The Commissioning Function of Primary Care Groups and Trusts

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1. Introduction

With the publication of the Labour Government's white paper, The New NHS: Modern, Dependable in 1997, the British National Health Service (NHS) embarked on its second major reorganisation within the space of a decade. The reforms outlined in the white paper heralded not only the creation of new organisations and the assigning of new responsibilities to already existing organisations, they were also concrete examples of the Labour Government's commitment to the 'Third Way.' The Government hoped to meld the benefits of the market and decentralisation such as choice and responsiveness with the benefits of hierarchies and planning such as equity and low transaction costs. Institutionally, the reforms built on previous organisational arrangements while including innovations such as an emphasis on cooperation and the creation of national regulatory bodies such as the National Institute for Clinical Excellence (NICE).

Of all the changes that have occurred to the NHS during the recent period of reform, perhaps the greatest was the reorganisation of primary care and the creation of primary care groups and trusts (PCG/Ts). While maintaining the idea of a primary care led NHS developed by the Conservatives, PCG/Ts altered the direction the NHS was heading. All the multifarious ways of in which primary care were organised in the internal market were replaced by a single model. PCG/Ts are local organisations including all GPs within the geographical are they represent and they are responsible for the delivery of the bulk of primary care services. Their remit is wider than the internal market organisations they most resemble.

PCG/Ts have been assigned three core functions: primary care development, health improvement and commissioning. Although the three functions overlap each other, this paper will have as its main focus the development of commissioning in PCG/Ts. In the next section, the policy context from which PCG/Ts emerged will be discussed by looking at the development of commissioning (or purchasing) in the internal market. In the following section PCG/Ts main institutional features will be described and the progress they have made in commissioning will be discussed. An international comparison with American Health Maintenance Organisations (HMOs) will be developed before a brief concluding discussion of the central issues raised in the paper.

2. The Internal Market

A complete understanding of PCG/T commissioning requires some background knowledge of the various commissioning (or purchasing as it was then generally referred to) that developed in the wake of the Conservative reforms of the NHS in the late 80s and early 90s. The structure of PCG/Ts was foreshadowed in many of the primary care commissioning organisations that were developed in the internal market. PCG/Ts reproduced many features of the organisations that preceded them; however, PCG/Ts' full significance in the New NHS is more fully appreciated by considering those aspects of the internal market that were discarded by the Labour government.

One of the distinguishing features of the Conservative Governments of the 80s and 90s was their commitment to the introduction of market mechanisms to the delivery of social policy objectives. Market mechanisms were perceived as a means of increasing both efficiency and choice and responsiveness. In relation to the NHS this preference was revealed in the white paper Working for Patients in 1989 that pledged the introduction of quasi-market reforms to the organisation of the NHS reforms while retaining funding from general taxation and keeping access free at the point of delivery. In 1991, the concrete institutional manifestation of this pledge was revealed with the introduction of fundholding general prac-

tices and health authority commissioning along with the conversion of hospitals into free standing trusts as the central..

The central innovation of the Conservative reforms was the split of purchasers from providers. Hospitals were transformed into freestanding trusts with the responsibility of providing services to purchasers. Purchasers were either fundholding general practitioners or health authority commissioning. Fundholding involved the devolving of budgets to primary care that covered prescribing budgets and a limited range of secondary care services such as elective surgery. The responsibility for the commissioning of the remainder of secondary care services was left to health authorities.

Fundholding was designed to improve both the information received by purchasers and the incentives guiding their decisions. General practitioners were considered to be uniquely placed to understand many of the needs of their patients through their regular contact with them and fundholding attempted to give them incentives to manage their budgets in an efficient way. Fundholders were able to retain under spends on their budgets that could be re-invested in their practices. Notably, the penalties for overspends did not match the incentives to underspend. The General Medical Services (GMS) budget was protected and the central sanction that fundholders faced was the removal of their status as fundholders. Health Authorities were charged with commissioning services that did not assume fundholding status or were not large enough to assume it. The information that they acted on was based on larger populations than that available to fundholding and the motivation to purchase responsibly was based on central direction; health authorities were charged with ensuring that trusts reduced costs by 3.5 % each year for the same services. Unlike fundholding GPs, health authorities did not receive the benefits of under spends while they bore the brunt of overspends.

Although fundholding and health authority commissioning represented extremes on the spectrum of purchasing bodies there were several intermediate organisations that mixed characteristics of each. They tried in different ways to trade off the attenuation of incentives associated with sharing large budgets with many actors with the advantages of bargaining clout and collective planning associated with collective determination of commissioning preferences. Examples include locality commissioning and total purchasing pilots. Locality commissioning included GPs collectively in the determination of purchasing priorities through giving them a consultative role while the responsibility for managing budgets remained with the health authority. Total purchasing pilots, on the other hand, involved practices in the collective determination of preferences combined with practices controlling budgets collectively.

Table 1 cross tabulates the different commissioning arrangements according to three dimensions: collective determination of preferences, practice influence on determination of preferences and whether or not practices controlled budgets. Information about preferences can be decentralised or it can be collected and acted on centrally. Incentives related to performance can be directed at individual practices, groups of practices or at collective organisations like health authorities.

Trying to determine which purchasing arrangement was superior to the other is difficult, not only because there was no single concerted effort to evaluate the internal market (but see Le Grand et al 1998), but also because any comprehensive evaluation must be based on

Table 1. Classification of primary care organisations in the internal market

	Collective determination of preferences	Practices influence determination of preferences	Practices Control budgets (either individually or collectively)
Fundholding	No	Yes	Yes
Total purchasing pilots	Yes	Yes	Yes
Locality Commissioning	Yes	Yes	No
Health authority commissioning	Yes	No	No

multidimensional set of criteria. Keeping in mind that caveat, it is possible to make some comparisons of the relative success of each of the arrangements and the internal market more generally.

On the positive side, fundholding and similar arrangements showed that GPs are able to maintain budgetary discipline and did respond to the incentives created by holding budgets. Unlike health authorities that generated deficits, fundholding practices generated budgetary surpluses. There is evidence that they reduced prescribing costs more effectively than practices that remained outside of fundholding. There is also evidence that they were more able to develop innovative services and exert pressures on providers to improve the services they provided.

On the negative side, fundholding created concerns about the effect of thousands of different purchasers maintaining contracts with a multitude of providers on planning within the NHS. In addition to the effect on the planning, the extensive use of contracts was blamed for increasing transaction costs in the NHS and leading to a heavy bureaucratic burden that was diverting resources away from patient care. Finally, and in some respects most crucially, the internal market was alleged to create a two tier service within the NHS with some patients receiving better care than others depending on whether their general practitioner was a fundholder or not.

Despite the contention surrounding so much of the internal market, there were certain areas where a consensus can be discerned that it achieved improvements in the quality and efficiency of care delivered to patients. The purchaser provider split and the influence of GPs on commissioning were generally accepted as increasing primary care's influence over secondary care and forcing trusts to be more responsive to the demands of their users. Where disagreement remained was over whether GP influence should be through individual practices or groups of GPs; whether and how responsible management of budgets should be linked to incentives to the behaviour of individual practices or groups of practices, and the relative worth of competition and cooperation in achieving commissioning aims. In the next section the manner in which PCT/Gs resolved these issues will be explored.

3. Primary Care Groups and Trusts: Information and Incentives

Organisation of PCG/Ts

The establishment of 481 PCG/Ts in April 1999 represented a significant step in the institutional development of the NHS. Prior forms of primary care commissioning were abolished and every general practice in England was compelled to take part in the scheme. Despite claiming to have dismantled the internal market, the reforms crucially left the purchaser provider split intact. Rather than discarding the concept of primary care commissioning it was incorporated into a four-stage model of PCG/T development. The four stages are:

- **Level 1:** GPs and community nurses acting as advisors to their health authority in commissioning care for its population.
- **Level 2:** GPs and community nurses, acting as a subcommittee of their health authority, with devolved responsibility for managing the budget for approximately 90% of services for their population.
- **Level 3:** A freestanding trust comprised of GPs and community nurses accountable to its health authority for commissioning services for its population.
- **Level 4:** A freestanding trust comprised of GPs and community nurses accountable to its health authority for commissioning services for its population, and with responsibility for provision of community health services.

Although it was initially felt that there would be a gradual transition from group to trust, in fact, the movement has been quite rapid. By October 2001 there were 164 PCTs and in April 2002 all remaining PCGs became PCTs. It is envisaged that eventually PCTs will be replaced by Care Trusts, which will involve a further integration of primary care and social services.

Perhaps as important as PCG/Ts' evolving functions and the new responsibilities that were allocated to primary care, were the new organisational arrangements that the reforms established. For a number of reasons PCG/Ts mark a significant shift away from what had preceded them. Hierarchical and competitive arrangements had been[1] the main organisational mechanisms used to achieve previous primary care commissioning objectives, but the reforms promoted co-operation and partnership to a position of equally central prominence[2].

PCG/Ts are large. They bring together groups of individual general practices and community nurses under a board with members representing GPs, nurses, the health authority, the local community and social services. When PCGs were created they had responsibility for geographi-

cally defined populations that were on average 100,000 (range: 43,000- 278,000). The average number of general practices in PCGs was 19 (range 5-66) and the average number of GPs was 55 (range 21-141). Since then PCG/Ts have only grown larger as there have been many mergers. While collaborative commissioning was increasingly common prior to the reforms, it was not nearly on the same scale as that envisaged for PCG/Ts. In the face of this organisational complexity, PCG/Ts have been charged with forging cohesive units that will allow them to take decisions that both reflect the health needs of their local populations while also meeting national standards.

The central decision making body in PCG/Ts is the board. Table 2 displays the membership, which is prescribed by the Department of Health.

As would be expected from their membership, studies of PCG boards have found that GPs have played a dominant role in board decision-making. This power has been increased by the fact that the vast majority of boards have elected general practitioners to be chairman. The influence of GPs on PCTs is muted. PCTs have two central decision making committees: a board and a professional executive committee.

The precise relationship between the board and the executive committee is not clear and varies from PCT to PCT; however, the executive committee is a forum for professionals and generally more concerned with deciding operational issues while the board is more concerned with accountability and strategic decisions. What is notable about both committees is that GPs' influence is reduced with a much stronger lay influence.

The work of both PCGs and PCTs is also supported by a variety of subcommittees dealing with topics such as prescribing and clinical governance. The membership of these is drawn from members of the board and/or executive committee as well as health professionals who are drawn from the wider PCG/T. Examples of these subcommittees are clinical governance sub-committees, prescribing sub-committees and commissioning sub-committees.

Commissioning instead of purchasing

In the new NHS that was created by the Labour Govern-

Table 2. Membership of PCG board and PCT board and executive committee

PCG board
• Chief executive
• 4-7 GP members
• 2 nurses
• Health authority non-executive
• Lay member
• Social services member
PCT board
• Lay chair
• Chief executive
• Finance director
• 5 non-executive directors
• GP executive chair
• GP clinical governance lead
• Nurse member
• Public health member
Executive committee members of PCT
• Chief executive*
• Finance director*
• GP chair*
• GP clinical governance lead*
• Public health member*
• 2 nurse members (one is the nurse board member)
• 3 executive GPs
• Social services member
• Other health professionals including, for example, community pharmacist member or professions allied to health member.

* member of board and executive committee

ment, the notion of commissioning secondary care replaced the notion of purchasing that had characterised primary care's relation to secondary care. While the split between purchasers (or commissioners) and providers was maintained, the nature of the link was altered. Light (1998) has criticised the change of terms as being at best politically correct and at worst representing an unserious attitude to purchasing. While Light has a point, the institutional context created by the reforms has the potential to create a real alternative to purchasing, although whether it has and whether the alternative will be as effective as purchasing are not yet clear.

The purchaser provider split was based on a model of primary and secondary care providers having divergent interests. Their relations were characterised by bargaining and competition and the role of exit was emphasised. If a purchaser was unhappy with the services it received from providers, it was encouraged to switch providers with annual contracting being the institutional expression. Through each side of the split pursuing its own interests, both sides would gain through an invisible hand mechanism. Purchasers would be able to secure a wider range of choices at higher quality to their patients and providers would be compelled to ensure that they more efficiently produced the types of services that purchasers wanted. It should be noted that this was often more the ideal than the reality as, for a variety of reasons, the opportunity provided by the purchaser provider split often did not result in competitive relationships between providers.

The commissioner provider split in the new NHS is based on the mutual interests of primary and secondary care in providing high quality services to the population that they both serve. Their relations are supposed to be based on deliberation and cooperation as each side uses its resources to plan the best provision of care. While commissioners still have the option of exit, it is not encouraged. The White Paper stated that commissioners should only switch main providers as a last resort. These intentions found their institutional expression in the replacement of annual contracting with three year service level agreements, the centring of commissioning on the local Health Improvement Program (HImP) and the creation of national targets in the form of national service frameworks (NSF). The HImP is a plan for delivery of services and health improvement for the local population served by the PCG/T. It is jointly agreed by PCG/Ts, health authorities and hospital trusts and sets commissioning priorities and targets that are to be achieved over a longer period than was allowed during the annual round of contracting in the internal market. Deviations from the HImP by either commissioners or providers incur sanctions.

As well as local targets, commissioning priorities are also guided by NSFs, nationally agreed targets of service delivery. So far the Department of Health has released three NSFs for mental health, coronary heart disease and old age with more planned for the future (the full text of each NSF can be accessed by going to http://www.doh.gov.uk/nsf/). These contain guidance on best practice, targets and potential service models. The NSF for Coronary heart disease, for example, expects all trusts to deliver thrombolysis to all patients suffering from a heart attack, local health communities to increase heart failure provision and suggests that rapid chest clinics are the best way of providing rapid diagnosis of angina. NSFs have a great influence on commissioning in the New NHS and set clear clear commissioning targets for PCG/Ts.

In sum, the New NHS involves deliberation and cooperation guiding commissioning at a local level and centrally driven targets guiding commissioning from at a national level. The trade off of local and national priorities will be a key parameter determining the direction of commissioning.

Although the new NHS envisages clear roles for commissioners and providers, it is another question whether the institutional structure provides the information and incentives to enable them to fulfil those roles. In the remainder of this section the institutional effect of the reforms on commissioners' information and incentives will be discussed before looking at their achievements to date.

Information and preferences

PCG/Ts are collective bodies representing the interests of many different stakeholders. In order to make commissioning decisions that are representative of these varied interests, PCG/Ts will require various forums for determining priorities as well as mechanisms for gathering information about the health needs of the population they serve.

Collective determination of preferences and health needs occurred in the internal market. What makes collective commissioning in PCG/Ts different from collective commissioning in total purchasing pilots or locality commissioning is that a wider set of interests are represented in decision making processes than just GPs: other

health professionals such as community nurses, social services and representatives of the local community all have a say in commissioning decisions.

The agenda of board meetings and executive committee meetings are crowded by a large number of topics other than commissioning, so they can only touch on few of the important issues affecting it. Instead of relying on boards and executive committees, PCG/Ts have tended to rely on subgroups with delegated responsibility for considering commissioning decisions in more detail. In a national random survey of PCG/Ts conducted by a team at Manchester University, 62% had established a commissioning subgroup. In terms of representing stakeholders 94% contained general practitioners and 58% contained community nurses with most other stakeholders having minimal representation. Interestingly, 16% included managers of acute trusts. Research has found that public involvement in PCG/T affairs has been through consultation with corporate bodies rather than through the lay members of the board or through directly consulting them through patient surveys. Manchester reports that while 86% of their sample consulted stakeholders on commissioning issues, only 44% of chief executives rated their influence highly.

Another factor determining the information and preferences of primary care groups and trusts is the set of national priorities and targets that have come out of Whitehall. These include the National Service Frameworks on coronary heart disease, mental health and ageing as well as guidance from NICE. These give PCG/Ts clear national standards on the type of care they should be providing as well as setting the direction and pace of change expected of PCG/Ts. These targets complement the local focus of the HImPs and reflect the Labour Government's intention of assuring that unnecessary variations in the provision of care are eliminated from the NHS.

As well as setting targets, the government has set reference costs for all procedures. These were established by asking all trusts to submit costs for 536 surgical procedures in 1997/98 by health resource group (HRG)[3] (National Casemix Office 1999) (eventually reference costs will include all trust activity).

The National Schedule of Reference costs gives the average cost of all these procedures, the highest and lowest costs and the inter-quartile range of costs. As well as the Schedule, an Index has been constructed comparing trusts on a scale based on all their costs. The Schedule is viewed by the government as a mechanism for creating greater transparency between commissioners and providers. Instead of prices emerging purely from two parties bargaining, a national basis for negotiation between purchasers and providers has been created although the wide variation in costs provided by trusts may undermine their validity. The schedule of costs is both a starting point for deliberation by local commissioners and providers as well as providing centrally driven pressures on high cost trusts.

Despite setting up local information gathering infrastructures and national guidelines, the major studies of PCG/Ts have noted that gathering of information is one of the weakest aspects of PCG/Ts. For the most part they have been reliant on health authorities infrastructures for assessing the health needs of the populations they serve. Much of information gathering and the determination of preferences has remained with health authorities and resembles health authority commissioning as much as any form of primary care commissioning that preceded it. With the abolition of health authorities and their replacement by strategic health authorities, which are more distant bodies, in April 2002, PCG/Ts will have to assume much greater information gathering responsibilities.

Incentives

The most significant change to the structure of incentives to local parties to participate in commissioning arrangements and to ensure secondary care is provided efficiently is the creation of a cash limited unified budget that includes prescribing, hospital and community health services (HCHS) and general medical services (GMS)[4]. PCG/Ts have been given the power to move money across these three budgets. This freedom, because of the inclusion of GMS which had been unaffected by the budget given to fundholders, goes beyond the freedoms granted fundholders to integrate budgets.

There is, however, one barrier to the flow of resources across budgets. GPs were concerned that funds that were dedicated to practice improvement, namely GMS funds, would be raided to fund deficits in prescribing and HCHS budgets. The Department of Health addressed this concern by allowing funds to be transferred from HCHS and prescribing into GMS but not the other way around unless the local medical committee[5] gives its consent. Growth in the GMS budget was, however, pegged to inflation, which will make it a smaller proportion of the unified budget over time as the other two will grow faster than the rate of inflation. These changes mean that prac-

tice investment will increasingly be dependent on efficiencies made in the other two budgets (Majeed and Malcolm 1999). This measure turns PCG/Ts into a community of interests, as increasingly practice investment will become dependent on the prescribing and referral patterns of other practices in the PCG/T. By including GMS in the unified budget, the potential effect on general practitioners as a group is greater in PCG/Ts than in fundholding arrangements.

Although the effects of efficient commissioning arrangements are greater for the group, the important question is whether there are incentives for individual general practitioners and other stakeholders to participate? Although as a group, fundholders may have had less to gain or to lose, as individual practices they had clear incentives to participate in commissioning decisions and to ensure that those decisions led to an efficient allocation of commissioning resources.

This interdependence sets up two incentive problems related to commissioning. The first relates to bargaining with the secondary care provider. The ability of PCG/Ts to ensure practice participation by its stakeholders in determining agreements between the PCG/T and providers of secondary care will be limited to the extent to which the marginal benefit the stakeholders receive from any improvement will compensate the costs they incur by participating. Using the terminology of bilateral bargaining the distribution of any benefits gained by a movement along the contract curve away from the bargainer's starting point must be great enough to compensate those in the PCG/T who take on the costs of bargaining. The magnitude of the marginal benefits they gain by moving along the contract curve will depend on whether the benefit is non-excludable and its jointness of supply[6]; namely, how public the good is.

Using the example of general practitioners and their participation in negotiations with secondary care providers, these effects can be demonstrated. An example where general practitioners will be motivated to participate in negotiations with secondary care providers is in the price of certain procedures. The negotiation of a lower price achieves a benefit for GPs that exhibits jointness of supply. It does not matter how many other GPs there are in the PCG/T, the price is not affected by how many others use it[7]. In this case, the set of incentives is the same for the GP fundholder and the GP commissioning subgroup member. There are no group effects on the set of incentives faced by the GP. In fact, bargaining might be more efficient in the PCG/T as instead of a collection of different individuals, each with variable bargaining skills, trying to bargain with the provider, the GP most capable at bargaining can represent all GPs.

An example of where there are group effects would be a situation where there is a single consultant willing to do a limited number of outreach clinics that must be shared by the patients of all members of the PCG/T. In this case, the more GPs, and hence potential users, the less benefit there will be to any single GP. In this case, the incentives of GPs to participate in negotiations with a secondary care provider will be attenuated as the PCG/T grows larger. In this situation group effects will have a negative effect on the PCG/T's ability to negotiate with secondary care providers.

Where GPs' incentives to become involved in participating in negotiation with secondary care providers are weak, the responsibility will fall to management. The history of the internal market does not indicate that managers make such effective bargainers as general practitioners. It should be noted, however, that the unified budget gives managers in PCG/Ts greater incentives to obtain the benefits of successful bargaining than the incentives facing health authority managers. Health authority managers did not have the budgetary freedoms that PCG/T managers have; the organisations they managed did not receive the benefits of efforts they made to keep the commissioning budget low. PCG/T managers can reap the benefits by switching funds across budgets so it is their organisation that reaps the benefits of successful bargaining.

The second level of incentives is related to the referral behaviour of general practitioners once an agreement has been made between the PCG/T and the secondary care provider. While a fundholding practice had an incentive to refer efficiently and appropriately because he/she would receive all benefits from any budgetary surplus, there are potential negative group effects affecting the incentives surrounding GPs' referral behaviour in PCG/Ts. The motivation to refer effectively is weakened if a large proportion of the benefits is distributed to other practitioners, some of whom might not be effectively commissioning themselves. This is not to say, for example, that GPs' professionalism does not guide them to refer effectively, only that, *ceteris paribus,* the institutional structure of PCG/Ts does not contain incentives to refer so efficiently as fundholding. This potential difficulty was noted in the Labour Government's white paper that en-

visaged a situation where practices would be given indicative HCHS budgets attached to incentives. In practice, however, this opportunity has not so far been seized. Manchester found that only 6 % of PCG/Ts in their survey had set indicative budgets for their practices and only 2 had linked these to incentives. The reason for this lack of devolution is not clear but it could be linked to PCG/Ts' inability to gain information about patterns of referrals from hospital trusts and health authorities.

While the unified budget has created a set of common interests and incentives locally, PCG/Ts face additional incentives from national targets. These targets are increasingly driving PCG/T priorities. Implementation of these targets is achieved through earmarking funds from the centre and through the monitoring of performance by health authorities and regional offices. There is some concern that the vast number of targets emerging from the centre will undermine local priorities and incentives. Especially with the danger of negative group effects on incentives to pursue local priorities, the only effective incentive system could possibly be related to national targets.

4. Achievements

PCG/Ts are new organisations that have emerged into an environment of rapid change in the NHS. As a consequence they have spent much of their time on organisational development. Despite that they have made significant progress on prescribing and clinical governance although much less on health improvement and public health. Although PCG/Ts are not without their achievements, few of those achievements are related to commissioning. For example, a study of twelve case PCG/Ts by a team of researchers at Birmingham University has found that PCG/Ts have made little progress in commissioning acute services with most of their achievements related to community care and services at the secondary-primary interface. It is surprising that there has been so little achievement following immediately after the internal market when, for the greater part of a decade, a variety of commissioning arrangements were in place. It could still be too early to judge whether PCG/Ts will become effective commissioners or whether their institutional structure will halt them from ever assuming that role; however, in what follows the first tentative steps taken by PCG/Ts will be discussed. What follows depends heavily on the two major studies of PCG/Ts carried out by teams at Birmingham and Manchester Universities.

Priorities

What have been the central commissioning priorities of PCG/Ts? Both studies have found that improving waiting times for secondary care and improving access have been viewed as most important. After these two issues the next most important have been quality issues and issues tied to NSFs. What is also notable about the findings is the importance that PCG/Ts place on developing intermediate services. Instead of viewing commissioning services from secondary care as being the central priority, PCG/Ts are increasingly placing higher value on developing intermediate services[8] that, where possible, can replace services provided by secondary care.

Involvement

In their first year of existence, PCG/Ts were concerned primarily with organisational development. Their role in commissioning was limited both by the fact that many inherited service level agreements that had been drawn up by health authorities and trusts and also by the fact that many commissioning responsibilities were still held by health authorities; however, they expected to assume greater responsibility as they conquered organisational problems. An initial way of checking their progress is to see the responsibility they have assumed in managing different commissioning budgets.

The Manchester findings suggest that PCG/Ts took increased responsibility for a number of different budgets. They held fully delegated responsibility for approximately 70% of both community services and general and acute secondary care services. They showed greatest progress in general and acute secondary care services where only 41% had previously assumed responsibility in the previous year. Between 50-60% had assumed fully delegate responsibility for community hospital budgets, A&E budgets and maternity care services. PCG/Ts had taken least responsibility for learning difficulties and mental health budgets, with 22% and 18%, respectively, assuming fully delegated responsibility.

A second measure of PCG/Ts' development is the extent to which they influence service level agreements. A minority of PCG/Ts reported that they had made changes to service level agreements: 34% reported changes to community health services and 43% for hospital services. Reasons for making changes included increasing the level of provision of secondary care to meet NSF and waiting

list targets, reducing financial risk to the PCG/T and moving services to practice base. PCG/Ts also reported that they perceived having greater influence on service level agreements[9] than they had in the previous year.

Health authorities have assumed the gaps in PCG/Ts responsibilities. Manchester reported that nearly two-thirds of health authorities reported that they had a great deal of influence on PCG/T commissioning on hospital services although only 30% reported that they had a great deal of influence on commissioning community services. Despite being reliant on health authorities many PCG/Ts have reported that they have not received adequate support from them. Many health authorities admitted that they were unable to provide adequate support. One of the greatest difficulties reported by Manchester was the inability of health authorities to provide PCG/Ts with adequate information.

As well as relying on health authorities, PCG/Ts have been relying on each other to commission services. All PCG/Ts in the Birmingham and Manchester studies reported engaging in some degree of joint commissioning with other PCG/Ts. As well as being able to collaborate with other PCG/Ts, they are able to commission jointly with social services through the Joint Investment Plan (JIP). Approximately a third of the PCG/Ts in Manchester's sample reported joint commissioning through JIP.

Achievements

There are not many obvious commissioning achievements noted by either Birmingham or Manchester. Most achievements that they do mention occurred either in community services or in developing new intermediate care services that involve transferring functions from hospitals to a primary care setting. Manchester asked commissioning leads about the achievement of their commissioning objectives. A quarter responded that they had achieved most or all of their objectives, half reported that all of them had been achieved and a quarter reported that none of them had. Manchester also asked chief executives to list the achievements of their PCG/T. Only 13% mentioned achievements related to their role in commissioning. Although achievements were limited, they were related to improving access, reducing waiting times and moving services from hospitals into practices.

An indirect measure of commissioning achievements is exploitation of the opportunities created by the unified budget. So far there have been few movements across budgetary headings and where there have, they have been reactive in character; however, Manchester report that 55% have plans to move money from the HCHS budget to prescribing and GMS budgets. Over 60% of PCGs reporting planned movements from the HCHS budget report that shifts will be directed toward GMS.

Discussion

Perhaps the most notable feature of PCG/Ts record in commissioning is the lack of achievement. In some ways this is quite remarkable following on from the internal market where a variety of forms of primary care commissioning organisations developed. One would have thought that commissioning would have been one of the first areas where PCG/Ts would make an impact. While a focus on organisational development to the exclusion of other priorities is understandable, it is surprising that topics such as clinical governance, which is a relatively new addition to the primary care agenda, should have been the site of such progress while commissioning has not.

What are the obstacles? Are the difficulties related more to a lack of ability or to a lack of incentives? Manchester and Birmingham cite similar problems relating to a lack of management support, a lack of financial clout, financial deficits, the unwillingness of hospital trusts to change and a lack of information. These obstacles all point to the problem being related to a weak commissioning infrastructure and PCTs' possessing little clout in the local health economy.

The two studies report little evidence that relates directly to the issue of incentives. There is, however, one notable finding in Manchester's report that indicates that PCG/Ts do not have great incentives to commission more effectively. When asked what they viewed as being key tasks in the future, only 7%, down from 23% the previous year, reported commissioning. Despite of the lack of achievement to date, chief executives do not rate commissioning high among their priorities. Whether the lack of incentives arises out of the organisational structure of PCG/Ts or whether it has to do with national targets removing effective authority from PCG/Ts is not clear but it does show that in the near future it is unlikely that PCG/Ts will be making much progress in commissioning

5. Comparison between PCG/Ts and HMOs

PCG/Ts will be briefly compared with Health Maintenance

Organisations (HMOs). HMOs are one of the central organisational features of the development of managed care in the United States. They are either groups of physicians who provide a range of services, independent practice associations (IPAs), or they are groups of physicians or intermediaries who hire a group of physicians to provide a range of services. They are the organisations through which a large proportion of private medicine in the United States is delivered. Any comparison must bear in mind that PCG/Ts and HMOs have somewhat differing aims that means each works under a different set of constraints. For instance, PCG/Ts have a much wider range of public health duties and a greater commitment to an equitable delivery of service that distinguishes them from HMOs. Also, HMOs tend to cover larger populations and to have much greater management support than PCG/Ts. While keeping these issues in mind the development of PCG/Ts is usefully contextualised by comparing some areas of difference and similarity between the two. In what follows the comparison will be organised around two themes: 1) clinical governance and the management of clinic behaviour and 2) the role of competitive pressures.

Clinical governance and the management of clinical behaviour

One of the central changes that managed care and HMOs have made to the delivery of health care in the United States has been to alter the incentives and clinical freedoms faced by physicians. Perhaps the greatest change has been in the way that physicians are remunerated. Fee for service payments have been replaced in many instances either by salary or by capitation. Other changes include utilisation review, which involves reviewing the clinical decisions made by physicians to see whether they are appropriate, and pre-certification, which involves physicians having to gain authorisation of their clinical decisions.

Many of these changes were introduced in a context where health costs were rising faster than in other countries and absorbing a greater proportion of the country's resources. These infringements on unfettered clinical freedoms were designed largely to halt the increase in health costs faced by America. They were intended both to remove the incentive of physicians to over utilise medical resources and to ensure that all decisions that were taken were truly necessary. These changes had as their central aim the objective of ensuring that the gap between the marginal health benefit of and the marginal cost of a medical procedure was narrowed.

The latest reforms of the NHS also involve incursions on clinical freedom. These changes have largely been introduced under the guise of clinical governance. Clinical governance is a broad topic that can include public health concerns as well as whether clinical decisions are evidence based. What unites the separate strands is a concern for quality in health care. A typical example of a clinical governance target would be to check whether all patients with high blood pressure are on stations; however, clinical governance concerns can range include such topics as whether all members of staff have a job description to whether medical records are kept in order.

While the escalating cost of health care has certainly lain behind the development of the concept of clinical governance, just as important, if not more, has been an emphasis on ensuring that minimal quality standards of care are guaranteed throughout the NHS. Clinical governance is a reaction against the variable standards of quality that have been perceived to exist in the NHS. In this sense standardisation and equity are considerations of equal importance in the development of clinical governance.

While different motivations have lain behind the trends toward restricting clinical freedoms in the two countries, the mechanisms have been somewhat different. In the United States, these changes have been managed through peer pressures but also through the authority granted by a labour contract. The threat of termination of employment or not renewing a contract is an effective disciplining mechanism. PCG/Ts have much less authority as general practitioners remain independent contractors who cannot so easily be removed from the PCG/T. Clinical governance changes are largely driven by consent, either through peer pressures or through incentive systems linked to clinical governance targets. The political sensitivity of clinical governance is reflected in the fact that one of the board GPs on PCT boards is responsible for clinical governance. As well as the powers that PCG/Ts can use themselves, the clinical governance agenda is also driven by the centre through NSF targets and through guidance from NICE.

HMOs and PCG/Ts have made similar attempts to manage the practice of individual practitioners. The pressures and motivations guiding the direction of change has been different for each; HMOs have largely been driven by cost pressures while PCG/Ts have been driven by cost pressures as well but also by issues of quality,

standardisation and equity. Although these themes do not directly bear on commissioning, they exemplify some of the different pressures and problems, as well as the mechanisms available to respond to those pressures, which are available to HMOs and PCG/Ts.

Competitive pressures and incentives in HMOs and PCG/Ts

HMOs face an environment of intense competition. Most of the purchasers of their services are employers with both the incentives and the resources to ensure that they are receiving the best deal available. They inhabit environments that include numerous other HMOs who could replace them. Many American health markets also have health resources that are surplus to requirements so there are plenty of competitive opportunities. These competitive pressures give HMOs the incentive to offer efficiently produced and organised health care. If HMOs fail to offer value for money, they face informed and able consumers who have alternatives.

The situation is generally quite different for PCG/Ts. PCG/Ts are both providers of primary care and purchasers of secondary care. While their role as purchasers has been discussed earlier, examining their role as providers shows the role of competition in creating pressures on PCG/Ts. In their role as providers, the pressures on PCG/Ts do not generally come from individual consumers of their services but from their agent in the guise of health authorities. PCG/Ts are performance managed with a range of different targets that they are required to meet. If they fail to meet those targets, the management can be removed. It is not clear, however, the extent to which this measure has been taken or, indeed, that it has needed to be. Even if taken it is not clear that it would be so effective as the professionals who hold influential positions in the PCG/T would still remain part of it. Also PCG/Ts cannot compete against each other; it is not possible for one PCG/T to offer a better service to consumers who are dissatisfied with the services of another.

While competitive market pressures drive HMOs, PCG/Ts are performance managed through targets and rely on cooperative relationships between their stakeholders and providers. These differences are largely intentional. The incentives gained from competition have been deemed by the Labour Government not to be worth the cost in terms of transaction costs and potential inequities and variations in services available to patients. These differences between PCG/Ts and HMOs are evident in the way that they have attempted to manage clinical behaviour. While HMOs have been motivated by cost pressures and relied on changes to contractual arrangements to effect change, PCG/Ts have been driven by cost and equity and they have used targets and cooperative mechanisms to achieve their aims.

6. Implication to Japanese Reform

For the governments not only in Europe but also in the US and the Far East, how to improve quality and efficiency of the health care system is of prime importance in their social policy. Even in the countries of free economy in Europe, their social policy used to be quite akin to that of the socialistic countries. After the demise of socialism, the review of the social structure pursued by the neo-liberal governments reached even to the social policy areas. The central tenet of the reform is to utilise the market mechanisms to improve the quality and efficiency of the system.

It is well know fact, however, that the market in these areas is doomed to failure if it is left uncontrolled. Various attempts to manage to make it work are on a way within the historical context of each country.

In the reform of the UK, the activity of costing and pricing was devolved to the matter between the GPFH and hospitals by the former government and then to that between PCG/T and hospitals. The labour government declared that the internal market was to be abolished but the basic structure to urge hospitals to improve efficiency of management was bequeathed, although the new arrangement may seem too weak for hospitals instantly to change their behaviours. At present, the new arrangement shows scarce sign to prove its effectiveness but it is clearly too early to conclude on its effects, as the agreement cycle between the both parties is every three years. It might be expected to yield substantial results in due course of time.

In the US, the HMOs are envisaged to introduce the wisdom of the management science to the health care and to work as the main actors of the managed competition in the health care market. The power of this arrangement has been proved by the fact that medical inflation in the US has been well subsided for these ten years.

In Japan, the universal health insurance scheme has long guaranteed equal health services to citizens. Patients are free to attend institutions that vary in terms of size, the specialities they offer, and their ownership structure. That means, the market is set between patients and

providers, and market mechanisms are expected to improve the quality and efficiency of care provided. The prices of care are decided centrally through the commissioning organisation named "Chuikyo[10]". The organisation for negotiating prices substantially decides the level of health expenditures and it has widely been accepted that this Japanese system was fairly successful in controlling the health expenditures.

However, this market set between patients and providers is quite different from what deserves of its name. The real features of how the market is really working differ from what is intended to. According to our analysis[11], the itemised fee-for-service payment induces an exaggerated consumption of resources. It is true that there is competition between institutions but it creates a vicious cycle of investing in facilities only to induce greater demand. Looking at the health data of the OECD, Japan belongs to the countries that have not been successful in controlling the growth of health expenditures[12].

In order to subside the over consumption of health resources, Japan has to re-examine carefully the incentive structure and to reform it in a way that professionals are motivated to maximise the resource values. The way of exact managed competition trodden by the US would be difficult for Japan to follow because it would be impossible to put insurers into competitive situation because they are mandated by law to organise people where they work or live. Japan will have to give up the itemised fee-for-service system that stimulates strong incentive for the professional to overuse health resources and to stop turning around the vicious cycle of the cost inflation.

In the UK's reform, it is noteworthy that the reform goes in line with devolution. The power to affect the cost of care of the secondary care was devolved from the government to the non-governmental parties, restricting its role just to the supplier of benchmark data on the prices of care of hospitals. Devolution, however, has recently gained momentum in Japan since the Local Autonomy Law was amended and came into force in 2000. At present, the major actors of the health policy in Japan are playing their roles in the central government, but gradually the local government will have to take over more responsibility.

For an instance, it would be another pivotal point for deliberation to utilise the power of the insurers and the local government is responsible for managing the National Health Insurance. The present status of them is quite passive and they are just the clerical managers of finance. They are given too little sovereignty to try to attain value of money that they are entrusted to manage. Thus, the future of health policy will be required to be in line with this trend although it is yet to be seen whether this will, in fact occur.

7. Conclusion

This paper has focused on the progress made by PCG/Ts in commissioning since their creation in 1999. The main points to arise from the discussion are listed below

- ·Of all the preceding primary care commissioning organisation, PCG/Ts most closely resemble locality commissioning and TPPs
- ·The purchaser provider was maintained but cooperative relationships replaced competitive ones.
- ·PCG/Ts face formidable information hurdles. It is not clear that they have the infrastructure to manage these hurdles.
- ·PCG/Ts have been given budgets that unify prescribing, GMS and HCHS budgets.
- ·The unified budget will have varying effects on the incentives of PCG/Ts to commission effectively.
- ·National targets including NSFs and guidance from NICE guide PCG/T commissioning.
- ·The record of commissioning is lacking many achievements to date.
- ·PCG/Ts have made greater progress in developing intermediate care and commissioning community care than they have in commissioning secondary care.
- ·PCG/Ts face a number of obstacles to commissioning including a lack of information, a lack of financial clout and hospital trusts unwilling to change.

PCG/Ts were created in reaction to the internal market. They combined features of the various organisations that were responsible for primary care purchasing. While maintaining the purchaser provider split, cooperation and deliberation replaced competitive bargaining. Commissioning decisions were granted to groups of practices along with other stakeholders in a manner that closely resembled locality commissioning and some TPPs. The unified budget increased the incentives for primary care to commission effectively but it is not clear that the increased group incentives will lead to increased incentives by individual stakeholder. PCG/Ts also face complex information problems if they are to discern the preferences of their stakeholders and manage to aggregate those preferences.

The record of PCG/Ts on commissioning is mea-

gre. They have noticeably few achievements and they do not appear to view commissioning as being a central priority for the future. There are a number of possible reasons for this lack of achievement. These include an infrastructure that is not suitable for the task of commissioning, a lack of incentives to devote energy to commissioning, central targets that might not leave much discretion to PCG/Ts to commission effectively or it just might be too early to judge the achievements of PCG/Ts. Despite retaining the purchaser provider split it is still not clear that effective primary care commissioning is a priority in the New NHS.

The Japanese itemised fee-for-service payment system that is centrally managed does not necessarily give care providers an incentive towards improving quality and efficiency but instead it brings about a vicious cycle of cost inflation. An incentive structure that is really effective to contain the medical cost inflation should be forged in line with the trend of devolution that is most fundamental policy of the country.

Notes

[1] This is not to say that norms of co-operation have not been prevalent in the NHS (Hausman and Le Grand 1999), rather that they had not formed the basis of formal organisational principles.

[2] The reforms did not, however, entirely replace authority and competition. The range of regulatory bodies and national standards which were introduced with the reforms and continuation of the purchaser provider split ensure that authority and competition respectively are still prominent organisational features of the new NHS

[3] The National Casemix Office has devised HRGs over the past decade and they are groupings of different procedures according to their resource implications. They were created so that costs could be compared across different institutions as well as ensuring that casemix was a consideration during contracting between purchasers and providers.

[4] The GMS budget includes investment in general practice infrastructure, equipment and staffing.

[5] The local medical committee is a group of doctors who are elected locally to represent the interests of GPs in their area.

[6] A good is non-excludable if potential users cannot be excluded from consuming the good or it is prohibitively costly to exclude potential users. A good exhibits jointness of supply, also known as indivisiblity, if the consumption of the good does not reduce the ability of others to consume the good.

[7] Of course, this is only partially the story. A lower price might be easier to negotiate in a larger PCT than in a smaller one. This example is to show what can happen holding the size effects of bargaining constant.

[8] Intermediate services are services that are developed at the interface of primary and secondary care. They can be used as a replacement for many services that have been in secondary care. Examples of intermediate care include the development of diabetes clinics in primary care and outreach clinics held by specialists in primary care.

[9] These are the three years agreements between trusts and PCG/Ts. They replaced the annual contracts that were used in the internal market.

[10] This is an acronym of the name of the commissioning organisation on pricing of health care items The name means “The Central Commission on the Health Insurance”.

[11] The Research Group on the Area Difference of Health Expense(2001, chaired by A. Gunji), The Area Difference of Health Expense in Japan, Toyo Keizai Shinpou (Jpn).

[12] According to the Health data base published by OECD in 2000, the Japanese average annual growth of the health expenditures since 1991 through 1997 is 7.6% that is the fifth position from the top among 29 member countries. In the same period, the UK is 5.6%(13th), the USA is 5%(21st) and France is 3.1%(26th).

Bibliography

Audit Commission (1999) PCGs: An early view of Primary Care Groups in England. London HMSO

Audit Commission (2000) The PCG agenda: early progress of Primary Care Groups in the New NHS. London, HMSO.

Bartlett, W. and Le grand, J. (1993), ‘ The theory of quasi-markets’, in Le Grand, J. and Bartlett, W. (eds), Quasi-markets and Social Policy, Macmillan, London

Department of Health White Paper (December 1997) CM 3807 The New NHS Modern and Dependable . (http://tap.ccta.gov.uk/doh/point.nsf/Publications?ReadForm)

Department of Health (2001) The New NHS- Reference Costs. (http://www.doh.gov.uk/nhsexec/refcosts.htm)

Gunji, A. (in process), Consequences of Privatising the

Provision of Health Care, in The Role of the Market in the Health and Welfare System, Seigakuin University Press.

Hausman D and Le Grand J •fIncentives and Health Policy: Primary and Secondary Care in the British National Health Service, Social Science and Medicine 49(1999): 1299-1307.

Le Grand J, Mays N and Mulligan J. (1998) Learning from the NHS Internal Market. King•fs Fund, London.

Light, D (1998) Effective Commissioning. Office of Health Economics, London

Majeed A and Malcolm L (1999) •eUnified budgets for primary care groups•fBritish Medical Journal 318: 772-776

Marwell, G and Oliver P. (1993) The Critical Mass in Collective Action: a Micro Social Theory, Cambridge University Press, Cambridge.

Mays N, Goodwin N, Malbon G, Leese B, Mahon A and Wyke S (1998) What are the achievements of Total Purchasing Pilot Projects in the first year and how can they be explained•fNational Evaluation of Total Purchasing Pilots Projects Working Paper. London King•fs Fund

National Casemix Office (1999) Healthcare Resource Groups: document 3. NHS Information, Winchester.

Olson, M. (1965), The Logic of Collective Action, Harvard University Press, Cambridge Mass.

Regen, EL, Smith JA and Shapiro J (1999) First off the starting block: lessons from GP commissioning pilots of Primary Care Groups. Health Services Management Centre, Birmingham.

Smith JA, Regen EL, Goodwin N, McLeod H and Shapiro(2000) Getting into their stride: interim report of the national evaluation of Primary Care Groups. Health Services Management Centre, Birmingham.

Smith, J., Regen, E., Goodwin, N., McLeod, H and Shapiro, J. (2001), Passing on the Baton: Final Report of a National Evaluation of Primary Care Groups and Trusts. Manchester University, Manchester.

Smith PC (1999) •eSetting budgets for general practice in the new NHS•fBritish Medical Journal 318: 776-779.

Stinchcombe A (1990) Information and Organizations. California University Press. Berkeley.

Wilkin D, Gillam S and Leese, B (eds.) (2000) National Tracker Survey of Primary Care Groups and Trusts: Progress and Challenges 1999/2000. National Primary Care and Research Development Centre, Manchester (http://www.npcrdc.man.ac.uk/Pages/NPCRDC/Home.htm)

Wilkin, D., Gillam, S. and Crawford, A. (2001), The National Tracker Survey of PCG/Ts 2000/2001: Modernising the NHS? University of Birmingham, Birmingham.

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(First received: November 6, 2002; Accepted: May 30, 2003)