Practice based Commissioning: not what it says on the tin

A 2020health discussion paper
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About this publication

This publication was inspired by a round table discussion meeting held on September 28th 2008 in Birmingham, chaired by Shadow Health Minister Mark Simmonds MP. The discussion focused on the performance of Practice based Commissioning [PbC], launched in 2006 by the Department of Health, and a subject of debate ever since. If PbC were to be developed further, what considerations, incentives and mindset needed to be taken into account? This paper takes these themes and explores them further. Both the dinner and this publication were enabled by unrestricted sponsorship from Sanofi-Aventis, for which we are very grateful.

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With thanks to our sponsor
Executive summary

The main challenge in the public sector lies in the degree of decentralisation that is allowed to occur. In health as elsewhere, the closer alignment of power and responsibility appeals to human nature and, with appropriate controls, will better meet the needs of the welfare state. Practice based Commissioning needs to be strengthened if it is to survive and deliver the improved, efficient patient outcomes for which it was originally designed. However, active political contamination, and passive resistance by the various vested interests already in the system, should not be underestimated.

In the early days of the NHS, clinical provision was generally regarded as distinct from funding, which was not large nor unpredictable enough to create many political difficulties.

However, rising demand and expectations put increasing pressure on resources and in the ensuing search for political solutions, the linkage began to be made between clinical and financial responsibilities. GP fundholding was the direct product of this idea: GP practices were allocated funds for a whole range of hospital procedures for their patients, and the GPs themselves had to decide how to spend that money. Any residue at the end of the year could be spent by the practices on extra patient services.

Fundholding evolved considerably during its existence but there were always some misgivings about the equity of the scheme, its higher transaction costs, the possibility of ‘cherry picking’, and the commercialisation of the NHS. These misgivings underpinned the actions of the new Labour Government in 1997, who attempted to overcome them by creating Primary Care Groups (PCGs), and later Primary Care Trusts. These were still intended to involve clinicians in ‘driving’ the system, but were supposed to be non-commercial, and with low transaction costs.

By 2005, PCTs had an average size of 175,000 patients and had taken over all the traditional roles of a health authority; elsewhere there was an increasing drive towards NHS funding of non-NHS provision, as exemplified by the development of some private providers, and the creation of Foundation Trusts; the ‘public sector’ was increasingly being defined by its tax based funding rather than by the public nature of its provision.

The term ‘commissioning’ has come to encompass all the aspects of procurement, including strategic planning, service procurement, and monitoring and evaluation. The simplicity of the term is misleading, and hides some grating discords; if the concept is to have any meaning, then all those involved need to have a common understanding and approach to its implementation.

There is a clear link between the size and complexity of each organisation involved in the commissioning process and its place in that process: thus, strategically focused organisations such as PCTs should carry out the strategically focused tasks, and have the capacity, the capability, and the incentives to do so.

Their role is to oversee their local health economies, and to facilitate the provision of health care, without becoming embroiled in its day to day delivery, their performance should be measured around this mission. PCTs are less well placed to cover the other aspects of commissioning; the mechanical aspects of service procurement need organisations that are more grounded in ‘real life’ and with the appropriate operational credibility and capability. This order of task, along with its monitoring and evaluation, is what was originally intended for practice based commissioners.
Practice based Commissioning: not what it says on the tin

(PbC), with their knowledge of clinical matters, their ability to challenge hospital activity, and to judge the quality, timeliness, and appropriateness of the services they received.

PbC gave its agents the incentive to carry out these activities well. They got a better sense of ‘ownership’ of their patients’ problems, and were incentivised to do more and spend less. As with fundholding, the intention was to encourage practices to decide how much they did themselves and how much they wanted to ‘subcontract’ elsewhere.

But PbC is not functioning in this manner; a number of issues have been identified including: confusion as to the respective roles and responsibilities of GPs, PbC clusters, and PCTs; lack of mature relationships amongst stakeholders; complexities around the management of financial and clinical risks; general lack of capacity and capability; perceived conflicts of interest at GP level and in the PCTs; and wider contextual factors such as changing political priorities.

PbC clusters were originally intended to take overall responsibility for the healthcare of their population, providing a natural counterweight to the supply side pressures exerted by Payment by Results (PbR). However, there has been a gradual retrenchment from that position, based partly on political resistance, and partly on passive resistance within the NHS itself. Without the symmetry of the PbC/PbR relationship, the balance between procurer and provider is impossible to achieve. PbC as it now exists cannot succeed because it isn’t in the interests of any of the vested parties for it to succeed: PCTs lose control, PbCs only gain bureaucracy.

At the heart of the problem lie many misaligned incentives. There is rarely any linkage between effort and perceptible reward, whether defined in terms of status, job satisfaction, or money. This may partly be a ‘public sector’ effect, with its need for transparency, but there is also a British puritanism about the concept of personal reward that needs to be addressed if new policies in this area are to succeed. The challenge is to construct a system with enough personal incentives to drive performance without political or social difficulties intervening. The philosophy underpinning PbC has the potential to offer incentives whilst ensuring equity, quality, and value for money.

It would not be difficult for the PbC/PbR system to be ‘fine tuned’ to achieve a balance of corporate and individual incentives at all levels of the NHS, so that power and responsibility are matched throughout.

For PCTs to carry responsibility for strategic commissioning, they need broad, strategic objectives with as few activity-based targets as possible. Their skills will need further development: strategic commissioning is still unfamiliar in the NHS, and political influences are still strong. Practice-based commissioning should be allowed to evolve, with direct links between the responsibilities carried by the cluster, and the resources required. The current perverse funding structures should change, with both funding and accountability channeled through PbC clusters.

Once the notion of funding all services through PbC is accepted, then internal conflicts of interest also disappear, as clusters spend ‘their’ money in ways that aligns risk with benefits. Patient choice would need to be protected however, with one of the few regulatory mechanisms checking how patients are offered choices of provider for secondary and specialised services.
How clusters manage their internal arrangements should not overly exercise PCT commissioners; some GPs may remain pure providers whilst others become involved in the management of the cluster. The **core accountability** of clusters to their PCT should be on the three arms of **disease outcomes**, **genuine patient satisfaction**, and **budgetary efficiency**.

At the other end, the Department of Health should create and maintain some distance between the NHS and itself, so that the day-to-day operation may run with as little political influence as possible. **Without these developments, the current gradual degradation of PbC will accelerate**; GPs will see little benefit in becoming involved in management, and PCTs will find themselves taking on the operational aspects of commissioning.
In the beginning was the Welfare State

In the early days of the NHS, the provision of clinical services was often regarded as distinct from their funding; hospitals were generally funded by means of large ‘block payments’, whilst the funding for primary care, although open ended, was not large or unpredictable enough to create many political difficulties. There was little if any attempt to penetrate the ‘black box’ of professional practice; instead, health care organisations were funded on the basis that their clinicians would ‘do the right thing’ in the traditional mode of archetypal Professionals.

However, as the service grew, ever-improving technology raised demand and expectations, putting increasing pressure on resources. By the mid-1980s, this was being expressed by a rise in waiting lists and waiting times for surgery; in the ensuing search for political solutions, the (now) self-evident realisation dawned that clinical expenditure was invoked almost entirely by clinicians (and in particular doctors) in the work that they carried out themselves, or engendered through referrals, investigations, and so on.

Observation: even with no competition in a system, market forces apply, and uncontrolled ‘supply’ will generate ‘demand’

The irony was that they invoked this massive spend with little apparent knowledge or ‘ownership’ of the sums involved. Actually, this ignorance was (at some level, at least) deliberate, as it had been felt until that time that NHS treatment should be carried out without clinicians needing to consider resources. In ‘ownership’ terms, the doctors owned the clinical problems but not the resources needed to solve them; whilst attractive in a Utopian sense, in the real, resource constrained world, the perception grew that this imbalance might be partly responsible for the financial pressures in the system: doctors could be said to have the ‘power’ to spend without the need for ‘responsibility’ for it. Conversely (and increasingly in recent years), a similar asymmetry was seen in the role of NHS management, stewarding the system’s finances and management targets, but perhaps with insufficient accountability for ‘real’ patient welfare.

Observation: for a complex human system to succeed, it must align the incentives for individuals as well as organisations. In the drive to make the NHS equitable and fair, it was designed without this imperative, and so tended to work against human nature, rather than with it
The rise of fundholding

Out of these perceptions (where clinicians were concerned, at least) rose the notion of aligning clinical and financial incentives, the intention being that it would be in the clinicians’ interests to spend NHS resources more carefully. The so-called ‘purchaser/provider split’ and GP Fundholding were the direct and most obvious products of this idea: the former sought to separate the interests of those who planned and procured health services (the purchasers) from those who provided them (generally seen as the hospitals whose ‘supply side pressures’ had been driving demand in the system). The concept, which created an innate tension in the system, is the most enduring aspect of the 1990 reforms. GP fundholding included general practice in the model by allocating accredited practices the funds deemed necessary for a whole range of (largely elective) hospital procedures for their patients, and it was up to the GPs themselves to decide how to spend that money.

Any residue at the end of the year could be spent by the practices in a discretionary way on extra patient services. The ‘checks and balances’ were partly in patient satisfaction, partly in financial terms, and partly in the fact that any potentially destabilizing decisions (whether in changing referral patterns or the use of surpluses) had to be negotiated with both the local institutional NHS providers and the health authority.

The theory was that once the GPs had ownership of both the problem and the resources, more balanced decisions could be made; if anything, the fear was that GPs would then under-refer patients in their attempts to ‘get rich quick’, hence the bureaucratic and ultimately paralysing processes that were created to negotiate the use of resources, that prevented most of the potential benefit in the system from being realised.

Observation: incentives should acknowledge both the public ‘need’ and individual ‘greed’ by balancing rewards and responsibilities

Fundholding (FH) evolved during the six or seven years of its existence to cover an ever wider range of clinical services (a few so called Total Purchasing Pilots even included all services), smaller practices, and a broader selection of potential providers to do the work paid for out of the fund. However, throughout the life of the scheme, there were rumbling misgivings about a number of issues: the equity of the scheme (did patients registered in FH practices have better (or worse..) access to services?); the higher transaction costs associated with the extra administration needed when the ‘money follows the patient’; the possibility of fundholders ‘cherry picking’ the low risk ‘easy’ services, and taking no responsibility for ‘difficult’ high risk residue; and about the potential commercialisation of the NHS.

Observation: the need for (a perception of) equity is still a force in UK society that should not be underestimated; we are affronted by any sense of unfairness in public services

More importantly perhaps, the overall effectiveness of the scheme was never fully proved; the total purchasing pilots certainly changed services in their local vicinities, but whether the health of patients in FH practices was changed more (or less) than that of patients elsewhere remains a moot point.
What does seem to have happened however, is that the relationship between the referring doctors and their specialist colleagues changed paradigmatically, with the balance of ‘patient ownership’ altering to include GPs in the hospital treatment choices considerably more than they had been in the past. Moreover, this change seems to have endured, and is conceptually strengthened under the aegis of practice based commissioning.
The New Labour Government 1997

These misgivings underpinned the initial abreaction of the incoming Labour Government when it won the 1997 election; its first Health Service policy (The New NHS: Modern, Dependable (SO, 1997)) attempted to overcome them by the creation of Primary Care Groups (PCGs). These were still intended to involve clinicians in ‘driving’ the system, but they did not directly control resources (and so were supposed to not be ‘commercial’ or inequitable), and were large enough (50,000 to 100,000 population in each) to reduce the transaction costs involved in running them.

Observation: Small may be beautiful, and certainly enhances local ‘ownership’ but large provides an economy of scale that minimizes transaction costs. The challenge is to create benefits of the latter whilst maintaining the sense of the former.

Initially, the focus was determinedly on PCGs, and the concept of a resource controlling Primary Care Trust (PCT) was raised only as an aspirational target. However, as time (and Secretaries of State for Health) passed, so PCTs came increasingly to the fore, and by 1999, the zeitgeist was less about whether PCGs should transform into PCTs, and more about when they would do so.

This sense was emphasised when the natural evolution of PCGs into PCTs was swamped by the external reconfiguration of ‘new’ PCTs in 2002 (Shifting the Balance of Power (SO 2002)), creating far fewer, far larger PCTs whose formation undid all the sense of ‘ownership’ amongst clinicians that had been growing as PCGs developed and matured.

Observation: enforced change is never as easily embedded as evolutionary change, even though it is quicker. Political timescales are intrinsically too fast for sustainable culture change amongst autonomous professionals.

By 2005 (Commissioning a patient-led NHS (SO 2005)), PCTs had an average size of approximately 175,000 patients (the population of the largest exceeding 1.25 million, although the smallest still had fewer than 100,000 people), and in addition to their roles of controlling general practice and providing community services, had taken over all the traditional roles of a ‘health authority’: the (nominal) control of their local health economies, responsibility for procurement (commissioning), public health function, and accountability to Parliament.

The evolution on the procurement side was matched by an equal and opposite force where provision was concerned, with an increasing drive towards independence, albeit still paid for by the NHS. This was exemplified by the development of alternative (non-NHS) provision for high-volume, predictable, low-cost services (e.g. hip replacements, cataract surgery, etc), as well as the move towards the creation of Foundation Trusts, and a growing sense that the ‘public sector’ was increasingly being defined by its tax based funding rather than by the public nature of its provision. These developments probably reached their apogee in 2005/06, when the vogue for Foundation Trusts was at its highest, when Independent Sector Treatment Centres were beginning to open across the country, and when the concept of Practice-based Commissioning (PbC) began to gain common currency. Since then, there has been a slow but steady retreat from this position.

Observation: the unfortunate obverse of the previous observation is that slower, evolutionary change has a tendency to dissipate. What is needed is change that is slow but inexorable.
What do we mean by commissioning?

The term commissioning came into common parlance in the late 1990s, when the incoming Labour government replaced the terms ‘purchaser’ and ‘provider’ with the less obviously commercial ‘commissioners’ and providers. Providers (particularly in the last few years) have come to include all manner of provision, including primary, secondary, and tertiary care; as the policy tides of the last decade have ebbed and flowed, so these providers have included NHS, commercial, and third sector organisations in varying proportions.

Where commissioning is concerned, the term has come to encompass all manner of activities linked to procurement, and as such has become a real ‘weasel word’ insofar as it is selectively interpreted in a number of different and often mutually exclusive ways.

Conceptually, commissioning may be considered to cover all the stages of the procurement process; these (with acknowledgements to The Health and Social Care Information Centre) may be broken down into three main phases:

- **strategic planning** which itself may be broken down into several steps: needs assessment, review of current service provision, and deciding on priorities

- **service procurement** which covers the specification of services, the assessment and modification of potential supply, and the management of both the supply of and demand for services

- **monitoring and evaluation**, which is intended to include the management of suppliers’ performance, assessing public (and users’) views of the services provided, and supporting patients through their use of the system

These eclectic activities may be seen to be extremely varied in terms of both the population involved, and where they lie on the strategic/operational spectrum. On the population aspect, for instance, needs assessment is a process for predicting the services required by a local population that requires knowledge of clinical and epidemiological issues as well as actuarial skills. To do this with any degree of accuracy needs the inclusion of relatively large ‘chunks’ of population, which will vary from 50,000 people or less to upwards of a million.

The precise size depends on the services being assessed: high volume, low complexity services (e.g. care of the elderly) may be done at the lower end, but low volume, extremely complex and expensive services such as paediatric intensive care or transplant surgery, need vast numbers of people to be included to gain any sense of predictability and planning ‘flow’.

Thus, the parts of the commissioning cycle that require needs assessment can only be done with any accuracy by organisations that cover large population groups, the precise size being dependent on the service being commissioned. Similarly, on the strategic/operational span, practical tasks such as monitoring users’ views of the system, and guiding them through it, are relatively small scale (in that they relate to individuals, albeit many thousands of them) and therefore more easily and effectively done close to the ‘coal face’ of service delivery.
Priority setting on the other hand, and the planning of service configuration, are obviously tasks that require clinical, financial and political factors to be taken into account, and so require a size and maturity of organisation that cannot be replicated in every enumeration district in the land.

To monitor providers’ performance effectively probably needs both ends of this spectrum: ‘customer experience’ varies on an individual basis, and so may best be collated at such a level, but to use the findings of such collation to drive large scale change (such as the re-provision of an entire hospital, for example) needs a process that can probably only be sustained on a very large scale.

The reason for exploring the commissioning process in such detail is to highlight its complexity, and the fact that its various components are too disparate to all be included under the same umbrella term; ‘putting a man on the moon’ sounds like a straightforward task, and all those involved in the NASA programme may have considered themselves to be part of it, but planning the global ring of radio telescopes was clearly not the same task as building the rocket engines or preparing the food.

The size and complexity of commissioning means that the simplicity of the term is misleading, and has come to hide a number of conflicting nuances and even some grating discords; if the concept of ‘world class commissioning’ (an unfortunately grandiose term if ever there was one) is to have any meaning, then all those involved need to have a common understanding and an agreed approach to its implementation.

To this end, it may be more helpful to consider how each of the current groups of commissioners might fit most easily into the overarching process; such a consideration might also help to explain some of the outstanding issues that continue to bedevil the development of commissioning, and go some way towards offering ways forward.

Observation: as with so many political aphorisms, meanings change over time, and it is probably time to replace the term ‘commissioning’ or at least to relegate it to its true meaning.
Horses for courses

In essence, there is a clear link between the size and complexity of each organisation involved in the commissioning process and its place in that process: thus, large, complex, strategically focused organisations such as PCTs have all the factors required to carry out the large scale, complex, and strategically focused tasks: they should (in theory at least) have the capacity, the capability, and importantly, the incentives to do so.

Their mission in life is to oversee their local health economies, and to facilitate the provision of health care, without having the remit (or the skills) to become embroiled in the day to day delivery of that care. Their performance is measured around this mission, and to fail in the strategic aspects of commissioning would be for them to fail completely.

Thus, one might expect them to be responsible for all of the strategic planning, and for those aspects of service procurement that make use of their large population base: dilution of risk (the larger the population, the more easily high risk services may be planned), and economy of scale (the physical parts of simple contract letting are easier to do for larger ‘chunks’ of population, once the decisions as to what specific services to purchase have been made). In fact, for a few very highly specialised services, the PCTs may need to work together to gain an even larger population base suitable for the procurement of services that are so expensive, or so rare, or so technically complex that they would be too unpredictable and disruptive to cover on their own.

On the other hand, PCTs are much less well placed to cover the middle and lower layers of the commissioning process, whereas other agencies might have been tailor made to encompass them. The mechanical aspects of service procurement that cover the assessment of potential supply (and its modification) at an operational level, and the management of the supply of and demand for services, both need organisations that are more grounded in ‘real life’ and with the operational credibility to which a necessarily stratospheric strategic commissioner could not (nor should not) ever aspire.

This order of task, along with the monitoring and evaluation discussed above, is what was originally intended for practice based commissioners (PbC), with their knowledge and credibility in all matters clinical, their ability to challenge their institutionally based hospital colleagues, and the connection with the day to day life of their patients to be able to take stock of the services they are receiving, in terms of their quality, timeliness, and appropriateness.

Moreover, in the original concept if not in its current execution, PbC gives these commissioners the incentive to carry out these activities well. Not only will they get a better sense of (that currently much overused word) ‘ownership’ of their patients’ problems and their solution, but at its core, PbC incentivises those in the practices to do more, and to spend less. As with fundholding, the original intention was to encourage practices to ‘own’ the clinical responsibility for their patients in its entirety, and to allow them to decide how much they did themselves in meeting this responsibility, and how much they wanted to ‘subcontract’ elsewhere.

Observation: the various parts of the ‘commissioning’ task should be carried out on the basis of generic ‘risk’: population size, skills and resources required, and organisational capacity. Accountability must be based on measures appropriate to the specific task.
And as with any other action involving the ownership of both responsibility and resources, such a process encourages us to make measured and prudent decisions: we look after the houses we buy much better than those we rent from distant landlords; we spend our own money much more prudently than we spend someone else’s cash; and we are more careful over decisions that have consequences for ourselves than for those for which we are invisible or otherwise unaccountable.

Thus the conceptual origins of PbC probably had the following intentions (see fig. 1): the PCTs, as the strategic agents in the piece, would represent all the public sector values in a local health economy. They would have the responsibility for ensuring that there was healthcare provision, that it was of good quality, equitably provided for the entire population that they covered, and that it was delivered within budget.

*Figure 1: the PCT and its providers*

PCTs would be intended to form contractual relationships with local provider organisations that would be based around the entire health needs of segments of the PCT’s population. These segments would probably be anything between 50,000 and 100,000 in size: the figure is empirical, but reflects the need to have a large enough risk pool to carry most risks, whilst keeping services locally sensitive, and able to engender a sense of ‘belonging’ to both users and staff. These providers are intended to be based on the current PbC clusters, although in an ‘ideology free’ model, the providers need not be defined in more detail; their only pre-requisites would be that they delivered their targets, and it would be the task of the strategic commissioners to hold them to these tasks.
Functionally, these local organisations would meet their responsibilities by fulfilling two main roles, identical in concept to the roles currently delivered by GP practices, or as intended to be delivered by PbC clusters: delivering appropriate care to their registered populations, and procuring those services that they could not deliver themselves from other ‘subcontractors’, who could themselves be other, similar providers, or larger institutions who were better placed to offer economy of scale where risk management was concerned (be it clinical, financial, technical, or even litigious risk).

**Observation: PbC is not about commissioning; it is about delivering appropriate care locally and subcontracting the rest**

What has been described so far is no more than a set of functions, that could be delivered by all manner of providers, public, private, or third sector, all of whom could be said to enacting the role of health maintenance: being rewarded for a set of outcomes that related wherever possible to the maintenance (or improvement) of health. Such health gain based targets (although never formally elucidated) would probably have been based on a combination of high level health measures, aggregated activity markers, and validated indicators of user satisfaction.

This model of ‘locally based provision and subcontracting’ parallels the role of the USA Health Maintenance Organisation (HMO), and in many ways, the generic models are identical; in fact, HMOs are direct descendants of the original model of British General Practice, the differences being around the direct financial rewards, and the range of services likely to be offered in a practice setting.
Practice based commissioning

In the climate of British realpolitik, these HMO providers could only have been based around general practices, or their aggregates. The lessons of the past fifteen years suggest that naturally evolving communities of practices lead to the most effective and motivated aggregations: PCGs engendered a startling feeling of involvement amongst primary care clinicians (GPs, nurses, and other allied health professionals), and this was preserved when PCGs began to collaborate and coalesce into PCTs by their own initiative.

The population base of an average British practice is too small to carry the degree of risk required for an HMO system to work as well as the unacceptably high transaction costs related to working with such small numbers, so the notion of practice based clusters emerged and grew. Such clusters were conceptually in line with the generic notion of ‘fitness for purpose’ being the main defining characteristic, and various evolutionary models were postulated (see fig 2.).

In some cases (fig 2: *1), usually in areas of well developed general practice (usually linked to a prosperous and less needy population), ‘traditional’ practices might be expected to coalesce and merge, provide more services, and begin to be more closely involved in the processes of subcontracting.

Observation: PbC is not about practices; larger clusters are needed to manage the risks

Figure 2: New models of health care provision
In many areas, the stock of existing practice is unlikely to be high enough to develop this relatively high order of working, and in such instances (fig 2: *2), one might expect the strategic commissioner (the PCT) to encourage alternative providers to develop their services as HMOs: these might be other (better developed and organized) practices, private companies, social enterprises, or voluntary sector providers. In theory, all that matters was their ability to meet the criteria laid down by the PCT.

Whichever of these organisational models emerges, one would expect the most advanced of them to want to develop their services further and further. They would work at establishing the capacity and capability to do more services ‘in house’ and hence under better control, and probably also more cheaply, than those services that they were obliged to procure elsewhere. The process of ‘vertical integration’ would begin from the community provision end (fig 2: *3), and one might expect such innovators and early adopters to offer simple surgery, ‘step up’ and ‘step down’ intermediate inpatient facilities, and many of the other attributes of integrated care.

Observation: all the models assume some entrepreneurialism, and the need to reward it

Such developments are likely to put intense pressure on the typical District General Hospital, already under pressure by the siphoning off of high risk patients into the tertiary sector, and one might expect a fourth model to emerge (fig 2: *4) in which such DGH Trusts might themselves promote the idea of vertical integration, but from the secondary end. They would offer community based services and a continuity of process that would be hard to surpass, as patients were provided with seamless service by DGH based clinicians from primary care through hospital where necessary, and home again.

Observation: such entrepreneurialism isn’t reserved just for PbC clusters, but for any providers and potential providers including hospitals, voluntary, and private organisations
So why isn’t it happening?

In considering the reasons why PbC is not working as it was intended, one needs to look at three things: the evidence for its lack of success, the issues from the PbC perspective, and the issues from the PCT point of view. It may also be worth challenging the markers of success being used.

In its report of November 2008 (‘Practice-based commissioning: Reinvigorate, replace or abandon?’ Curry N, Goodwin N et al Kings Fund 2008), the Kings Fund concluded that

‘Progress to date has been slow in all sites: very few PbC-led initiatives have been established and there seems to have been little impact in terms of better services for patients or more efficient use of resources. Where initiatives have been developed, they have tended to be small scale, local pilots focusing on providing hospital services in community settings.’

Their study (based on four PCTs) is borne out by other anecdotal evidence, and there are few places where any significant change in services may be pinned down directly to the effects of PbC. Whether there have been any other changes, be they organisational, cultural, or attitudinal, is also hard to discern, but the general sense seems to be that even in these qualitative areas PbC has not achieved its initial objectives. The Kings Fund paper, whilst not exhaustive in its analysis of the reasons for this failure, came up with the following set of issues:

- Confusion as to the respective roles and responsibilities of GPs, PbC clusters, and the PCT
- Lack of mature relationships (and hence communications and trust) amongst stakeholders
- Complexities around the perception and management of financial and clinical risk
- Lack of good data means clusters have little information to inform their commissioning ideas
- Lack of capacity, and capability amongst GPs (with not much more in many PCTs)
- Perceived conflicts of interest at GP level (they may be both providers and commissioners of their own service) and in the PCTs (who could favour the services they themselves provide)
- Wider contextual factors (e.g. changing political priorities) have also affected implementation

Many of these issues are interlinked; thus, the confusion as to the respective roles and responsibilities of the various stakeholders reflects the lack of mature relationships amongst them, and a whole range of differing perceptions around both the management of financial and clinical risk, and the conflicts of interest.

The perception of this commentator is that when the notion of PbC was initially elucidated, it was in its purest form, as described above. In other words, PBC clusters, as the HMOs of the NHS, were intended to take on responsibility for the entire healthcare of their population, providing what services they could legitimately do, and subcontracting the rest.

Such a mechanism (see figure 3) offered a natural counterweight to the pressures exerted by Payment by Results (PbR), and demonstrates the simplest and purest form of market pressures at work: Foundation Trusts work hard to maximize their income and minimize their work, whilst PBC clusters work equally hard to minimize their spend and maximize the quality of the services they procure.

Since that time, there has been a gradual retrenchment from that position, based partly on active resistance within the Labour Party, and partly on passive resistance within the NHS itself.
This latter was based on the misalignment of power and responsibility; historically, the NHS is a very hierarchical organisation, and PCTs see themselves as remaining responsible for the delivery of PbC services, even if they are no longer in a position to control them directly.

The best way of preventing this from happening, is not to cede control in the first place, and essentially that is what has happened. PCTs have paid all sorts of lip service to the notion of devolution, with training programmes, diagnostic processes, allocation of roles, and so on, but at some level there remains an intrinsic and deep-seated reluctance to let go of the reins of power, particularly as PCT feel that they will still be held to account for the effectiveness of their local clusters.

Without the symmetry of the PbC/PbR relationship, the notion of balance between procurer and provider is impossible to achieve in any natural way, but is bound to need constant regulation and interference to offer any functionality; eventually, the pain will be seen to outweigh the gain.

**Observation: Hospital ‘Payment by Results’ assumes the balance of some form of true Practice based Commissioning; the degradation of one will eventually destroy the other**

To make matters worse, there is a self-fulfilling prophecy at work: the traditional mistrust between the NHS and its GP contractors is being played out in the arguments about conflict-of-interest, and even the GPs with the most enthusiasm for the concept of practice-based commissioning have found their efforts and zeal thwarted by the reluctance of the PCT to allow them any sense of genuine ownership. The fact that money has never been linked directly to the decision-making does not help; currently, funding for activities carried out within primary care under the aegis of PbC is funded entirely separately from those services funded through PbR, even when it is procured through PbC. Thus for example, if a cluster decides to re-provide diabetes services in the community, it may be paid a small (marginal at best) sum to do so, but this payment is entirely unrelated to any savings made by the reduction in hospital activity and the consequent diminution in PbR payments to the local Trust. In other words, the cluster has no real control of its resources, and cannot fully realize the potential benefits of changing its spending behaviour.
And whilst this is the situation, there is little incentive (moral, financial or otherwise) within the cluster to find the time and effort required to build up their expertise capacity or capability. The corollary of that is that the PCTs can justify the status quo precisely because the clusters are not increasing their capacity and capability. In this way, progress is prevented, and the longer the period over which progress is not made, the easier it is to justify the uselessness of the concept, and the need for a new model of commissioning.

Observation: PbC hasn’t succeeded because, as it is now set up, it isn’t in the interests of any of the vested parties for it succeed: PCTs lose control, PbCs only gain bureaucracy
The role of incentives

At the heart of the problem lies a tangled web of misaligned incentives, something which the public sector in general, and the NHS in particular, has developed to a fine art. Beyond the ‘coalface’ of the clinical interaction itself, there is rarely any linkage between the effort of input and any perceptible reward, whether this is measured in terms of status, job satisfaction, or money. Partly, this may be the penalty of working in the public sector, with its abhorrence of the possibility of corruption, and its need for absolute transparency.

However, within the UK there is also a curious Puritanism about the whole concept of personal reward, something which needs to be factored into the development of any new policies if they are to become embedded and sustainable; the consequences of crises such as the current ‘credit crunch’ merely reinforce both these causes, but there does seem to be a slowly dawning awareness that individuals work best when they see some form of personal benefit rewarding their efforts, but that such rewards need to be proportional and justifiable both within the organisation involved and to the wider (taxpaying) society.

Altruistic, external benefit appeals to a very high level of intellect and societal awareness; in today’s society of greed, such drivers are often not enough to retain the motivation of all those involved in the delivery of a particular service, and it is worth considering more basic aspects of human nature when designing a sustainable system for the 21st century.

That is not the same as suggesting that financial reward is the only driver one should consider; on the contrary, financial incentives tend to be highly inflationary, and ultimately unsatisfying. When used appropriately, financial incentives generally signal other forms of rewards such as status, job satisfaction, peer approval, and celebrity.

The challenge is to construct a system that has enough personal incentives to drive individuals to perform at their best, without creating politically and socially unacceptable models that bring with them inordinate bonus and corruption. In fact, the model underpinning PbC has the potential to do exactly that: offer sufficient organisational and personal incentive whilst ensuring equity, quality, and value for money.

Observation: personal incentives are vital to develop and maintain ‘ownership’ of problems and their solution. Using money as the only such incentive is reductive, unimaginative, and ultimately futile; people in general, and professionals in particular, respond to other markers of personal approval including self worth, peer support, and external approbation.
Possible futures for PbC and commissioning

Traditionally, there has been a spectrum for the delivery of public services across the developed world that has ranged from what might be termed ‘Stalinist’ at one end to ‘Darwinian’ at the other. At the Stalinist end, the needs of the State take absolute priority over the needs of the individual, and the system is driven by the ‘greater good’ (a value often imposed rather than felt). Such a system allows the centralization of planning and delivery, has the potential to deliver equality (if not equity), and is in theory probably the most efficient system in that duplication is kept to a minimum. Its downside is that it allows little or no room for individuality of need, of want, or of context. The NHS at its inception showed many features of such a model, as indeed did health services in the old USSR.

At the Darwinian end, evolutionary pressures are what drive progress: without any form of centralised planning, the system is driven entirely by the wants (and the term is used advisedly) of the individual. Market pressures create their own response, and progress may only be tracked retrospectively. At its best, one gets islands of highly evolved, successful, and popular treatments, but neither equity nor corporate efficiency (as opposed to individual cost savings) are high on the list of priorities. Such systems focused purely on the needs of the individual are rarely seen, but the private healthcare systems seen in the USA probably come closest, with their islands of excellence riding in a swamp of unmet need and institutionalised inequity.

The optimum probably lies somewhere in-between, with the emergence of models that combine a degree of equity and an acceptance of the ‘greater good’ with some individuality and choice. The current emerging model of the NHS, like many other models across the rest of Europe, aspire to find a point between these two ends that provides a system that will protect the needs of the poor and disadvantaged, whilst recognising that personal reward and competitiveness are an intrinsic part of human nature that need to be acknowledged in any system if it is to remain innovative, efficient, and sustainable.

Observation: the UK public sector is a model of ‘social democracy’ that combines a degree of planning and equity with some individual focus and consumerism

In terms of the current commissioning environment of the NHS, it would not be difficult for the emerging system of PbC and PbR to be tuned to achieve this balance of corporate and individual incentives. Ideally, one might wish to encourage the further alignment of incentives at all levels of the NHS, so that power and responsibility are matched throughout.

Thus, if PCTs are to carry responsibility for the strategic commissioning, one might expect them to be given a set of very broad, strategic objectives (i.e. large-scale, long-term, and with few if any specific activity-based targets). Their skills, whilst growing significantly in the past year or two, will need to be developed further, as the genuine role of strategic commissioning is not one that is familiar within the traditional NHS, where strategy is seen to be anything that happens beyond next Friday, and political influences trump everything. Their role in service provision will need to reduce, allowing them to take a more dispassionate role without having the ‘baggage’ of a vested interest in the delivery of individual patient care.

At the next level down, one might expect practice-based commissioning to develop along the lines described earlier, with a direct linkage between the responsibilities carried by the cluster, and the resources required. The current perverse funding structures will need to change, with virtually all
funding (and the concomitant accountability) being channeled through the PbC clusters. In order to gain their ‘HMO’ status, there will need to be some form of accreditation and quality assurance, both for their direct provision and for their ability to subcontract other services.

Once one accepts the notion of funding the HMO for all services, then the problem of internal conflicts of interest also disappear, as each cluster would be spending ‘its’ money in a way that directly aligns risks with benefits. Patient choice would need to be protected however, and one of the few regulatory mechanisms would need to check explicitly how patients were offered significant choice of provider for secondary and specialized services.

The analogy could be that of building a home extension: the purchaser might contract for each element of the task separately, and directly contract architect, builders, plumbers, electricians, and so on; alternatively (and more usually), they are likely to offer the overall contract to one provider, and leave it to that agency to sort out the operational logistics of delivery. Payment for the whole job passes to that provider, and as long as markers of cost, quality, and timeliness are met, purchasers do not usually concern themselves with the the subcontracting issues. In such a scenario (as in PbC), one needs to ensure adequate choice, and enough regulation to ensure safety, but any further interference undermines the role and concept of the model of provision and subcontracting.

Observation: unified resourcing mechanisms would be simpler and more coherent than the current multiplicity of funding streams; they would allow more flexibility and more explicit accountability

How the HMO manages its own internal arrangements should not (in theory, anyway) exercise the PCT commissioners excessively; some GPs may prefer to remain as pure providers, others may choose to become involved in the management of the cluster, or indeed much of the management may be outsourced by the cluster to another provider entirely.

In the end, the accountability of the cluster to the PCT will need to be based on the triad of broadly based disease outcomes, genuine patient satisfaction (as opposed to the tokenistic patient surveys currently carried out), and budgetary efficiency.

Observation: it is the commissioner’s role to determine the principles of what needs to be provided; it should be up to the providers to determine how

At the other end, one might expect the Department of Health to create and maintain some distance between it and the service, so that the day-to-day operation of the system will not be contaminated by media driven political pressures, and issues that pertain to vested interests more than to healthcare principles.

If this model is not allowed to develop in the way described, then the gradual degradation of the PbC system might be expected to accelerate; GPs, and others in the front line of patient contact will see less and less benefit in becoming involved in the management process, and parental PCTs would find themselves taking on more and more operational aspects of the commissioning and subcontracting process.

In that case, their capacity and capabilities will need to be developed (and in a different direction from that currently envisaged) to compensate for the lack of grass roots input. The mismatch of power and
responsibility within and across the clinical and managerial world will re-emerge, with the tension between ‘doing the right thing’ and ‘doing things right’ becoming evident once more.

**Observation:** Organisations do not stand still, and if PbC is not seen to make a significant impact, then its current moribund state will become terminal, and an important opportunity to engender real cultural change will have been lost.

The temptation in those circumstances would be to re-establish a much more Stalinist model of care, but even during these constrained recessionary times, such a model would be politically unpalatable in the ‘social democracy’ world we now inhabit. It would be interesting to see how the tension between the forces of centralisation and those of devolution would then be played out.

**Conclusions**

The general principles of commissioning and provision have been established over the past two decades, and the different stages within the commissioning process identified.

There are clearly understood benefits in linking the different aspects of the commissioning process to the appropriate organisation, in terms both of patient benefit and systemic efficiency; these advantages have been described and to some extent enacted by both sides of the political divide, so it would be reasonable to assume that the principals are here to stay, and will be disseminated and embedded further.

**Observation:** there are only degrees of nuance separating the political parties where PbC is concerned, so it should be relatively easy to gain a consensus over its future progress; moreover, once a positive direction has been established and progress made, it should be generally sustainable.

The main challenge lies in the degree of decentralisation that is allowed to occur, and the various mechanisms by which it is encouraged; this paper suggests that closer alignment of power and responsibility appeals to human nature and with the appropriate controls, will better meet the needs of the welfare state. To put the principles suggested into practice would seem to be an incremental rather than a revolutionary task. However, active political contamination, and passive resistance by the various vested interests already in the system, should not be underestimated.

The second challenge lies in the actual expression of this decentralisation, and the manner in which the associated funding is allocated. PbC currently allows its practitioners only indicative budgets; this paper suggests that for the scheme to realise its benefits, the incentives need to be much more closely aligned to the activities, with real money being allocated in line with real responsibility. The ‘wicked issues’ here lie in ensuring that the risk inherent in such an approach is managed properly, without (as now) paralysing the whole system in bureaucracy and thus emasculating its impact.

The reality of the changes described is that they should be seen as much more than a simple operational adjustment, but rather as a paradigm shift in both culture and attitude that will require clear, consistent and enduring political and managerial pressure to implement. Carried out in an inclusive, rational, and realistic manner that involves clinicians, managers, and keeps the public well-informed, the opportunity is crying out to create a genuinely sustainable, publicly funded, high quality, health service that will once again make the NHS the envy of the developed world.
Observations

Even with no competition in a system, market forces apply, and uncontrolled ‘supply’ will generate ‘demand’.

For a complex human system to succeed, it must align the incentives for individuals as well as organisations. In the drive to make the NHS equitable and fair, it was designed without this imperative, and so tended to work against human nature, rather than with it.

Incentives should acknowledge both the public ‘need’ and individual ‘greed’ by balancing rewards and responsibilities.

The need for (a perception of) equity is still a force in UK society that should not be underestimated; we are affronted by any sense of unfairness in public services.

Small may be beautiful, and certainly enhances local ‘ownership’ but large provides an economy of scale that minimizes transaction costs. The challenge is to create benefits of the latter whilst maintaining the sense of the former.

Enforced change is never as easily embedded as evolutionary change, even though it is quicker. Political timescales are intrinsically too fast for sustainable culture change amongst autonomous professionals.

The unfortunate obverse of the previous observation is that slower, evolutionary change has a tendency to dissipate. What is needed is change that is slow but inexorable.

As with so many political aphorisms, meanings change over time, and it is probably time to replace the term ‘commissioning’ or at least to relegate it to its true meaning.

The various parts of the ‘commissioning’ task should be carried out on the basis of generic ‘risk’: population size, skills and resources required, and organisational capacity. Accountability must be based on measures appropriate to the specific task.

PbC is not about commissioning; it is about delivering appropriate care locally and subcontracting the rest.

PbC is not about practices; larger clusters are needed to manage the risks.

All the models assume some entrepreneurialism, and the need to reward it.

Such entrepreneurialism isn’t reserved just for PbC clusters, but for any providers and potential providers including hospitals, voluntary, and private organisations.

Hospital ‘Payment by Results’ assumes the balance of some form of true Practice based Commissioning; the degradation of one will eventually destroy the other.

PbC hasn’t succeeded because, as it is now set up, it isn’t in the interests of any of the vested parties for it succeed: PCTs lose control, PbCs only gain bureaucracy.
Observations (continued)

Personal incentives are vital to develop and maintain ‘ownership’ of problems and their solution. Using money as the only such incentive is reductive, unimaginative, and ultimately futile; people in general, and professionals in particular, respond to other markers of personal approval including self worth, peer support, and external approbation.

The UK public sector is a model of ‘social democracy’ that combines a degree of planning and equity with some individual focus and consumerism.

Unified resourcing mechanisms would be simpler and more coherent than the current multiplicity of funding streams; they would allow more flexibility and more explicit accountability.

It is the commissioner’s role to determine the principles of what needs to be provided; it should be up to the providers to determine how.

Organisations do not stand still, and if PbC is not seen to make a significant impact, then its current moribund state will become terminal, and an important opportunity to engender real cultural change will have been lost.

There are only degrees of nuance separating the political parties where PbC is concerned, so it should be relatively easy to gain a consensus over its future progress; moreover, once a positive direction has been established and progress made, it should be generally sustainable.
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Dr Jonathan Shapiro is Senior Lecturer, Healthcare Development Unit, in the University of Birmingham Medical School. Jonathan has had a career that spans Natural Science, Medicine, and NHS management, all of which have had an academic flavour. With a background in primary care, Jonathan’s interests have centred on a whole system approach to the analysis and improvement of healthcare. In particular, his work looks at the organisational and professional boundaries that obstruct the delivery of truly holistic care.

Originally, Dr Shapiro worked within the NHS as a general practitioner for over ten years. When he left clinical medicine, he became the Independent Medical Adviser to an FHSA, and was involved in the development of the purchaser/provider split, and the involvement of clinicians in the running of the health service through initiatives such as GP fund-holding and total purchasing, as well as the development of better primary care itself.

In 1993, Jonathan joined Birmingham University’s Health Services Management Centre where he co-ordinated much of the Centre’s work on the development of primary care and its place in the wider NHS. This work combined research, consultancy, teaching and writing, as well as exploring and developing the interface between clinicians and management.

In more recent years, Dr Shapiro was Chairman of one of the largest NHS Mental Health Trusts in the country, through which he was closely involved in leading organisational development and the management of change, in areas including PFI, Foundation Trust development, and so on.

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