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Discussion paper

Quality in primary care commissioning

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ABSTRACT

This paper discusses the policy background and development of primary care commissioning and discusses potential measures for maintaining and improving practice-based commissioning as well as the quality of the commissioning process itself.

Keywords: commissioning, fundholding, general practice

How this fits in with quality in primary care

What do we know?
Successive governments have vested primary care organisations with responsibility for the planning and purchasing of health services. Models of primary care-based commissioning have evolved incrementally with little acknowledgement of past experience or the limited evidence on what is likely to make them effective.

What does this paper add?
The evidence base summarised here is descriptive rather than experimental, focusing largely on process rather than outcomes. Necessary pre-requisites of effective commissioning include the right blend of financial and non-financial incentives to increase professional engagement, valid information and various forms of managerial support. If the particular challenges identified here are not overcome, practice-based commissioning may be supplanted as swiftly as its predecessors.

Introduction

Over the seven years to 2005, the total budget of the NHS doubled but, even after these years of plenty, strategic health authorities and primary care trusts were overspent. Primary care trusts were perceived as unable to control secondary care expenditure or to commission effectively. The government therefore turned once more to general practitioners (GPs) to reduce demand, speed the transformation of services and generate financial savings. The vehicle that was created to give front-line primary care staff real influence is practice-based commissioning (PBC). PBCs are provided with indicative budgets for health care, freedoms to reinvest any budgetary surpluses, the responsibility for redesigning health services and new opportunities to increase their scope as care providers.

In this article, we draw on evidence relating to previous forms of primary care-led commissioning and apply it to the implementation of PBC.

What does history suggest is needed to allow practice teams to improve the quality of care through the processes of commissioning? But first ...

What is commissioning?

The notion of 'commissioning' emerged from the creation of an NHS 'quasi-market' as part of the Conservative reforms of 1990.[1] Within this quasi-market

('quasi' because market entry was restricted and market signals were closely managed by government) the roles of planning and procuring care were formally separated from that of provision. It was the role of commissioners to secure, rather than directly provide, services that met the needs of the populations for whose health they were responsible.

Commissioning is, in essence, a mechanism to deal with potential market failure, i.e. it is an intervention to protect consumers (patients) from abuse by suppliers or from poor choices that they might make. In addition, commissioning is intended to guard against an inefficient oversupply of care that might result in a market where patients do not pay for services directly. The potential for market failure is most obvious in relation to the information asymmetries that exist between patient and provider as to what care it is appropriate to offer and at what level of quality.[2] Commissioners are therefore agents of the patients that they serve, more able to discriminate between providers to maximise value and to exert influence over providers in terms of quality and price.

Commissioning comprises a set of related activities that serve four distinct functions: assessing needs; setting priorities and allocating resources; contracting with providers; and monitoring and evaluating outcomes.[3]

The rise of 'primary care commissioning'

Since its inception in the NHS, commissioning responsibilities have been divided between formal NHS agencies operating on behalf of large populations (often in the region of 200 000–500 000) and general practices acting alone or in groups. This latter form of commissioning ('primary care commissioning') builds on the role of the GP as 'gatekeeper' to hospital services. As it is the clinical decisions of GPs (for example, whether or not to refer a patient for further investigation or treatment) that are responsible for allocating most NHS resources, it was a natural step to align formal commissioning and budgetary responsibilities with those clinical responsibilities.

However, primary care commissioning has been characterised by organisational instability. The 1990 reforms introduced the first example of this type of primary care-led commissioning in the shape of GP fundholding. This initiative was designed to harness the entrepreneurial spirit within primary care through financial incentives to reduce unnecessary utilisation of care, promote new community-based services and negotiate lower prices for and faster access to hospital treatment. GP fundholders were legally autonomous commissioners with real budgets for a limited range of services.

Fundholders as alternatives to the institutional commissioners (district health authorities) were often highly individualistic and were responsible for only a minority of NHS services (elective hospital inpatient treatment, as well as outpatient care, prescribing and community health services). These characteristics led to a number of problems: fundholders competed with health authorities and could obtain preferential terms from providers (the gains for fundholders were often offset by losses for health authority commissioners),[4] and strategic planning of services across so many independent commissioners proved difficult.

This led to experimentation with more collective forms of primary care commissioning.[5] Groups of fundholders came together to form 'total purchasing pilots' responsible for commissioning services beyond the restricted list of mainly elective surgery. Non-fundholders formed GP 'locality commissioning groups' in an attempt to reintroduce population-based planning.

However, the election of the Labour government saw the imposition of a more systematic approach to collective primary care commissioning. Primary care groups and then primary care trusts (PCTs) were created with responsibilities for larger populations. In these new arrangements, the involvement of primary care clinicians became less direct, fed in through consultation or via the professional executive committee (a committee of clinicians advising the PCT board and management).

In these circumstances, the direct link between a general practice's management of patients and a clear financial budget was broken. This link has been rebuilt in 'practice-based commissioning' which, to all intents and purposes, re-embraces the principles of GP fundholding and total purchasing.[6,7]

What impact has commissioning had on health services?

The different forms of primary care-led commissioning discussed above have given rise to a canon of research literature with sometimes inconsistent messages. The impact of primary care commissioning in the past gives some indication of the likely impact of practice-based commissioning in the future.

In their comprehensive review of the published evidence, Smith *et al* conclude starkly that 'there is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services' (p. 15).[8] Given that a prime policy objective of

commissioning is to shape health systems around the needs of patients and, in particular, to challenge the propensity of hospitals to attract the lion's share of available resources, this is a disappointment.

That primary care commissioning (or any other form of commissioning) has not fundamentally influenced the actions of hospital providers does not, however, mean that those commissioners have had no impact at all. Research demonstrates that primary care commissioning led to both reduced demand for hospital services and greater responsiveness from hospitals when patients are referred.[9]

GP fundholding incentives had the desired effect on admission rates for those elective procedures covered by the initiative, with fundholders responsible for 3–5% fewer admissions than non-fundholders.[10] Waiting times for those admissions were lower under fundholding, with waiting times for included elective procedures rising between 3.5% and 5.1% on the abolition of the fundholding scheme.[11] Primary care commissioning was also effective in reducing demand for emergency hospital services (which were outside the scope of fundholding). A majority of total purchasing pilots achieved a reduction in emergency-related occupied-bed days.[12]

However, it is outside the hospital domain that primary care-led commissioning has proved most effective, with consistent evidence of the development of services in primary and intermediate care, new forms of quality assessment in primary care, and reductions in the costs of prescribing.[8]

Primary care-led commissioning appears to have delivered benefits in terms of some aspects of service quality and in costs. Yet are these benefits enough to justify continued faith in this approach to commissioning? As Smith and colleagues point out, fundholders' reductions in waiting times of around 5% look modest when compared to far greater reductions achieved across the NHS subsequently through the stringent regime of national targets.[8]

Moreover, primary care-led commissioning also resulted in some negative outcomes that must be set against any benefits. That GP fundholding and total purchasing pilots resulted in service and quality inequities is generally accepted – and was inevitable given that both schemes delivered benefits that were not universal. Moreover, fundholding tended to attract well-organised practices from better-off parts of the country, with inner-city practices particularly under-represented.[13] GP fundholding actually resulted in lower levels of patient satisfaction,[14] and all variants of primary care-led commissioning were associated with high transaction costs. The Audit Commission found that most fundholders were not making full use of the increasing body of knowledge about clinical effectiveness to change the way they commission.[15] Most fundholders were also reluctant to challenge the standards of clinical care provided in hospitals.[16]

Maximising the benefits of primary care-led commissioning

It appears that primary care-led commissioning in the past delivered both desirable and undesirable outcomes; but are these outcomes related to the way in which primary care-led commissioning has been implemented?

The evidence suggests that GP fundholding, total purchasing and GP commissioning pilots all faced a number of common challenges that held back their development. These included a lack of organisational stability and clinical engagement, insufficient management support and, perhaps above all, a lack of timely and accurate information on which to base their commissioning decisions.[8,17] This suggests that the relatively modest impact of commissioners in the past might be significantly increased if support for practice-based commissioners is improved.

With PCTs now granted (at least temporary) respite from further organisational turbulence, they have an opportunity to focus on developing their technical capacity to commission in their own right and to support practice-based commissioners. The latter require more advanced forms of support than they have enjoyed hitherto, in particular in developing a range of skills and competencies such as the stratification of patients according to risk, advanced case management, predictive modelling of 'high-user' patients, handling and analysis of routine data, and more refined assessment of service quality and outcomes.[18]

Past evidence is less helpful, however, in determining what the optimum size of population is for practice-based commissioning. There appears to be no 'ideal' size for a commissioning organisation. Different population bases are needed for commissioning different services, and there is little compelling evidence suggesting that bigger is necessarily better.[19]

The changing context

Of course, practice-based commissioners exist in a very different world from that of their predecessors. Since 2002 the government has introduced more market-oriented reforms, particularly in the shape of more competition among providers and more rights for patients to choose where to receive treatment. This has a profound impact on the very nature of

commissioning. Commissioners are no longer able to allocate resources directly. Instead, patients will allocate money through the choices that they make (at least for those services that are subject to patient choice). The new and more subtle arts of commissioning are focused more on the creation and shaping of markets than they are on allocating resources directly to providers.[18]

In some respects the new NHS environment may be more conducive to effective commissioning than it once was, and some of the historical problems of primary care commissioning may be avoided.[20] While total purchasing pilots failed to convert their hard-won reductions in referral activity into actual hard cash,[21] new fee-for-service payments ('payment by results') means that the full costs of any activity reductions will automatically flow to practice-based commissioners.

Realising the benefits of PBC

Notwithstanding this changed context, the history and research summarised above consistently draws attentions to several challenges that continue to exist for practice-based commissioners today.[22] In light of this, what is required for successful PBC?

Clinical engagement

Perhaps the most fundamental impediment to practice-based commissioning is the limited involvement of clinicians. Different health professional groups inhabiting separate hierarchies and networks define 'quality' in different ways.[23] The processes of determining what constitutes good-quality practice diverge between different groups. It is no wonder that healthcare professionals have limited understanding of the latest concepts and methods underlying quality improvement: indeed, they are often not convinced that quality needs to be improved. Medical professionals resist encroachment on this territory by managers. Guidelines and referral frameworks are perceived as hampering clinical freedom. The use of flawed, inaccurate data for what is seen as essentially cost-cutting purposes aggravates this underlying paranoia.

Direct involvement in decisions about resource allocation places the GP in the role of rationer, a task with which many GPs feel uncomfortable because it conflicts with their preferred role as patient's advocate.[24] Moreover, patients may be less willing to accept the advice that they do need treatment or referral if they believe the GP's decision is influenced by budgetary considerations.

Engendering collective responsibility among all practitioners for staying within budget or adhering to prescribing and referral protocols will prove difficult. The extent to which they will share a commitment to the needs of the locality as opposed to those of their own practice will crucially affect the development of PBC.

PBC has fewer direct financial incentives than GP fundholding. This may be wise, as crude external incentives can displace the intrinsic motivations most health professionals have to improve their patients' care. This has been evidenced in the manner of implementation of the new GP contract.[25] However, if the incentives feel 'owned' by the recipients, then they can reinforce internal motivation.[26]

Valid information and evidence

Much of the data used to assess health needs are based on electoral wards, i.e. geographical boundaries rather than practice boundaries. Practice boundaries do not necessarily fit into 'natural' communities, nor are they co-terminous with local authority boundaries used by social services and other agencies. Co-ordination of information sources can be especially difficult in urban areas where practice selection effects operate more powerfully. Technical obstacles such as the difficulties of controlling for case-mix are not easily resolved. The data most easily obtainable are often least easily interpreted. Both high and low referral rates, for example, may be markers of inadequate practice.[13]

Just as evidence-based clinical practice applies the judicious use of the best evidence available when making decisions for individual patients, evidence-based commissioning implies the consistent use of evidence when planning populations' health services. Needs and demands are not the same thing, and practice-based commissioning may encourage responsiveness at the expense of appropriateness and cost-effectiveness.

Managerial expertise

Effective purchasing requires a wide range of skills, including needs assessment, contracting, performance monitoring, accounting and budget management. Beyond an understanding of the processes of commissioning, some specialist knowledge is required to make strategically coherent purchasing decisions. This knowledge is in short supply in PCTs, let alone general practice. Even where PCTs have encouraged the growth of PBC collaboratives, the availability of experienced managers and financial expertise is limited.

Practice-based commissioners are 'learning by doing'. In time, training opportunities need to emerge that are PBC-led, multidisciplinary, use existing resources (in PCTs and trusts) and are based on assessment of existing skills.

Equity and public health

It remains to be seen whether GPs and practice staff working in 'difficult' areas will have the time or the inclination to get involved in PBC, and whether the scheme will help to improve services in disadvantaged areas.

PBC consortia include practices at different levels of development with a variety of practice styles; as a result some practices could be marginalised. Practices with low referral rates or efficient prescribing policies may be unwilling to share risk with practices perceived as less developed. However, closer working between more- and less-developed practices has most potential to raise the quality of primary care in a locality.

Preventive services risk being ignored as PBC focuses largely on secondary care. PCTs and PBC consortia are receiving some encouragement through recent government policy (e.g. the *Commissioning Framework for Health and Well-being*) to think about services upstream of hospitals. In theory, practice-level budgets can support 'business cases' for longer term health promotion and disease prevention.[27] However, overall a public health focus lacks champions at the level of PBC.

Meaningful public involvement

A commonly stated advantage of involving GPs in the commissioning process is that they are closer to patients and therefore can help to ensure that plans take account of patients' needs and preferences.[28] The assumption that GPs' views and priorities are congruent with their patients' needs has not been tested.

PBC consortia are struggling to secure user involvement. While patients might find it easy to identify with their own general practice, aggregates of practices or localities seem less relevant to them. Accountability arrangements for fundholders tended to focus on financial management, with little emphasis on accountability to patients or the local public. It will be important to examine ways in which PBC collaboratives can make themselves accountable to the people on whose behalf they are securing services.

Conclusions

Lack of time, resources or expertise are always adduced as the main barriers to further involvement in commissioning – but there are others. Organisational impediments include absence of clear leadership, and managerial and strategic naivety in underdeveloped organisations. Factors likely to increase clinical involvement and thereby the effectiveness of PBC include:

- a blend of incentives, financial and non-financial, that will promote the engagement of clinicians from different backgrounds in the primary and secondary sector
- trustworthy information at practice level that can be used to assess the potential and actual impact of policies designed to shift the locus of care from hospitals into the community
- worthwhile in-service training opportunities for those leading PBC
- even distribution of the managerial resources required to underpin PBC, working in collaboration rather than opposition to PCTs. These skills go beyond strategic direction setting and budget management to find ways of innovation through the devolved, networked structures that make up PBC consortia
- tried and tested mechanisms of public accountability.

The past is not always a faithful guide to the future, but previous experience is illuminating. It highlights particular challenges that will need to be overcome if PBC is not to sink swiftly beneath the sands of past policy.

REFERENCES

1 Secretaries of State for Health. *Working for Patients*. Cm 555. London: HMSO, 1989.
2 Arrow KJ. Uncertainty and the welfare economics of medical care. *American Economic Review* 1963;53:941–73.
3 Roche B. *PCTs: an unfinished agenda*. London: Institute for Public Policy Research, 2004.
4 Goodwin N. GP fundholding. In: Le Grand J, Mays N and Mulligan J (eds) *Learning from the NHS Internal Market*. London: King's Fund, 1998, pp.43–68.
5 Lewis R. *Practice Led Commissioning, Harnessing the Power of the Primary Care Front Line*. London: King's Fund, 2004.
6 Department of Health. *Practice-Based Commissioning: engaging practices in commissioning*. London: DoH, 2004.
7 Department of Health. *Health Reform in England: update and commissioning framework*. London: Department of Health, 2006.

8 Smith JA, Mays N, Dixon J *et al. A Review of the Effectiveness of Primary Care-led Commissioning and its Place in the UK NHS*. London: The Health Foundation, 2004.
9 Mays N, Mulligan J-A and Goodwin N. The British quasi market in health care: a balance sheet of the evidence. *Journal of Health Services Research and Policy* 2000;5:49–58.
10 Dusheiko M, Gravelle H, Jacobs R and Smith P. The effect of financial incentives on gatekeeping doctors; evidence from a natural experiment. *Journal of Health Economics* 2006;23:449–78.
11 Dusheiko M, Gravelle H and Jacobs R. The effect of practice budgets on patient waiting times: allowing for selection bias. *Health Economics* 2004;13:941–58.
12 Mays N, Wyke S, Malbon G and Goodwin N (eds). *The Purchasing of Health Care by Primary Care Organisations: an evaluation and guide to future policy*. Buckingham: Open University Press, 2001.
13 Roland M and Coulter A (eds). *Hospital Referrals*. Oxford: Oxford University Press, 1993.
14 Dusheiko M, Gravelle H and Yu N. *The Impact of Budgets for Gatekeeping Physicians on Patient Satisfaction: evidence from fundholding*. CHE Technical Paper Series 30. York: University of York, Centre for Health Economics, 2004.
15 Audit Commission. *Fundholding: the main report*. London: Audit Commission, 1996.
16 Douglas H, Humphrey C, Lloyd M *et al*. Promoting clinically effective practice: attitudes of general practitioners to the role of commissioning. *Journal of Management in Medicine* 1997;11:26–34.
17 Goodwin N. Developing effective joint commissioning between health and social care: prospects for the future based on lessons from the past. *Journal of Care Services Management* 2007;1:279–93.
18 Smith JA, Lewis R and Harrison T. *Making Commissioning Effective in the Reformed NHS in England*. London: Health Policy Forum, 2006.
19 Bojke C, Gravelle H and Wilkin D. Is bigger better for primary care groups and trusts? *BMJ* 2001;322:599–602.
20 Lewis R. Back to the future. *BMJ* 2004;329:932.
21 Goodwin N, Abbott S, Baxter K *et al. The Dynamics of Primary Care Commissioning: a close up of total purchasing pilots – analysis and implications of eleven case studies*. London: King's Fund, 2000.
22 Lewis R, Curry N and Dixon M. *Practice Based Commissioning – from good idea to effective practice*. London: King's Fund, 2007. www.kingsfund.org.uk/publications/kings_fund_publications/practicebased.htm (accessed 17 September 2007).
23 Davies H, Powell A and Rushmer R. *Healthcare Professionals' Views on Clinician Engagement in Quality Improvement. A literature review. Universities of Dundee and St Andrew's*. London: The Health Foundation, 2007.
24 Robinson R and Hayter P. *Why do General Practitioners Choose Not to Apply for Fundholding?* Southampton: Institute of Health Policy Studies, 1995.
25 Roland M. Linking physician's pay to the quality of care – a major experiment in the United Kingdom. *New England Journal of Medicine* 2004;351:1448–54.
26 Marshall M and Harrison S. It's about more than money: financial incentives and internal motivation. *Quality and Safety in Health Care* 2005;14:4–5.
27 Department of Health. *Commissioning Framework for Health and Well-being*. London: Department of Health, 2007.
28 NHS Executive. *Towards a Primary Care-led NHS: an accountability framework for GP fundholding*. EL(94092) Leeds: NHS Executive, 1994.

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