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HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

This issue

Practice based commissioning: a summary of the evidence

Introduction

Since 1 April 2005, general practices in England can hold an indicative commissioning budget from their Primary Care Trust to manage the delivery of services for their patients. By promoting a policy of Practice Based Commissioning (PBC) the Department of Health envisages a range of beneficial outcomes for the delivery of health care services:

- **a greater variety of services, from a greater number of providers in settings that are closer to home and more convenient to patients;**
- **increased support of clinician-to-clinician dialogue about improving and developing care processes;**
- **early and continuing involvement of practitioners in service development;**
- **an additional set of levers to aid demand management.[1]**

The NHS has used practice level commissioning arrangements before. PBC bears many similarities with GP fundholding and its later variants developed in the NHS between 1991-1999. It is therefore timely to ask what meaningful evidence based lessons may be drawn from the experience of previous incarnations of PBC? This paper provides an overview of the GP budgeting literature, draws out policy implications of the review and looks forward at the emerging research agenda.[2]

The Department of Health's guidance states that given the strategic importance of commissioning to the system reform agenda, it expects to see PCTs make arrangements for 100% coverage of PBC by no later than the end of 2006. However individual practices will retain the option to take on commissioning to a greater or lesser extent depending on their wishes and capabilities.

Box 1 The new model of practice based commissioning

Commissioning is the process by which the health needs of a population are assessed, and responsibility is taken for ensuring that appropriate services are available which meet these needs. PBC transfers these responsibilities, along with the associated budget from the PCT to primary care clinicians, including nurses. The key elements of the new approach are set out below.

- PCTs will continue to hold the actual budget and retain responsibility for securing service level agreements with secondary care providers.
- Using the indicative budget the practice or locality (a local group or network of practices) take on the responsibility of identifying the health needs of the local population and, in conjunction with local stakeholders, identify the appropriate services to be provided.
- Resources freed up by cost-effective commissioning may be used only for patient services (with the exception of the deduction of 'reasonable management costs').
- The delegated budget may be limited to selected service areas or may include all services currently commissioned by the PCT.
- Each participating practice is expected to keep its average annual expenditure within its budget.
- Initially indicative budgets are based on historical spend for the year 2003/04 with the appropriate uplift. Over time, budgets will be based on a 'fair shares' division of the PCT allocation based on the national resource allocation formula.
- Commissioning practices are responsible for ensuring that patients are offered a choice of provider for elective care in line with national policy.

This issue of *Health Policy Matters* has been written by Russell Mannion, Centre for Health Economics, University of York, England, rm15@york.ac.uk

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Box 2 Key benefits and drawbacks of PBC

Practice level budgeting/commissioning has taken a variety of forms in the NHS, including, standard GP fundholding (GPFH) Total Purchasing Pilots (TPPs) and locality/GP commissioning pilots (CPs). To aid interpretation of the published evidence a star rating system is used, ranging from three stars (high) to one star (low) to indicate our assessment of the quality of evidence.

Benefits

The available evidence is suggestive of the following potential beneficial outcomes for variants of PBC compared to non-PBC approaches:

- lower elective referral/admission rates (GPFH and TPs) ***
- reduced emergency related occupied bed days (TPPs) *
- lower waiting times for non-emergency treatment (GPFH, TPPs) **
- improved coordination of primary, intermediate and community support services (GPFH and TPPs) *
- improvements in financial risk management (TPPs) *
- better collaboration between GPs across practices (CPs) *
- reductions in the growth in prescribing costs (GPFH and TPPs, CPs) **
- engagement of clinicians in the commissioning process (All) **

Drawbacks and limitations

There is evidence to suggest that PBC may induce limited or even deleterious outcomes for patients and the delivery of care:

- reduced patient satisfaction (GPFH) ***
- increased management and transaction costs (GPFH, TPs) *
- inequities of access (GPFH, TPs) ***
- little impact on the way hospital care is organised and delivered (All) **

The Evidence

Quality of evidence

The early evidence on the impact of GPFH has a number of limitations. First, the government decided not to evaluate formally GPFH and consequently the initiative was not subject to a rigorous national evaluation: studies tended to be small scale, piecemeal and lack adequate controls. Second, GPFHs were a self-selected group and therefore cannot be straightforwardly compared to non-GPFHs. Third, it was not until relatively recently that data sources have improved to allow examination of admission rates of GPFH and non-GPFH practices on a national basis, rather than within single Health Authorities.

Recently a number of studies evaluating the impact of GPFH have used advanced econometric modelling techniques to analyse newly constructed longitudinal data sets on purchaser and provider activity. These studies are better able to control for selection bias (and other biases) and represent the most rigorous assessments of the impact of GPFH available. The rest of the paper draws selectively on this evidence.

Elective admission rates

Dusheiko et al[3] use the opportunity afforded by the abolition of the voluntary fundholding regime and its replacement by the compulsory PCT regime to examine the effect of budgetary regimes on the behaviour of fundholding practices. They use a data set that includes admissions for over 7,000 practices (fundholding and non-fundholding) for the two years before (1997/8, and 1998/9) and the two years after (1999/2000, 2000/1) GPFH was abolished. In December 1997 practices were given a clear signal that GPFH was to end in April 1999. The fact that all practices that were fundholders had to switch from the fundholding regime to the PCT regime meant that a 'difference in differences' methodology could be used to identify the effect of the change in budgetary regimes. The results suggest that elective surgical admission rates amongst the practices that chose to become GPFHs were **3.3%** lower than they would have been in the absence of GPFH (this can be seen as the incentive effect of the budgetary regime). The authors were unable to conclude whether the reductions in admissions from fundholding were achieved at the expense of patient welfare since they did not have data on the use of cost savings or the health of patients.

Non-elective admission rates

The most rigorous quantitative assessment of the impact of standard fundholding on non-elective admission rates found that fundholding had no effect on these types of referrals.[3]

A specific aim of a third of the first wave total purchasing projects (TPPs) was to reduce the volume of inappropriate non-elective acute admissions and reduce lengths of stay through the extension of services outside the scope of the original fundholding initiative. Eleven of the sixteen pilots with this objective did indeed reduce the number of emergency-related occupied bed days by significantly more than comparable practices in the same area.

Waiting times

Dusheiko et al[4] compared three groups of methods of allowing for potential selection bias in estimating the effect of fundholding on fundholding practices. The cross-sectional methods used suggested that GPFH reduced waiting times by around **3-5 days**. The study also found that patients of fundholder practices had shorter waits (by **2 days**) for non-chargeable elective admissions, suggesting that fundholders were able to obtain shorter waits for all types of elective admissions.

Patient satisfaction

Dusheiko et al[5] provide the most robust assessment of the impact of GPFH on the overall satisfaction of patients. The study used a cross-sectional survey of 4311 patients from 60 practices in the last year of GPFH (1998). Their analysis indicates that patients belonging to fundholding practices were less satisfied than non-fundholder patients. Applying numerical values to the satisfaction categories (from a score of 1 for completely dissatisfied to a score of 7 for completely satisfied), the mean satisfaction of patients in fundholding practices is 5.42, compared with mean of 5.61 for patients in non-fundholding practices, a difference of **4.1%**.

The authors conclude that the results provide evidence that budgetary arrangements and financial incentives in GP practice affected the agency role of fundholding GPs, and hence the nature of care experienced by patients. They suggest that savings by fundholding practices may have been at the expense of patient welfare, despite the ability of fundholding practices to invest their savings to improve patient care.

Quality of primary, intermediate and community care services

The fundholding scheme was intended to enhance primary care infrastructure and 'savings' could be used to improve practice-based facilities and develop outpatient clinics.
A number of studies have shown that fundholders offered a wider range of services for patients following the introduction of the scheme. This was mainly accounted for by increased outreach clinics performed by hospital clinicians – thus primarily a shift in the location of secondary care. Some of the TPP initiatives resulted in greater integration between primary and secondary care services, and/or primary, community and social care services.[6]

Provider responsiveness

A rationale of GPFH was to give an additional incentive to hospitals to be more responsive to general practitioners and through them to their patients. A number of studies report improvement in the process of care due to fundholding, including: more informative and prompt discharge letters; a faster response to GPs' enquiries; and improved access to services such as physiotherapy, inpatient care and specialist outreach clinics.

Pharmaceutical costs

The evidence suggests that compared with non-GPFH practices, GPFHs appear to have had a relatively slower growth in pharmaceutical costs, particularly during the early years of the scheme. GPFH practices were able to make what were largely 'one-off' savings in spending through a variety of strategies, including increased use of generic prescriptions, the use of practice formularies and feedback to practitioners of improved prescribing information. However, once these strategies had been implemented, prescribing cost growth among fundholders reverted to that of non-fundholders.[7, 8]

Risk management

A key factor determining the TPP pilots exposure to financial risk was how much of their total purchasing budgets remained the responsibility of the pilots, and how much was 'blocked back' to their health authority.
A specific study of risk management by TPP practices found that 29/32 (87%) carried some financial risk and budgetary responsibility.[9] Many pilots introduced innovations in financial management designed to control expenditure. GPs in TPP practices also worked together to control demand by discussing individual cases and agreeing protocols. Single practice and smaller TPP practices appeared to perform better than multi-practice or larger TPP practices in terms of risk management.[9]

Transaction costs

Place et al[10] assessed the additional transaction costs incurred in seven TPPs as compared to their purchasing as GPFHs. The incremental transaction costs were identified by taking the annual budgetary responsibility of staff dedicated to the management of total purchasing together with the cost of time spent by all of the affected parties in meeting related activities undertaken as part of the total purchasing scheme. In the preparatory year the average total cost per capita for the incremental transactions costs associated with total purchasing was £2.68. This increased to £2.85 in the first live year and fell to £2.23 in the second live year.

Policy and research implications

The empirical studies reviewed here highlight potential areas where PBC might be expected to deliver benefits or deleterious outcomes to the NHS and patients (Box 2) However, translating these findings into the current policy environment is not straightforward. The NHS has changed fundamentally since the internal market and these changes need be to be taken into account when inferring lessons for the present initiative.[8, 11,12]

There are a number of important unresolved policy questions and gaps in knowledge that need further theoretical and empirical investigation (see Box 3).

Given the need to improve the performance of primary care teams with PBC, the lessons from evaluation of GPFH indicate that incentives will have to be improved and the diversity of innovation carefully managed and evaluated to ensure that improved patient benefits can be delivered.

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Box 3

- Individual GPFH practices were given a clear incentive to be efficient, as savings from their budget could be retained for enhancing their practice's premises. Under the latest approach to PBC any savings that accrue may only be allocated to other forms of patient care. Will this be enough of an incentive for practices to engage fully with PBC?
- Geographical and other inequities may arise if the PBC delivers improved outcomes for patients and if take up by practices across the country is slow and uneven. This should be monitored and policies put in place to ensure that patchy take up does not worsen health inequalities.
- There is an incentive under PBC for practices to provide services 'in house'. PBC therefore has the potential to limit the range of services that are offered by GPs to their patients and therefore serve to attenuate wider system reforms intended to enhance patient choice.
- Existing constraints within the system may limit the extent to which it is feasible for practices to switch providers and influence service delivery. For example, Foundation Trusts have three year service contracts with PCTs, and, PFI may lock hospitals into guaranteeing funding flows for up to 30 years.
- The creation of more autonomous commissioning practices may inhibit inter-organisational co-ordination and the shared accomplishment of care delivery, not least, multi-agency alliances forged to manage complex care pathways across sectors.

The absence of prescriptive central guidance concerning the implementation of PBC may result in the development of a wide diversity of approaches and outcome . Any future research programme will need to:

- be designed to learn from the relative successes and failures of different approaches to PBC that develop at the local level;
- use quantitative and qualitative evaluation methods to capture the breadth and depth of any changes;
- identify any adverse and dysfunctional outcomes of PBC for staff, patients and the wider health community.

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