

The NHS revolution: health care in the market place

Practice based commissioning: applying the research evidence

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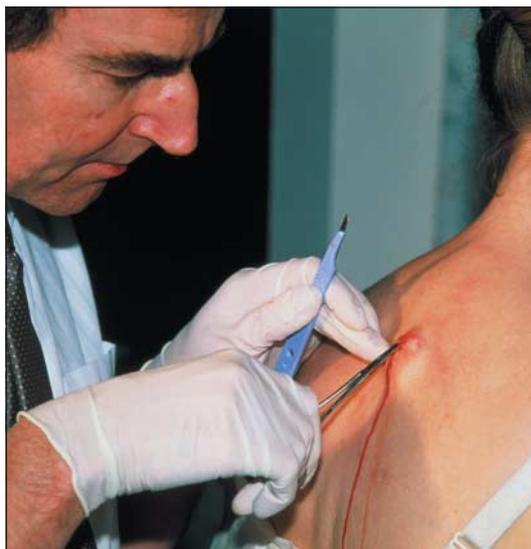
General practitioners are being asked to retake responsibility for commissioning healthcare services. What can we learn from previous experience?

The English NHS is unusual in its continuing faith in primary care based organisations to carry out effective purchasing of healthcare services. The latest incarnation of this approach is to encourage all general practices to be responsible for a budget to purchase community health services and secondary care on behalf of their enrolled populations by the end of 2006.^{1 2} The logic is that in doing so, they will act more cost effectively, scrutinising the demand for hospital care and redesigning services across the hospital-community interface. Some evidence supports this logic.³ We assess current policy on purchasing in the light of evidence from research concerning purchasing by primary care organisations in the 1990s and more recent evaluations of primary care groups and trusts and draw out some key messages that may be helpful in its further development.

Commissioning by primary care

Purchasing is typically considered to be a process whereby services are specified upfront on the basis of quality and value for money, with only those who can meet such requirements tendering to provide the service.³ Commissioning is used to describe what is arguably a more sophisticated and strategic process of assessing health needs, developing new services or providers to meet those needs if required, contracting for services, and undertaking a range of strategic efforts to improve population health.⁴ We previously defined primary care led commissioning as "Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients' needs and of the performance of services, together with their experience as agents for their patients and control over resources."³

Commissioning by primary care, and particularly practice based commissioning (which involves clinicians directly) is a response to the limitations of two fundamentally different approaches to determining how healthcare resources are used and what services are provided and to whom. One approach is driven by the interests of individual consumers and competition between healthcare organisations (for example, parts of the US health system) and the other by government in the form of centralised bureaucratic planning (for example, the NHS before the 1990s). Primary care led commissioning offers a middle way between these two extremes, seeking to enable informed general practitioners to improve health services for their patients by directly influencing the content and location of their care.



Will the ability to provide more services be sufficient incentive for general practitioners to take on commissioning?

The commissioning general practitioner (or nurse) has to deal with a perennial tension: on the one hand being the agent for the individual patient and on the other being the guardian of resources for a wider population of patients. For example, a general practitioner holding a budget is likely to scrutinise the appropriateness of a referral for hospital care. Budget holding will necessarily entail potential conflicts of interest between the provider and purchaser role, and thus the NHS will need appropriate regulation to minimise such risks and assure proper stewardship of public resources—for example, to prevent general practitioners preferentially referring patients to providers in which they have a financial stake. General practitioners will also, to a lesser or greater extent, be engaged in strategic decisions, such as ensuring that care between hospital and community services is integrated, and making efforts to improve public health.

Importance of context

Numerous evaluations of commissioning by primary care have sought to explain how the environment in which general practitioner purchasers operate helps or hinders their effectiveness.⁵⁻⁷ Evidence suggests that practice based commissioners will need time, and a degree of stability and continuity of management

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and organisation, if they are to make sustained progress in improving local services.^{3 5 8} New primary care commissioning organisations are inclined to focus internally in their initial stages, and only later develop relationships with secondary care and other providers to influence the local health system.^{7 9} Frequent, imposed structural changes to the wider health system are likely to be particularly detrimental.³ Unfortunately, it seems that primary care trusts are about to be reorganised and may disappear altogether in their current form.¹⁰ Similarly, it took about eight years for general practice fundholding to be taken up by about half of the practices in England, yet current policy calls for 100% coverage of practice based commissioning by December 2006.²

Research evidence from similar schemes in the NHS in the 1990s highlights two key issues in the local environment: the extent to which commissioners can exercise choice between providers and the quality and configuration of primary care provision.³ For commissioning by primary care to flourish, local providers have to believe that there is genuine competition among suppliers and primary care needs to be sufficiently developed to start providing new community based services.

Practice based commissioning is being re-introduced at a time when government policy requires commissioners to offer patients a choice of providers.¹¹ Similarly, the government seems to be seeking to increase the range of providers of both primary and secondary care serving the NHS, and in so doing to stimulate improvements in quality, access, and choice through competition.¹² Thus the policy context seems favourable, and, arguably, more favourable than in the 1990s when fundholding was introduced. On the other hand, new practice based commissioners in the NHS cannot negotiate better prices for services (unlike with fundholding in the 1990s) because the payment by results system rewards hospital activity on the basis of a common national tariff.

Effect of practice based commissioning

Much of the research on previous forms of commissioning by primary care concentrates on issues of process and organisation rather than its effect.³ One of the main reasons for this gap in evidence is the speed with which purchasing arrangements have been changed in the NHS over the past 15 years, thwarting attempts to carry out longer term research on their impact. The evidence suggests that commissioning by primary care has had greatest effect on primary and intermediate care, enabling a wider range of practice based services, community based alternatives to hospital care, and new forms of clinical governance and peer review to be developed.^{3 9}

The evidence of its effect on secondary care services is equivocal. Although general practice fundholding and total purchasing helped to improve the responsiveness of secondary care, for instance, through shorter waiting times for outpatient appointments and elective care,^{5 6 13 14} it had little effect on hospital care provided by specialists.^{3 6 9} This may be

Factors known to facilitate effective commissioning by primary care

- Stability in organisation of health care, especially the structure of commissioning bodies
- Sufficient time to enable clinicians to become engaged, and strategies for commissioning to be developed and implemented
- Policy that supports offering patients and commissioners a choice of providers
- Policy that enables resources to be shifted between providers and services
- A local service configuration that enables commissioners to choose between providers
- A local primary care system that is sufficiently developed to provide additional services
- Incentives that engage general practitioners and practices in seeking to develop new forms of care across the primary-secondary care interface.
- Effective management and information support for practice based commissioners
- Appropriate regulation to minimise conflicts of interest arising from general practitioners being both commissioners and providers

because the overall incentives in the health system were too weak and the political constraints designed to avoid harming hospitals were too strong.⁶ The current incentives are far sharper, in principle, and more likely to bring about change, than those of the 1990s internal market.

Process of practice based commissioning

Plenty of evidence shows the importance of good management and information for effective commissioning by primary care.^{3 5-9} These elements need to be infused into the new practice based model. However, the strongest evidence relates to the importance of engaging clinicians (especially general practitioners) for successful primary care led commissioning; indeed, without engagement, it cannot be said to exist.^{3 6 7 9 15} For such engagement to be real and sustained, the right incentives must be in place to enhance motivation, particularly of practice staff. Practice based models of commissioning are more likely to secure real clinical involvement than primary care trust driven approaches,¹⁵ partly because of smaller scale and greater intimacy of organisation, and partly because general practitioners own practices but not primary care trusts or their equivalent.

The incentives for clinical engagement need to encourage the development of services across primary and secondary care providers—for example, encouraging specialists to work in partnership with primary care providers. It is also important to avoid the potential perverse incentives for competitive behaviour between assertive practice based commissioners and defensive hospital providers, who may feel that their territory is under threat as they did with fundholding.¹⁶ Without these incentives, effective management and good information are not sufficient and necessary change will not occur. More research is

needed on the combinations of incentives that encourage effective commissioning by primary care, and most importantly, their impact on services and patients.

Challenges for the future

Existing research provides us with clear messages about the factors that facilitate effective commissioning by primary care (box). Of these factors, the one that poses the greatest challenge is to create a set of incentives that will engage general practitioners, enable the development of new forms of seamless services for people with long term conditions, and ultimately make a real impact on the wider care system, which previous forms of primary care led commissioning have struggled to achieve.

Recent surveys show that about half of general practitioners are not interested in taking on a commissioning budget.^{17 18} What will motivate them to change their mind? General practitioner fundholding (and other models of primary care commissioning) represented an opportunity for clinicians to assume power and influence previously the preserve of managers, but this power was typically distributed unevenly among doctors.^{15 19} Others have suggested that an important incentive within fundholding and total purchasing was the freedom to produce change and try to improve services, particularly if, in the process, there were benefits for practices themselves.²⁰ Much sharper incentives will now be needed to engage all general practitioners in taking on budgets with the aim of improving services, maybe linking part of their income with the responsibility to manage a budget.

Perhaps the development of the new NHS market will offer the strongest incentive for general practices and nurses to become practice based commissioners. A commissioning budget would allow them to buy services from new providers of primary care and diagnostics offering a wider range of primary care based services. However, this, in turn, raises the possibility that non-NHS providers of primary care should and may increasingly demand to take on a commissioning budget and thus compete equally with NHS general practitioners and nurses. Arguably, these new providers should be able to do just that in a contestable primary care market, particularly as this would reduce the risk of them cost shifting. The response of NHS general practitioners and any new entrants to this new more competitive environment holds the key to understanding the development of effective practice based commissioning in the English NHS.

Contributors and sources: The authors have all been involved in research and development activity related to health commissioning, general practice, and the implementation and impact of primary care organisations for over 10 years. They have contributed extensively to national and international debate about the management of primary care and the use of primary care organisations as the basis for purchasing health services. This paper draws on a review of the research evidence on effective primary care led commissioning that was carried out in 2004 and funded by the Health Foundation. The framework for the article was developed by JS, NM, and JD. The initial draft of the paper was written by JS. All members of the research team commented on drafts of the paper. JS is the guarantor of the paper.

Summary points

Practice based commissioning is to be rolled out across all general practices in the English NHS by the end of 2006

Research evidence from previous experiments with practice based commissioning in the UK provides valuable insight

The evidence points to the importance of ensuring clear incentives for general practitioners if practice based commissioning is to succeed

The main incentives for practice based commissioning lie in the potential for practices to extend their role as providers of care in an increasingly contestable NHS market

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