Editorials

Implementing practice based commissioning

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Is happening slowly but not necessarily surely

In its recent report, the Audit Commission described the current state of implementation of practice based commissioning.**1** The commission defined such commissioning as a way of managing financial risk as well as a means of improving services and use of resources. Under practice based commissioning, primary care trusts devolve indicative budgets to practices (practices do not receive the actual money, but operate within an agreed budget held and administered by the primary care trust) to give them financial incentives to manage referrals, and to commission and redesign services to make them more convenient, appropriate, and cost effective.

Practice based commissioning has been a central part of the government's current reforms of the National Health Service (NHS) since April 2005, when interested practices were first entitled to an indicative budget. Any assessment of progress must therefore be of interest in assessing the fate of government health policy overall.

The Audit Commission studied the second year of practice based commissioning (2006-7) in 16 primary care trusts. The study was based on semi-structured interviews with trust staff, selected general practitioners, and selected practice managers, combined with a survey of local general practitioners (20% response rate, unfortunately) and information from local audits of primary care trusts and NHS trusts. The study aimed to determine whether the financial incentive of devolving budgets to general practitioners had enabled primary care trusts to manage their financial resources better.

The report suggests that only modest progress has been made in implementing practice based commissioning. On the positive side, general practices had a better understanding of the financial consequences of their decisions and engaged more in managing their patients' use of secondary care (demand management). However, these achievements cost £98m (€137m; $203m) in payments to general practitioners to participate in practice based commissioning in 2006-7 (and this ignores the opportunity costs of staff time within primary care trusts).

Moreover, the Audit Commission identified a longer list of areas where progress had been slow or problematic and where more development was needed. Genuine engagement of general practitioners in practice based commissioning was not yet widespread, and the incentives to engage were not strong enough. Many primary care trusts had been unwilling to relinquish their control over commissioning priorities and needed to improve their support for practice based commissioning, particularly in relation to providing information and setting budgets. Service redesign and the transfer of care from secondary to primary care, though widely discussed, had progressed only modestly.

Perhaps most tellingly, many practices saw practice based commissioning more as a way to fund an increase in their provision of new services than as a means to commission health care from others or manage financial risk. The ability of practice based commissioners to commission services from themselves requires robust governance arrangements that have yet to be tested fully in practice.

The commission's findings are consistent with our ongoing research. The inadequacy of support for practice based commissioners by primary care trusts—at least in the minds of general practitioners—was also identified in a recent national survey of practice based commissioning carried out in a sample of general practitioners by the Department of Health.[2]

The similarities with research done in the 1990s into general practitioner fundholding and its extension—the "total purchasing pilots"—are striking. And, although practice based commissioning is not the same as general practitioner fundholding, as the Audit Commission makes plain, it shares several characteristics.[3] It is most similar to total purchasing pilots which, like practice based commissioning, involved collaboration between a statutory commissioning organisation (then the health authorities) and a group of general practitioner fundholders, with the statutory body having the ultimate financial responsibility.[4]

The advance of general practitioner fundholding and total purchasing pilots in the internal NHS market of the 1990s was checked by several factors that are familiar today—weak engagement of ordinary general practitioners not in leadership positions, insufficient management support from health authorities, and a lack of timely and accurate information on which to base budgets and commissioning decisions.[5]

However, these two initiatives did lower the use of hospital services where this was their priority, despite these hurdles.[4 5] Does this mean that, in time, practice based commissioning will be similarly successful? Not necessarily. General practitioner fundholding and total purchasing pilots had greater autonomy from the health authorities; these initiatives also had complete freedom to choose the practices they wished to work with and enjoyed stronger financial incentives than practice based commissioning. This lack of clear incentives and freedom to act may impede the progress of practice based commissioning.[6 7]

So, is practice based commissioning the sick man of the NHS reforms? This would be too harsh a judgment. As the Audit Commission points out, their study took place during only the second full year of implementation. This may partly account for the modest progress made. Moreover, primary care trusts are putting the rigours of reconfiguration behind them and are about to enter a development phase intended to deliver "world class commissioning."[8] If successful, the capacity of trusts to support practice based commissioning should improve. Surveys suggest that general practitioners support the idea of practice based commissioning, even if their practical engagement to date remains limited.[2 9]

Nevertheless, practice based commissioning was first mentioned as an aspiration by the incoming Labour government in its first major policy document in 1997,**10** and the first dedicated guidance emerged as far back as 2004.**11** Against this timescale, progress can only be regarded as slow.

Footnotes

- Competing interests: RQL is a director of Ernst and Young and provides paid consultancy to NHS organisations and the Department of Health. NM is scientific coordinator of the Department of Health funded Health Reform Evaluation Programme, 2006-10.

- Provenance and peer review: Commissioned based on an idea from the author; not externally peer reviewed.

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Back to top