General practitioner-led commissioning in the NHS: progress, prospects and pitfalls

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The latest NHS reforms in England will require all general practices to become members of general practitioner (GP) consortia. These organisations will have responsibility for commissioning the majority of health care for their local populations. This article reviews the history and evidence on impact of the previous models of GP commissioning that have been introduced in the NHS with the aim of distilling key lessons for the design, implementation and evaluation of the latest reforms. GP commissioning has the potential to generate a variety of benefits for the NHS and patients, including lowering elective and non-elective referrals, reducing waiting times, improved coordination of primary and community support services and better financial risk management. GP commissioning has also the potential to reduce patient satisfaction, increase inequalities between geographical areas and may generate substantial management and transaction costs. The GP community will need to display strong directive leadership as well as nurture a culture of collaboration and group camaraderie among practices if the GP consortia model of commissioning is to deliver the desired improvements in quality and performance. The implementation of the new GP consortia model of commissioning needs to be monitored and evaluated to ensure that the benefits are maximized and any unintended and dysfunctional effects mitigated.

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Introduction

For many years general practitioners (GPs) in the NHS were allowed to function independently with little or no requirement to work collaboratively with other health professionals or to consider the cost and resource implications of their referral, treatment and prescribing decisions.\textsuperscript{1,2} However, over the last two decades policy-makers have experimented with ways of better aligning the objectives of GPs with those of the wider health system through the development of a variety of models of GP-led commissioning, including the GP fundholding initiative (GPFH), total purchasing pilots (TPPs) and practice-based commissioning (PBC). The logic underpinning these initiatives is a belief that as the clinicians closest to their patients on a regular basis, GPs are best placed to understand their needs and commission services on their behalf. In this sense, the role of the GP is to serve both as an expert clinical agent (acting on behalf of the patient) and as a rationing agent (acting on behalf of the funders of care).

The recent White Paper, \textit{Equity and Excellence: Liberating the NHS}, introduces yet another new model of GP involvement whereby ‘consortia’ of general practices will hold real budgets and take on the responsibility for commissioning the majority of health and community care services for their local populations. This paper reviews the evidence on the development and impact of GP-led commissioning in its various guises over the last 20 years with the aim of informing the design, implementation and evaluation of the latest model of commissioning. The discussion draws on the findings of previous literature reviews as well as recent empirical work in the area.

Evolution of GP commissioning in the NHS

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. GP commissioning in the English NHS dates back to the 1991 internal market reforms that introduced a mandatory separation of purchaser and provider functions. Prior to this date, local health authorities were responsible for both the planning and the delivery of services for their patients. A key element of the internal market reforms was the introduction of the GPFH scheme under which GPs could volunteer to hold real budgets to purchase primarily non-emergency elective and community care on their patients’ behalf. The aim behind GPFH was to provide GPs with a personal incentive to bear down on the costs of services as any...
accrued savings could be retained by practices and to exert competitive pressure on hospital providers as ‘money would follow the patient’ and provide an incentive for secondary-care providers to increase quality and be more responsive to the needs and wishes of patients. Fundholders self-selected into the scheme in seven waves up to 1997/98 with eventually about half of all general practices became fundholder. In addition to the standard model of GPFH, several innovative groups of fundholding GPs negotiated devolved financial responsibility with indicative rather than real budgets for a range of health and community care services with their local health authorities. In an attempt to build on the perceived success of these local initiatives the TPPs were established by the government in 1994 and served as sub-committees of their parent health authorities.

In opposition the Labour party were critical of the GPFH initiative and when elected in 1997 abolished the scheme amid concerns that the scheme was inequitable and helped to foster a ‘two-tier’ health service. However, the purchaser-provider split was retained and later health authorities were replaced by primary care groups and then by primary care trusts (PCTs) as the primary commissioners of health care. In April 2005 the Labour government introduced a new form of GP-led commissioning under the banner of PBC. PBC is a voluntary scheme whereby individual practices are allocated an indicative budget by their parent PCT and GPs are allowed to invest a proportion of any efficiency savings they make in the development of new primary care services.

The following section reviews the evidence on the impact of various models of GP-led commissioning in eight key areas: (i) elective admission rates, (ii) non-elective and emergency admissions, (iii) waiting times, (iv) provider responsiveness, (v) patient satisfaction, (vi) pharmaceutical costs, (vii) risk management and (viii) transaction costs.

**Elective admission rates**

A key aim of GPFH was to lower the volume of elective admissions to secondary care. Evidence on the impact of GPFH on elective admissions in the 1990s is mixed. Although some studies indicate that GPFH practices did lower their referral rates to secondary care compared with non-GPFH practices, other studies at the time identified no variance in the rate of growth of elective admission rates between GPFH and non-GPFHs practices. An important methodological limitation of these evaluations is that they did control for selection bias and those GPs electing to become a fundholder may have differed in terms of key background factors which influenced commissioning practice.
Research by Dusheiko et al., based on more robust methodology, has explored the impact of budgetary regimes on the admission rates of fundholding practices. The study involved the analysis of admissions data for over 7000 practices (fundholding and non-fundholding) for the 2 years before (1997/8, and 1998/9) and the following 2 years (1999/2000, 2000). The study found that rates for elective surgical admissions amongst those practices that elected to become GPFHs, was 3.3% lower than they would have been in the absence of GPFH (this was interpreted as the incentive effect of GPFH). However, the researchers were unable to determine whether lower admissions from GPFH were achieved at the expense of patient welfare. In-depth qualitative case studies of TPPs also support the case that GP-led commissioning may help lower elective-care admissions.

Non-elective and emergency admission rates

The most robust large-scale quantitative study on the impact of GPFH on non-elective (emergency) admission rates found that this mode of commissioning had little or no effect on non-elective referrals. A key objective of TPPs was to reduce the inappropriate emergency admissions as well as reduce lengths of stay through the extension of services outside the scope of the original fundholding initiative. An evaluation undertaken at the time found that 11 of the 16 pilots with this objective were indeed successful in reducing the number of emergency-related occupied bed days by significantly more than comparable practices in the same area. However, TPPs were assessed as being less successful in negotiating with acute providers to change their contract volumes accordingly to free up resources for the future.

Waiting times

Another key objective of GPFH was to reduce hospital waiting times for their patients on due to the credible threat of potentially switching contracts to providers with shorter waiting times. In their assessment of the impact of GPFH on waiting times, Dusheiko et al. analysed the mean waiting times for over 7000 practices (fundholding and non-fundholding) for the 2 years before and 2 years after GPFH was abolished. They found that GPFH lowered waiting times by an average of between ~3 and 5 days. The study also found that patients of fundholder practices had shorter waits (by 2 days) for non-chargeable elective admissions, suggesting than GPFH were able to secure shorter waits for a broad range of elective admissions.
Provider responsiveness

A rationale of GPFH was to provide an additional incentive to hospital trusts to be more responsive to GPs and through them to their patients. Indeed, a number of studies report that improvements to secondary and hospital care due to GPFH including examples of more information provided to GPs and their patients, prompter discharge letter, faster responses to enquiries and improved access to services such as physiotherapy, inpatient care and specialist outreach clinics. Recent evaluations of PBC indicate that it has had little impact on improving provider responsiveness with 80% of GPs in a national survey feeling that they lacked some or all of the necessary skills to be an effective commissioner.15

Patient satisfaction

In many health systems, information on the views and experiences of patients is increasingly viewed as an important source of data on the quality of care. Dusheiko et al.16 assessed the impact of GPFH on patient satisfaction using a cross-sectional survey of 4311 patients from 60 practices in the last year of GPFH (1998). The study found that those patients belonging to fundholding practices were less satisfied than non-fundholder patients. Using numerical values to the satisfaction categories (from a score of 1 for completely dissatisfied and to a score of 7 for completely satisfied), the mean satisfaction of patients in fundholding practices is 5.42, compared with a mean of 5.61 for patients in non-fundholding practices, a difference of 4.1%. The authors conclude that any 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. They also speculate that the added managerial responsibility and transaction costs to fundholder practices may have diverted GP attention away from the care of their patients.

Pharmaceutical costs

The research suggests that compared with non-GPFH practices, GPFHs appear to have had a slightly slower growth in their pharmaceutical costs, particularly during the initial stages of the scheme. GPFH practices were able to make what were largely ‘one off’ 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 were
implemented, prescribing cost growth among GPFH reverted to that of non-fundholders.\textsuperscript{2,17}

**Risk management**

A key determinant of the TPP pilots’ exposure to financial risk was the degree to which financial budgets remained the responsibility of the pilot sites, and how much was ‘blocked back’ to their local health authority.\textsuperscript{18,19} A research evaluation of risk management by TPP practices found that 29/32 (87\%) carried some financial risk and budgetary responsibility.\textsuperscript{20} Many pilots introduced financial management mechanisms designed to control expenditure (for example, monitoring specialist activity and imposing penalties for under- or over-performing. GPs in TPP practices also collaborated with the aim of limiting demand by discussing individual cases and agreeing protocols. In terms of risk management, single practice and smaller TPP practices appeared to perform better than multi-practice or larger TPP practices. The authors conclude there is a necessary trade off between choosing the scale at which to encourage GPs to take on the role of insurer. Groups of practices covering larger populations are exposed to less financial risk due to random variation, but GPs in such groups may be less able to collaborate and hence less willing to change their clinical practice in the face of budgetary constraints.\textsuperscript{20}

**Transaction costs**

Prior to the introduction of GPFH, some commentators predicted that devolving budgets to individual practices would induce considerable costs for GPs and secondary providers because of the additional management and administrative burden associated with negotiating and monitoring contracts and devising purchasing and commissioning strategies.\textsuperscript{21,22} Place et al.\textsuperscript{23} assessed the additional transaction costs incurred in seven TPPs as compared with 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. Most of the cost (\textasciitilde 85\%) was borne by the TPP
site themselves, but a substantial burden (~25%) fell to GPs and their time input was not compensated fully. Slow progress in the take up and impact of PBC has been attributed in part to the bureaucracy and transaction costs associated with PCT approval of business cases and a general lack of engagement of GPs in the PCT commissioning process.\textsuperscript{15,24}

Summary and implications

This review of the impact of different models of GP-led commissioning highlights potential areas where GP-consortia commissioning might be expected to deliver benefits for the NHS and patients as well as some of the limitations, pitfalls and dysfunctional consequences of transitioning towards this form of commissioning. The possible benefits of mandatory GP-led commissioning compared with other modes of commissioning include:

- lowering elective referral and admission rates;
- reduced emergency related occupied bed days;
- lower waiting times for non-emergency treatment;
- improved coordination of primary, intermediate and community support services;
- improvement in financial risk management;
- better collaboration between GPs across practices;
- better engagement of clinicians in the commissioning process.

Based on previous experience of GP-led commissioning, the new commissioning arrangements may also induce limited or even negative outcomes for patients and care delivery, including:

- the potential for reducing patient satisfaction;
- increased management and transaction costs;
- increased inequities in access and use of services;
- a limited impact in making secondary providers more responsive to the needs for patients.

What is clear is that the new GP consortia model of commissioning will need effective management support to assist in the commissioning process and the GP community will need to display strong directive leadership as well as foster a culture of collaboration and group camaraderie among practices if the reforms are to deliver the desired improvements in quality and performance.\textsuperscript{25} The absence of prescriptive central guidance concerning the implementation and operation of
consortia may result in the development of a wide variety of local approaches and outcomes, which will need to be monitored, and strategies put in place to ensure that the benefits are maximized and any deleterious consequences are mitigated.

References
