum to the development of a primary care led NHS but considerable management challenges must be faced in order to ensure their successful operation.

Arguably, total purchasing is the closest existing model to PCGs. The insights to be gained from those involved in Total Purchasing Pilots (TPPs) are likely to prove valuable in informing the development of PCGs, and we conducted a series of workshops designed to capture some of these insights.

The workshops were designed to fulfil the following purposes:

1. To outline policy on Primary Care Groups;
2. To disseminate findings from the National Evaluation of Total Purchasing Pilots, particularly relating to their achievements and transactions costs;
3. To encourage attendees to explore some of the challenges of working in Primary Care Groups through workshop sessions in the context of their TPP experience and the requirements of the new NHS.

1.1 Primary Care Groups

The White Paper, *The New NHS*, formally announced the demise of fundholding and related models in favour of arrangements which are to involve all GPs in the commissioning process and cover the entire population (Department of Health 1997). PCGs are to be made up of primary care professionals serving populations of around 100,000 people.

Unlike involvement in previous primary care based commissioning schemes, participation in PCGs is not optional. However, the PCG as a whole has discretion about the extent of responsibility assumed for commissioning services. Table 1.1 presents the options outlined in the White Paper. All PCGs will enter the scheme at levels I or II, and can progress to levels III and IV only when legislation is passed allowing the groups to become freestanding bodies, when they assume Trust status.

Table 1.1: Options for Primary Care Groups

PCG I	Support the Health Authority (HA) mmissioning care for its population, acting in an advisory capacity
PCG II	Take devolved responsibility for managing the budget for healthcare in their area, formally as part of the Health Authority
PCT III	Become established as freestanding bodies accountable to the Health Authority for commissioning care
PCT IV	Become established as freestanding bodies accountable to the Health Authority for commissioning care and with added responsibility for the provision of community health services for their population

Beyond level I, the White Paper indicates that PCGs are to be responsible for their population's share of money for hospital and community services, prescribing and general practice infrastructure. This is to be allocated to the PCG in the form of a unified budget, allowing the PCG to determine spending priorities across these traditionally separate areas. The inclusion of the practice infrastructure component of general medical services (GMS) in the budget has been of particular concern to GPs, but subsequent policy indicates that expenditure on staff, premises and computers will be subject to a minimum guaranteed floor (Milburn 1998).

PCGs are expected to fulfil six main functions defined in the White Paper:

1. to contribute to and work towards the HA's Health Improvement Programme (HImP), and to develop their own Primary Care Investment Plans in the light of the HImP;
2. to promote the health of the local population;
3. to commission health services;
4. to monitor performance, both of service providers and of member practices;
5. to develop primary care, including joint working across practices, sharing skills, professional development, audit and peer review, clinical governance and deployment of resources for general practice; and
6. to improve the integration of primary and community health services and to work more closely with social services.

In fulfilling these functions, PCGs must satisfy a number of requirements:

1. they are to be representative of all practices in the group;
2. they are to have a governing board which includes community nursing and social services as well as GPs from the area;
3. they are to take account of social services and HA boundaries to help promote integration in service planning and provision;
4. they are to abide by the local HImP;
5. they are to have clear arrangements for public involvement including open meetings; and
6. they are to have efficient and effective arrangements for management and financial accountability.

PCGs are to become operational in April 1999. This short timescale emphasises the importance of learning from the experience of TPPs.

1.2 Relationship of Total Purchasing to PCGs

While locality commissioning can be considered similar to PCG I, Total Purchasing comes closest to that of PCG II. However, there are important respects with which TPP and PCG II differ:

- PCGs are much larger organisations than TPPs. The median TPP population covered amounted to 23,000 while PCGs are expected to represent populations of 100,000 (Mays *et al* 1998).
- Despite their name, TPPs commissioned services selectively, often blocking back services to the HA. Also, their fundholding and total purchasing budgets were formally separate. Under PCGs, while some specific specialist services are to be commissioned at a level above the PCG, all HCHS, prescribing and cash limited GMS monies are to form a unitary budget.
- TPP was a voluntary scheme, while it is mandatory for GPs to participate in their PCGs. As many TPPs succeeded through the enthusiasm and powers of persuasion exerted by a self-selected and small group of individuals, it may be unwise to generalise to the wider population of GPs.
- PCGs are to undertake a much wider range of functions than TPPs, including public health, primary care development, and working with social services.

1.3 Lessons from the National Evaluation of Total Purchasing

The King's Fund led evaluation of Total Purchasing drew lessons of value to those involved in establishing and working in PCGs. Most of these are drawn together in a King's Fund report (Mays *et al* 1998), but some of the key points about the relationship between organisational arrangements and the achievements and management costs of TPP are worth reiterating here.

Achievements of the first wave TPP sites are summarised in Table 1.2. The table reports the four main objectives identified by each pilot when they became TPPs, and the proportion of TPPs which felt that significant progress had been made against their objectives over the course of their first year of operation. Overall, just over half of TPPs felt that progress had been made, with this varying according to the service area considered. For instance, TPPs generally reported less success than they had hoped in improving mental health services but were more positive about the impact TPP had on developing the primary care team. Generally, greater success was observed when efforts were directed at issues over which the TPPs had immediate control, while it was evident that some GPs were frustrated at the difficulty of changing the behaviour of others. This frustration may have derived from over ambitious expectations about the extent of their influence and an underestimation of the complexity of the task.

Table 1.2: Achievements of first wave TPPs 1996/97

Service Area	Stated objective	% Achieved
Early discharge	22	64
Community & continuing care	19	53
Maternity services	27	52
Emergency services	32	44
Mental health services	28	39
Developing primary care team	15	87
Information/needs assessment	12	83
Total (including other)	**190**	**54**

The ability of these TPPs to achieve their objectives in their first 'live' year (1996/97) was influenced by key characteristics of the site. First, single practice pilots were able to achieve more than multi-practice pilots. This is probably related to the time required to establish a

workable organisational structure across practices, and suggests that there may be a protracted lead time before PCGs can be shown to have been successful at fulfilling their functions and ambitions.

Second, TPPs holding a budget were more successful than those which enjoyed limited financial autonomy. Interestingly, however, few TPPs used their budget to make significant changes to their contracts or used the contracting process directly to facilitate change. Rather, success seems to have derived more from the legitimacy that budget holding confers on the TPP. Irrespective of whether PCGs use their budget aggressively, the TPP evaluation suggests that simply by assuming financial responsibility the views and wishes of the PCG will be taken seriously.

Finally, achievement was positively related to the level of management allowance provided. This has implications for the appropriate level of funding that should be made available to facilitate PCG working.

PCGs are to receive a management cost envelope of £3 per capita in addition to the current £10 per capita allocated directly to HAs. Analysis of the transactions costs of TPP suggests that PCGs may have difficulties living within this envelope, particularly if contributing parties (GPs, nurses and other professionals) are to be adequately reimbursed for their (management) time devoted to the PCG. Over time as PCGs move to higher levels, the balance of monies between the PCG and HA may change, although this will require a scaling down of HA duties, perhaps facilitated by further HA mergers.

Analysis of both the management costs of TPPs and a detailed assessment of managerial inputs at selected TPPs suggested that the cost of running total purchasing *over and above* fundholding amounts to almost £3 per head (Posnett *et al*, 1998). Removal of the distinction between the fundholding and total purchasing budgets may deliver economies of scope unrealisable under TPP. Economies of scale may be reaped if savings are associated with PCGs taking responsibility for much larger populations than TPP.

There are good theoretical reasons to support the possibility of scale economies. Larger organisations can reduce duplication of functions and savings can be made by spreading the fixed cost elements of primary care involvement in the commissioning process, such as developing the Primary Care Investment Plan, commissioning, data collection and analysis,

and the requirement that there be a Governing Board. These activities and functions suggest that the larger the population served, the lower the administrative cost per capita.

The evaluation of TPP, however, suggests caution should be exercised in accepting the argument for economies of scale. The evaluation demonstrated that some 40% of managerial efforts were expended on issues relating to co-ordination and organisation, and that these efforts increased more than proportionately as the TPPs grew larger and more complex. Much of the reason for this lay in the difficulty of establishing effective means of communication, delegation and involvement. The requirement that PCGs be representative of all practices in the group may impose substantial co-ordination costs on the organisation. This has implications for the design of an optimal organisational structure.

Analysis of the transactions costs of TPPs is of specific relevance to PCGs. The experiences of those involved in the formation and development of TPPs can inform PCGs of the implications of alternative organisational strategies which they will be considering. Particular issues include:

- co-ordination of professionals;
- size of organisations;
- structure of organisations;
- information technology; and
- communication strategies.

These have wider relevance within the NHS whenever organisational arrangements are being considered. These issues, arising from experience with TPPs, raise fundamental questions about the direction that PCGs should take, as follows:

1. Is it wise or necessary to expect or insist on a high level of GP involvement since GPs are an expensive and non-managerial resource?
2. Is the size of 100,000 for PCGs appropriate? They may be too small to be effectively managed and too large for GPs to control.
3. How should PCGs be organised and managed?
4. Are adequate resources being made available to manage and inform PCGs?
5. What mechanisms will PCGs employ to monitor and manage their global budgets?
6. How will PCGs ensure they are representative of all practices and what can they do if some practices do not wish to co-operate?

Before turning to discussion of these issues, an outline of the strengths and weaknesses of the PCGs as perceived by workshop participants is provided.

2 Strengths and Weaknesses of PCGs

During May to June 1998 we held a series of workshops which built on our previous work into the transactions costs associated with total purchasing. The host HA of the TPP which had contributed to the transactions cost study was asked to invite participants to the workshops including representatives from the local TPP and a wider audience of those involved in the local development of PCGs. All but one HA responded to the invitation, and a separate visit was made to the TPP in the HA which did not participate.

The workshop sessions were structured around three vignettes, which presented hypothetical scenarios and encouraged participants to work through the problem presented and arrive at solutions. A spokesperson for each workshop completed a group response sheet and summarised the discussion to the wider audience. Notes were also taken during the workshop by members of the study team acting as observers. Supplementary information was collected using an individual questionnaire completed by all workshop participants.

A total of 81 people attended, including 16 GPs, 6 nurses, 14 practice managers, 30 HA staff, 6 provider staff, and 9 from a variety of backgrounds, such as Community Health Council officers, HA non-executives, dental practitioners and public health physicians.

2.1 Level of PCG Development

Workshop participants were asked in the questionnaire about the level at which their local PCG would start and the level to which they anticipated it would develop. The majority (76%) of participants felt that their PCG would commence at level II, with this being the option favoured almost unanimously by GPs (Table 2.1). This is not surprising given the background of the participants in TPPs and because PCG II is seen as a natural extension of TPP. Twenty four percent of HA staff felt their local PCGs would start at level I, a slightly higher percentage than that of the primary care representatives generally (GPs, nurses and practice staff) where only 15% felt that level I would be the starting point.

Views as to the level their PCG would ultimately achieve were more consistent among those with different professional backgrounds. While a small proportion of respondents felt that level II would be as far as their local PCG would want to go, 73% indicated that level IV was the aim, where the Primary Care Trust is responsible for commissioning most, if not all, services and for the provision of community health services.

Table 2.1: Anticipated level of PCG development

	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	Total
Starting level							
PCG I	1	2	2	7	4	2	**18**
PCG II	14	4	11	22	0	5	**56**
Ultimate level							
PCG II	0	1	1	1	0	0	**3**
PCT III	3	1	2	6	0	3	**15**
PCT IV	10	2	10	18	4	4	**48**

2.2 Strengths

Participants were asked what they considered to be the main advantages of and barriers to working in PCGs. Slightly more barriers (189) than advantages (161) were cited and the comments are summarised in Tables 2.2 and 2.3.

Table 2.2: Main advantages of working in PCGs

Improvements	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	% of all comments
Working together	10	5	5	19	4	2	**28**
Local focus	6	2	2	10	2	5	**17**
Good practice	3	1	4	10	0	7	**16**
Influencing services	6	0	2	12	1	1	**14**
Wider commissioning	6	0	4	1	0	2	**8**
Equity	5	0	3	4	0	0	**7**
Better information	1	2	3	4	0	1	7
Job satisfaction	5	0	0	0	0	1	**4**

The most frequently cited advantage of PCGs was the opportunity they created to establish improved inter-agency and inter-professional working, this theme accounting for 31% of

advantages suggested. PCGs offer the prospect of integrating care which fundholding had not addressed, with the promise of greater co-operation among practices, multi-disciplinary working in primary care teams, improved integration of primary and community care, and, perhaps most innovatively, the development of links with social services. While TPPs had made progress in these areas, it was felt that PCGs would take things further, particularly in view of the greater emphasis given to involvement of nurses, social services, and the public in the arrangements.

Among other advantages, 17% of comments related to the hope that, compared to health authorities, PCGs would allow an improved local focus in the commissioning process because of the greater understanding of the needs of their population. Fourteen percent emphasised the potential of the PCG to improve service provision generally. PCGs would be able to bring influence to bear both at practice level and with other agencies, the collective bargaining power of the PCG and its wider commissioning remit offering the prospect of addressing services and service providers which had not previously been tackled comprehensively by GPs operating as fundholders or TPPs, even though the latter had this opportunity.

It was also felt that PCGs would facilitate the diffusion of good practice within primary care itself, this being mentioned on 16% of occasions. The introduction of clinical governance mechanisms (designed to assure and improve clinical standards at local level throughout the NHS), peer review, an emphasis on common standards of best practice and care protocols to promote consistent referral patterns across practices and cost-effective prescribing were seen as beneficial.

Similarly, budget holding, the ability to commission on a larger scale and the integration of commissioning and referral decisions were cited as important strengths. GPs and practice staff, in particular, saw benefits in assuming greater financial accountability and responsibility.

Among other comments, it was noted that service provision would be augmented by the PCG's involvement in developing the Health Improvement Programme and the opportunity to engage in the planning processes. The prospect of more equitable provision for the PCG's population was foreseen both through the allocation of resources to the PCG and improved standards of care. It was also felt that the PCG would encourage professionals to take an holistic view of health, rather than focusing merely on health services, and that perceived inequalities, particularly between fundholding and non-fundholding practices, would be

reduced. GPs also recognised that the challenging nature of working in PCGs might enhance their job satisfaction.

2.3 Weaknesses

Interestingly, while the majority of positive comment was to the affect that PCGs would facilitate improved working relationships, the requirement that practices co-operate was also seen as the main barrier to effective working, accounting for 31% of comments (Table 2.3). The responses suggest a willingness to engage in multi-disciplinary working and to build relationships and links which extend beyond traditional service boundaries, but that this enthusiasm is tempered by a recognition that many GPs (in particular) will be reluctant to engage in the process and that reaching consensus among practices used to operating independently may prove a major obstacle to effective working. While it was anticipated that there would be problems getting uninterested practices involved, more serious concerns were expressed about the prospect of managing conflicting opinions. Anxieties were raised about bringing together people with different personalities, cultures and agendas. Distrust and suspicion were recurring themes.

Table 2.3: Main barriers to effective working in PCGs

Barriers	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	% of all comments
Enforced co-operation	13	3	10	24	3	6	**31**
Time inputs	6	3	7	17	2	4	**21**
Size	6	1	7	5	2	1	**12**
Budget setting	7	0	4	8	0	1	**11**
Unclear roles	5	2	1	10	1	1	**11**
Timescale	2	1	1	2	0	2	**4**
IT support	2	0	1	2	0	3	**4**
Unclear incentives	1	1	2	2	0	2	**4**
Free riders	3	1	1	0	0	0	**3**

After comments about enforced working relationships, the next major anxiety related to the time inputs required and fears that the management allowance would be insufficient to cover administrative duties. In addition to recognising that many GPs do not wish to undertake

greater managerial duties, there was concern about the trade-off between providing administrative support and clinical duties, and the possibility that patient care and choice might be compromised as a result of the increased administrative burden.

The size and composition of the PCG was cited as a barrier in 12% of instances, particularly the difficulties associated with obtaining consensus from a large number of GPs and other representatives and of establishing effective communication networks and decision making processes.

A similar number of comments was made about the PCG budget, including the importance of establishing an equitable allocation to the PCG, and problems of setting indicative budgets at practice level without which it would be difficult to ensure 'ownership' and budgetary responsibility. The importance of having a 'fair budget' was a consistent theme as was the necessity of starting with a clean financial slate (ie not inheriting overspends). Related to this, concerns were raised about the problem of over-spending practices within the PCG or those not contributing being supported by their colleagues.

Other issues were more a reflection of the stage of policy development, there being a sense that the timescale adopted for the introduction of PCGs was over-hasty, and that insufficient guidance had been provided on organisational structure, and the roles and responsibilities of those involved. It was also noted that the incentives to participate were less clear than they have been for previous primary care commissioning models, but that GPs will have to co-operate if they wish to preserve the advantages and influence gained under fundholding and total purchasing.

3 Organisational Structure

3.1 The Issues

Primary Care Groups are to be collective organisations with a common (shared) budget. Little has been stipulated about the way PCGs will be structured, other than that they are to be administered by a Governing Board (Table 3.1). The composition of the Governing Board generated considerable discussion immediately following release of the White Paper, particularly as issues of 'ownership' and professional mix remained unclear. Subsequent guidance places GPs firmly in the driving seat, with the options of majority representation (they can choose to fill between 4 and 7 seats) and first refusal on the chair (Milburn 1998). While the nursing role was originally heralded by nurses as a timely recognition of the contribution of the nursing profession in primary care, initial enthusiasm has been dampened by the advice that there are to be only 1 or 2 nurses on the Governing Board. The four remaining seats are to be taken by a social services nominee, a lay member, a HA non-executive and a PCG chief executive, although the board has the power to co-opt other members as it feels appropriate.

Table 3.1: Composition of PCG Governing Board

4-7 GPs	• GPs have the right (but not the obligation) to be in the majority and to decide whether to have a GP chairperson. All GPs within the PCG are expected to vote on the election to the Board.
1-2 nurses	• Nursing members can be drawn from practice and community nursing, midwifery or health visiting, but are not intended to reflect professional groups. Representation may be determined either through a ballot or interview process.
1 social services member	• In most cases, the social services representative is expected to be an operational manager appointed by social services.
1 lay member	• The lay member is to be appointed by the HA, probably following advertisement.
1 HA non-executive	• Appointed by the HA.
1 PCG chief executive	• Probably appointed subsequent to formation of the Board.
Co-opted members	

Source: Milburn (1998)

Initially the collective nature of the organisation will be evident in the commissioning process and in managing a common prescribing budget although in due course, when legislation allows their formation, Primary Care Trusts will also co-operate in organising local services, particularly community care.

Mandatory collective working is a new approach to developing primary care in the NHS. Previously GPs, as independent contractors, have only worked together and with other primary care professionals on a voluntary basis, whether at practice level or in larger commissioning bodies. Crucial to the success of PCGs will be their ability to communicate a common vision throughout the organisation such that members of the PCG have a commitment to its objectives and contribute to their achievement.

Successful working is likely to be observed where practices in the PCG make an active contribution to its strategic and operational decision-making. However, substantial involvement in these processes may be prohibitive because of the time commitments entailed, implying that participation will have to balanced by delegation of responsibility. Organisational arrangements will develop according to local circumstances, but three possible models of organisation are as follows:

1. A **voluntary** model in which representatives from all practices take an active role in the strategic and operational activities of the PCG.

2. A **representative** model in which practices form working arrangements below the PCG level, possibly based around localities, to pursue operational activities.

3. A **managerial** model, in which all responsibility for decision-making is delegated to a core management team of the PCG, with paid professionals, including one or more GPs, appointed to undertake organisational and commissioning functions.

The TPP evaluation revealed that no standard organisational model was adopted across all TPPs but that there were characteristics of the TPP which influenced the model chosen (Mays *et al* 1997). Voluntary participation was more common in smaller groups, particularly where the TPP comprised a single practice. This form of working was generally less sustainable in larger groups for a number of reasons. For example, logistical problems arose in co-ordinating efforts and finding the time to hold meetings. Also the more GPs involved, the more complicated communication became, making it hard to establish common agendas and to implement decisions. Some TPPs had to establish feedback mechanisms, such as newsletters, rather than relying on less formal methods, such as reporting back at practice meetings. The result was that larger TPPs generally vested decision-making in a core team of GPs and managers, with the majority of GPs adopting relatively passive roles.

PCGs are to be larger and, consequently, more complex organisations than TPPs. Nevertheless many of the methods developed to facilitate effective working in TPPs have

direct applicability to PCGs and the following workshop vignette was devised to draw out these lessons.

Vignette 1 Organisation

You are a member of a practice which will be part of a PCG involving ten practices and around 50 GPs. One of the important functions of a PCG, even at level 1, will be to provide a primary care input into the commissioning of community, secondary and tertiary care. It is expected that this will involve a direct input from GPs.

A practice meeting has been called to consider the level of involvement of your practice in the commissioning process. There are three main options:

A. Your practice agrees that some or all of your GPs will take an active part in the commissioning role of the PCG. This will probably involve regular meetings to discuss service specifications, indicative volumes of activity, costs and choice of provider for one or more specialties and monitoring performance.

B. Your practice decides to work together with a group of other practices in your immediate area and nominates one or more GPs from the group to provide an input to the commissioning function of the PCG.

C. Your practice decides to have no direct involvement in the commissioning role of the PCG and agrees to accept the arrangements negotiated by the PCG on your behalf.

On the basis of your knowledge of your partners and other practices in the area which option do you think will be chosen and what do you think will be the main reasons for this choice?

3.2 Workshop Discussion

The general consensus emerging from the workshops was that the representative model (option B) was the most realistic, although participants felt that a voluntary arrangement (option A) was the ideal but prohibitive because of the resource implications. The key points relating to each model arising from the workshop discussions are summarised in Table 3.1.

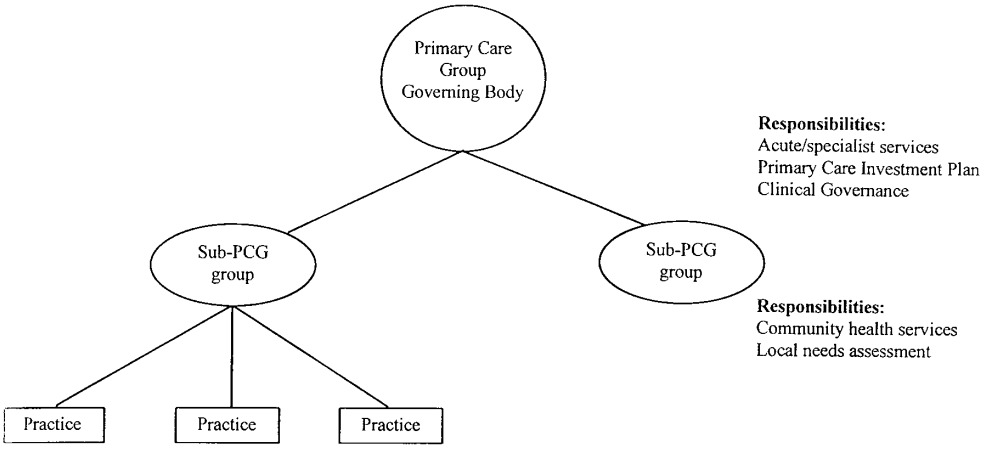
Table 3.1 Summarised comments about organisational arrangements

Model	Key Points
A: Voluntary	Generally perceived as the ideal organisational form, but prohibitive because of resource implications. Likely to be a transitional arrangement, while organisational structures are developed and the model of delegation determined.
B: Representative	Most realistic scenario. PCGs would be hierarchically split, with groups forming at sub-PCG level, either on a geographical basis or around specific service areas. Strikes a balance between the greater opportunity to effect change by working in a larger organisation with the local focus achieved through sub-group working thereby allowing a relatively large PCG to operate effectively at a local level. Relies on nominated enthusiasts to advance the aims of the PCG.
C: Managerial	Felt to be the least risky option, but also outside the spirit of PCG and allows 'free riders'. More likely to be favoured by smaller practices and those non-fundholding practices which are not interested in the commissioning process.

The representative form of working (model B) was particularly favoured because it struck a balance between size and local knowledge. It has been recognised that while PCGs may be large enough for GPs to facilitate strategic developments and influence services, they are "too large to reflect local communities in any meaningful way" (Marks and Hunter 1998). Sub-group working was seen as a means to overcome this deficiency. Locality based groups within PCGs would allow specific problems to be addressed and facilitate a bottom-up approach to decision-making, which better identifies local needs and priorities.

Such working arrangements are reflected in Figure 3.1. At the PCG level, the Governing Board would have overall responsibility for the PCG, including the Primary Care Investment Plan and clinical governance arrangements. This would also be the appropriate level at which to organise the commissioning of acute and specialist services on behalf of all practices in the group. Below this level, sub-groups could focus on local priorities and, perhaps, the commissioning (or provision) of community health services (Mays and Dixon 1996).

Figure 3.1: Model B Organisational Structure



The workshop consensus was confirmed by responses from the questionnaires, which showed that more than 70% of respondents felt that model B was the most likely option (Table 3.2). Agreement was most obvious among GPs, all but one of whom selected model B. HA managers and practice managers tended to be slightly more disposed to the voluntary model. No participant felt that the managerial model would be chosen.

Table 3.2: How do you expect your PCG to be organised?

Professional background	A: Voluntary model	B: Representative model	C: Managerial model
GPs	1	14	0
Nurses	2	3	0
Practice management	6	3	0
HA management	10	17	0
Other	1	12	0
Total	**20**	**49**	**0**

A number of additional points about organisational arrangements were raised during the workshops.

- *Timescale.* In the first instance, the PCG is likely to draw on the views of as many members as possible: until the model of delegation is decided, most GPs will want to be involved along with other professionals. Effective joint working and delegation requires time for participants to establish mutual respect and trust, a process likely to take longer in an environment in which independence has traditionally been the norm. This suggests that while the PCG is being established, and certainly prior to the appointment of a chief executive, a loose organisational structure most closely resembling the voluntary model will suffice. As the business of the PCG shifts its focus from determining internal working arrangements to addressing its core commissioning responsibilities, the organisation will evolve a representative structure.

- *Practice characteristics.* It was generally felt that PCGs would opt for a managerial model if they comprised a high proportion of non-fundholders, suggesting limited commissioning experience or interest, and of small, particularly single-handed, practices, which would be unable to deal with the managerial workload and time lost to clinical care implied by the alternative models. It was generally recognised that larger practices would find it easier to be actively involved, leading to fears that they could dominate the process, and that the views of smaller practices would not be heard.

- *Locums.* Participants were unanimous in believing that administrative support should be adequately compensated for, particularly for GPs, given their independent contractor status and need to employ locums. Drawing on their TPP experience, finding locum cover was cited as a problem in a number of workshops, and locums were also considered as a poor substitute for GP time because of the disruption to patient contact and because paperwork was left untouched. However, unlike in TPPs, this was an issue where the greater size of the PCG could be advantageous. At one workshop, it was suggested that the PCG management allowance could be used to employ a pool of salaried GPs to provide regular cover. This option was not sustainable for the smaller number of practices grouped under a TPP.

- *Unnatural alliances.* Much of the debate, particularly at local level, immediately following release of the White Paper focused on the geographical configuration of PCGs, and arrangements to satisfy the requirement that PCGs cover populations of around 100,000 and/or 'natural communities'. In some instances strict adherence to the guidance may have forced groups of practices into uncomfortable alliances, for

example, where a PCG covers two or three towns. Internal differences will probably be resolved by creating separate locality based sub-groups. It is hoped that benefits of working within a larger organisation, such as when it comes to dealing with acute services or re-configurations, will become evident over time as those involved grow familiar with each other and witness the advantages of acting co-operatively.

4 Financial Accountability

4.1 The Issues

PCGs are to receive their population's fair share of resources for hospital and community health services, prescribing and the cash limited component (practice infrastructure) of General Medical Services expenditure. The PCG will be required to manage this in the form of a global budget, allowing shifts in expenditure across traditionally separate service areas. It is probable that there will be indicative budgets for each practice.

Further devolution of the management of financial resources to PCGs continues the trend introduced by fundholding of encouraging GPs to consider both clinical and budgetary implications in their prescribing and referral behaviour. Budgetary delegation has been shown to be associated with greater achievement by TPPs, which gives further support to the moves in this direction (Mays *et al* 1998).

If PCGs are to work effectively it is essential that they are able to operate within the resources at their disposal. As in any organisation, achieving this is a major challenge and requires a balance of rewards and penalties. Health authorities have found it difficult to manage activity and their global budgets, in part because they are a step removed from the GPs who make many of the decisions which determine the pattern of service provision. It is hoped that PCGs will be in a better position to operate within a global budget by virtue of involving GPs in the management structure.

However, with a comprehensive budget set at PCG level GPs may face restrictions on their referral and prescribing behaviour in order to meet the constraints of this global budget. Nevertheless, the government has given assurances that this will not be the case:

> ***Patients will continue to be guaranteed the drugs, investigations and the treatments they need.*** *If a primary care group overspends, the overspend will be managed within the funds made available to health authorities generally and to the NHS more widely, much as health authority overspends are handled now. There is no question of anyone being denied the drugs they need because a GP runs out of cash. GPs' participation within a PCG, or membership of a PCG board will not affect their ability to fulfil their terms of service obligation always to prescribe and refer in the best interests of their patients.* ***I can guarantee that the freedom to refer and prescribe remains unchanged.*** (Milburn 1998).

One of the central concerns running through the White Paper and subsequent documents is the variability in access to and use of services throughout the country (Department of Health 1997; 1998). This is being addressed at all levels of the NHS, with the National Institute for Clinical Excellence providing overall guidance about effective and cost-effective practices, Health Authorities being monitored according to their performance in reducing variations, and Trusts and PCGs having to introduce clinical governance mechanisms.

Clearly, if referral and prescribing variations impact negatively on the budget, the PCG is expected to act. Alignment of clinical and financial accountability and the desire to reduce treatment variations does not square easily with Department of Health's assurances that the freedom to refer and prescribe remains unchanged.

The get-out clause from the Department's perspective is that the Milburn (1998) letter states that "patients will continue to be guaranteed the drugs, investigations and the treatments they *need*" [emphasis added]. It is the definition of need that is open to interpretation and allows GPs to question their colleagues' behaviour: thus it can be interpreted that the freedom to refer and prescribe remains so long as it is justifiable.

In general, GPs appear to be under no illusion that limits are to be placed on their clinical freedom and that the 'best interests of patients' should be defined as the overall interests of the broader population for which the PCG is responsible, rather than merely the patient in the consulting room. Among the challenges facing those working in PCGs is their ability to manage a global budget and, in particular, what mechanisms they should employ to rectify the situation when over-spending is likely. These issues were explored in the context of the following vignette.

Vignette 2 Budgets

Your PCG reviews its financial position each month. In each of the first three months there were signs of overspending and all practices agreed to make efforts to come back into line with their indicative budgets. At the half year end (reported in mid-October) the review shows that spending by the PCG is 2% above budget. Further analysis shows that 8 of the 16 practices are now 4% over their indicative budgets and the other 8 are in line with theirs.

The PCG has to meet its budget by the year end. (There are no cash reserves. No more money can be borrowed. The HA is under pressure as most of its PCGs are threatening to overspend). The PCG, therefore, has to recover the overspend of the first half by spending 2% below budget in the second half - which effectively means trimming the first half rate of spend by 4%.

What action should the PCG take?

1. Should the over-spenders be responsible for making all the second half savings, or should everyone make savings on an equal basis?
2. How should the PCG control the spending of the practices and their individual PCGs?
3. In what areas should the PCG require savings to be made, and what guidance should it give about how to make savings?
4. What additional action should be taken if the third quarter results show insufficient improvements?
5. What improvements should be made for the future to avoid this happening again?

4.2 Workshop Discussion

In all workshop sessions on this topic, consideration of budgetary problems commenced with a discussion of the budget setting process and the activity data. One of the key factors emphasised by participants was that the budget setting process must be perceived as fair, both for the PCG as a whole and in determining indicative budgets at practice level. If this was not so, participants foresaw difficulties in adhering to their budgets.

It is clear that there are concerns both about the accuracy of Health Service data and the interpretations that might be applied to them. It was generally felt that substantial efforts would have to be made in improving information systems in primary care, and it is hoped that current deficiencies will be addressed in the forthcoming Information Management and Technology strategy for the NHS.

Participants were conscious that interpretation of data, particularly at practice level, must take account of the possibility that observed variation among practices arises not because of

differences in behaviour but are purely random. Even if systematic variations were observed, participants were concerned that over-spending practices should have the opportunity to justify differential expenditure, which might reflect needs of their practice population not adequately accounted for in the formula used to devise indicative budgets.

Generally it was felt that if there was evidence of over-spending by particular practices then the problem would have to be resolved collectively by the PCG because it would be counter-productive to expect these practices to accept full responsibility for making savings. The only realistic way to ensure that individual practices take account of the broader objectives of the PCG is for practices to perceive that working within the PCG is to their advantage. If the PCG starts imposing sanctions and controls on practices, co-operation is unlikely to be forthcoming, particularly if practices are opposed to the idea of a PCG in the first place. Coercion is not really an option while GPs are not directly employed by the PCG, and PCGs will have to develop powers of persuasion other than withholding income or dismissal. These will have to be balanced against a concern that GPs themselves might come to be seen as acting to protect their budgets rather than on behalf of their patients.

Among suggested mechanisms, clinical protocols, referral guidelines and peer review were frequently mentioned. Although it was clear that there might be some discomfort about GPs being expected to question the clinical practice of their colleagues, the development of clinical standards in primary care was often mentioned as one of the advantages of working in PCGs (Table 2.1). These strategies, and 'clinical governance' generally, are unlikely to develop quickly. For example, clinical governance appears demanding as it "includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care" (Department of Health 1997). However, it was felt that the longer term planning horizon facilitated by the introduction of three year agreements might allow greater time for their development as well as providing more flexibility in controlling year on year expenditure.

There was a general failure to face up to the fact that the money might run out, and action might need to be taken to deal with the situation. If there is no commitment to living within budget, there may well be significant overspending. This possibility is more likely given the government's advice that over-spending will be handled by the health authority (Milburn 1998). Unless PCGs are prepared to take the budget seriously, health authorities may be

forced to hold back substantial reserves, penalising all their local PCGs. Further tensions may arise where central advice on treatments conflicts with the resources available to the PCG.

5 Free Riders

5.1 The Issue

Although it is mandatory to be part of a PCG, crucial to their success in improving services for the local population will be a perception that working as part of a larger organisation will deliver greater benefits than can be achieved through isolated practice-based working. Without this belief there will be no incentive for staff to participate actively in the scheme, particularly as there appear to be no direct financial incentives.

However, the perceived advantages of joint working are insufficient to guarantee that these benefits will be realised. The problem is that many improvements accrue to the PCG population as a whole, rather than merely to the patients from practices which have devoted time and energy to securing them. The incentive to provide managerial input into running the PCG is diluted by the diffusion of benefits accruing to the wider community, rather than in proportion to effort. Much of the success of the PCG, therefore, will rely on good will and the confidence that a significant number of practices are contributing.

The enthusiasts may be willing to increase their managerial contributions to compensate for practices which are unable or unwilling to participate actively, but it is questionable how much they would be prepared to do this or for how long. Ultimately, all practices might reduce or withdraw their co-operation if they felt sufficient of their colleagues were not pulling their weight. In such cases, even where all practices recognise the potential benefits of collaboration, if individual parties are unable to ensure that their colleagues are contributing, the benefits will not be realised.

Issues relating to 'free riding' - whereby practices do not actively participate yet are not excluded from sharing the benefits of their colleagues' efforts - were explored using a vignette which cast a single-handed practice as the non-cooperative party in a PCG. The vignette is reproduced below.

Vignette 3 Mavericks

You are on the Governing Board of a Primary Care Group responsible for a population of 100,000 and comprising 15 practices. One of these practices, which is single-handed, has no representation on the Governing Board and has declined overtures to join clinical subgroups or take on any managerial responsibility on behalf of the PCG. A review of activity data indicates that this practice has consistently higher referral and prescribing rates than other practices in the PCG.

1. What strategies would you employ to encourage this practice to consider the wider interests of the PCG in making clinical decisions?
2. The members of the PCG have decided that a proportion of savings should be invested in practice development. Should these be made available to all practices irrespective of their input into the PCG? On what basis should money be allocated?

5.2 Workshop Discussion

Generally, the outcome of the workshop can best be described as a sequential approach to addressing the problem of 'maverick' behaviour. This sequence is summarised in Table 5.1.

Table 5.1: Facilitating participation

Stage	Approach
1	Determine whether the problem is significant enough to merit attention
2	Check that data are accurate and variations cannot be justified by other factors
3	Consider means by which the PCG can support the practice in enhancing its involvement in the PCG
4	Challenge practice behaviour using 'clinical governance', protocols, peer review
5	Restrict access to practice development funds generated from PCG savings
6	Consider punitive measures

The first action taken by the Governing Body would be to determine whether the problem is of sufficient import to merit attention. Many participants advocated ignoring the problem. If the maverick practice has a small list size the overall impact on the position of the PCG will be minimal and time spent solving the problem will divert attention from more pressing

issues. This was felt to be an acceptable strategy when only one practice was involved, but could not be sustained if the PCG contained a number of 'mavericks'.

If it was decided that the 'problem' deserved attention, participants then addressed the quality of the data. Before accepting that there is a problem, it must be first established that the higher referral and prescribing rates are neither a reflection of inaccurate data nor explained by other factors, such as higher needs of the practice's patients.

Once assured of the veracity of the information, participants generally felt that punitive measures would not be appropriate, at least not until other approaches had been exhausted. Many workshop participants emphasised the need to understand the reasons for the practice's non-involvement and higher rates of activity. It was recognised that single practices do not have the capacity to devote time to meetings, and that the PCG might consider making resources available to such practices if this was a barrier.

Punitive measures would only be introduced as a last resort. After all, as one participant remarked:

> *If a practice wants nothing to do with the PCG it's difficult to know what to do. Their contract cannot be withdrawn as they're independent.*

Instead, more persuasive strategies would be employed, which might involve peer review or access to the practice development funds. This latter opportunity is considered the main incentive for GPs to participate in PCGs:

> *For the GP, Primary Care Groups will provide an opportunity to secure new resources for the practice, the primary health care team and for primary care in general. These could be used to establish additional services in the practice, new services in the area and professional development opportunities. On top of this, PCGs will have the opportunity to help the GP directly, by organising systematic support and cover for the practice, through educational schemes, locum registers, and prescribing advice* (Milburn 1998).

By vesting the PCG with power to determine the use of additional resources and savings, the Governing Body at least has a few potential 'carrots' with which to encourage practices to participate. A number of suggestions were made as to how such funds should be allocated.

Few participants felt that access to development resources should be determined solely on the basis of administrative contribution or ability to keep within the practice's indicative budget. It was felt that administrative time should be compensated from the management allowance, but that savings arising from specific projects - such as encouraging more efficient prescribing for peptic ulcers - might be allocated according to criteria established at the project's outset.

While such strategies reward good performance, the PCG has a responsibility to all patients in the group and it will be important to ensure that poor performing practices do not get left behind. The problem will be in determining a strategy to support improvement which is not seen as a reward for underachievement. One set of workshop participants suggested conditional funding. For example, if the GP had cited lack of support as a problem, the PCG might formally employ practice staff and make them available to the 'maverick' practice, and if behaviour did not improve, the staff would be withdrawn and offered to another practice.

The question of financial incentives and penalties was explored further in the questionnaire. Overall, 60% of respondents felt that financial incentives or penalties should be used to differentiate between practices making an active contribution to the PCG (Table 5.2). Interestingly, those working in primary care were more likely to favour discriminating between practices than were health authority staff, where views were evenly split. Where discrimination was considered appropriate, most felt that incentives rather than penalties should be employed. Penalties were considered de-motivating, fail to engender corporate identity and co-operation, and, ultimately, may impact negatively on patient care.

Table 5.2: Should financial incentives/penalties differentiate between contributing practices?

	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	Total
No	6	2	4	14	1	2	**29**
Yes	9	4	9	13	2	6	**43**

In practice, active participation in running the PCG is likely to be concentrated among a few individuals or practices, whose enthusiasm brings the others along. However, the willingness of practices to take this leadership role may depend on the extent to which their colleagues

share the burden. This was explored further in the questionnaire in which two questions were asked:

1. Do you think a majority of practices in your area will be willing to give time to the PCG?
2. What would be the attitude of your practice if other practices were not willing to make any contribution to the work involved?

Responses are summarised in Tables 5.3 and 5.4. Seventy-six percent of respondents indicated that, while they felt that a majority of practices would actively participate, they would have to be fully compensated for doing so. GPs, in particular, felt that time inputs must be fully compensated. This is in marked contrast to the experience of TPPs where leadership depended on a few people who endured heavy workloads for which they did not necessarily receive full financial recompense (Posnett *et al* 1998).

Table 5.3: Do you think a majority of practices in your area will be willing to give time to the PCG?

	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	Total
If fully compensated	15	1	11	20	4	6	**57**
Even if only partially compensated	1	5	0	6	0	2	**14**
No	0	0	3	4	0	0	**4**

In terms of their response to non-involvement of neighbouring practices, 70% of participants altruistically suggested that the decision of other practices not to contribute to the administrative workload would not change the extent of their involvement. However, 18% felt that they would make reduced efforts, with only 12% willing to increase their input to cover the work.

Table 5.4: What would be the attitude of your practice if other practices were not willing to make any contribution to the work involved? [1]

	GPs	Nurses	Practice staff	HA staff	Provider staff	Other	Total
Maintain involvement	7	6	10	15	1	7	**46**
Reduce involvement	4	0	2	5	0	1	**12**
Increase involvement	4	0	2	1	1	0	**8**

[1] Participants who did not belong to a practice were asked to base their answers on the practice(s) with which they were most familiar.

6 Key Concerns

As a final question, participants were asked if they had any particular message about Primary Care Groups they would like to convey to the NHS Executive. Broadly, three key areas of concern were apparent.

First, around a quarter of participants were anxious about the *timescale* adopted for change. It was felt that PCGs would be climbing a steep learning curve, and that all professions would require time to develop into their new roles, particularly those with limited previous commissioning responsibilities. It was considered important to recognise that hasty implementation may come at the expense of long term gains, and that further guidance and consultation would be welcomed.

Second, a similar proportion felt that the PCG model would be more *costly* to manage than the health authority and fundholding mix it replaced. It would be important to ensure that adequate management funds be made available. However, offsetting these costs, many felt that the *benefits* of this form of organisation would justify the additional expense.

Finally, there is a substantial concern that the *information technology* to support PCGs is currently inadequate. Significant investment is required to improve the activity and cost data available to primary care, and development of IT systems and information sets should be undertaken at national, rather than local, level.

7 Conclusions

While it is clear that there are considerable challenges to establishing PCGs, there is also a belief that this form of organisation will be beneficial, both to healthcare professionals and to patients. It is important that existing enthusiasm and energy is not dissipated by forcing a tight timetable for implementation.

The TPP evaluation revealed that organisational arrangements were key to the success of the pilots. PCGs are to be larger and more complex than were TPPs, and PCGs face additional challenges in developing corporate identity and common vision. There is a danger that the promise of an enhanced local focus for commissioning will not be realised because of their size: a balance must be struck between their being "large enough to cope and small enough to care" (Butcher 1998). It was generally felt that problems with managing an organisation covering populations of 100,000 or more would be resolved by developing a hierarchical model involving sub-groups within the PCG.

The budget-setting process is likely to prove important to how well PCGs function, and budgets will have to be perceived to be fair in order to engender financial responsibility for referral and prescribing behaviour. Much time was spent negotiating budget allocations between health authorities and TPPs, and the prospect of central guidance on resource allocation may allow less time to be spent on local discussion of this issue by PCGs.

There was a general failure to face up to the fact that the money might run out and that action might need to be taken to deal with the situation. Moreover, the Department of Health is unwilling to place restrictions on GP's freedom to refer and prescribe (Milburn 1998). In the absence of fiscal responsibility and limits on GP behaviour it is difficult to see how the government's desire to reduce variations in treatment and prescribing practice will be achieved.

There is always a danger that reliance on co-operative working will be undermined by those who do not actively participate. It was felt strongly that such people would be brought on board by encouragement rather than by coercion.

The overall outcome from the workshops is best summed up by the participants' own key messages for ensuring the success of PCGs:

1. It will take time to achieve success;
2. It will take resources to manage successfully;
3. First class information technology is essential.

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INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF SOUTHAMPTON 129 University Road, Highfield, Southampton, SO17 1BJ T: 01703 593176 F: 01703 593177 ***Lead:*** Ray Robinson ***Other members:*** Judy Robison, David Evans	***Project Responsibilities:*** Dorset, Romsey, Trowbridge Bath & Frome, Winchester, Bexhill, East Grinstead, Epsom, Kingston & Richmond, Merton Sutton & Wandsworth, West Byfleet. ***Other Main Responsibilities:*** Contracting methods (Robinson, Raftery, HSMC and Robison; case studies (Evans).
HEALTH ECONOMICS FACILITY, HSMC, UNIVERSITY OF BIRMINGHAM 40 Edgbaston Park Road, Birmingham, B15 2RT T: 0121 414 6215 F: 0121 414 7051 ***Lead*** James Raftery ***Other member:*** Hugh McLeod	***Main Responsibilities:*** Activity changes in in-patient services; contracting methods (with Robinson and Robison, IHPS); service costs and purchaser efficiency (with Le Grand).
HEALTH SERVICES RESEARCH UNIT, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE Keppel Street, London, WC1E 7HT T: 0171 927 2231 F: 0171 580 8183 ***Lead:*** Colin Sanderson with Jennifer Dixon, Nicholas Mays and Jo-Ann Mulligan (King's Fund), James Raftery (HSMC) ***Other member:*** Peter Walls	***Main Responsibility*** A&E services and emergency admissions.
LSE HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE Houghton Street, London, WC2A 2AE T: 0171 955 7540 F: 0171 955 6803 ***Lead:*** Gwyn Bevan	***Main Responsibilities:*** Resource allocation methods.

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