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Devolved Purchasing in Health Care

A Review of the Issues

Peter C. Smith

Introduction by
John Wyn Owen

The Nuffield Trust
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INTRODUCTION

The government is once again undertaking a comprehensive health spending review. At the same time it has found funds to avoid a winter of emergency inpatient closures and lengthening waiting lists.

Sustainable financing of health care with appropriate mechanisms for individual community and national priority setting are important public policy objectives which have been under scrutiny for many years and must now be addressed with some urgency. The Trust has informed this debate in the past and will continue to do so.

These Occasional Papers offer the economists' contribution and should be of interest to policy-makers at the highest level as they strive to improve the effectiveness of the National Health Service, improve patient care and create the right incentives to reward efficient performance within inevitable financial constraints.

Paper 2 – *Devolved Purchasing in Health Care: a Review of the Issues* – by Peter C. Smith, examines the implications of moving towards a devolved model of purchasing in the National Health Service. The principle of devolution is embodied in the previous government's policy of general practice fundholding and the present government's commitment to locality commissioning.

The author suggests that the main managerial device for successful devolution of purchasing powers is the budget and examines the history of setting devolved budgets in the NHS. He concludes that the most appropriate system is likely to be heavily influenced by political priorities and local circumstances and recommends the retention of maximum flexibility in any future system of devolved purchasing.

John Wyn Owen
December 1997

FOREWORD

The application of economic analysis to health and health care has grown rapidly in recent decades. Alan Williams' conversion of Archie Cochrane to the virtues of the economic approach led the latter to conclude that:

> "allocation of funds and facilities are nearly always based on the opinion of consultants but, more and more, requests for additional facilities will have to be based on detailed arguments with 'hard evidence' as to the gain to be expected from the patient's angle and the cost. Few could possibly object to this." *

During most of the subsequent twenty-five years many clinicians have ignored Cochrane's arguments whilst economists busily colonised the minds of those receptive to their arguments. More recently clinicians and policy makers have come to equate, erroneously of course, health economics with economic evaluation. Thus the architects of the Department of Health's R&D strategy have insisted that all clinical trials should have economic components and tended to ignore the broader framework of policy in which economic techniques can be used to inform policy choices by clinicians, managers and politicians. †

The purpose of this series of Occasional Papers on health economics is to demonstrate how this broad approach to the use of economic techniques in policy analysis can inform choices across a wide spectrum of issues which have challenged decision makers for decades. The authors do not offer 'final solutions' but demonstrate the complexity of their subjects and how economics can provide useful insights into the processes by which the performance of the NHS and other health care systems can be enhanced.

The papers in this series are stimulating and informative, offering readers unique insights into many aspects of health care policy which will continue to challenge decision makers in the next decade regardless of the form of government or the structure of health care finance and delivery.

Professor Alan Maynard
University of York

* Cochrane AL. *Effectiveness and Efficiency: random reflections on health services.* Nuffield Provincial Hospitals Trust, London, 1972.

† Maynard A and Chalmers I (eds). *Non-random Reflections on Health Services Research: on the 25th anniversary of Archie Cochrane's Effectiveness and Efficiency.* British Medical Journal Publishing, London, 1997.

PREFACE

The 1991 National Health Service reforms set up an explicit distinction between purchasers and providers. Initially, purchasers were of just two types: health authorities, responsible for large populations and most health care activity; and general practitioner fundholders, responsible for relatively small numbers of patients and only a subset of total activity.[1] Since the introduction of the reforms, however, there has been an organic growth in alternative purchasing models. Formal and informal arrangements have led to the emergence of a wide variety of organisations which seek to manage or influence the purchasing function in the NHS.

The recently elected Labour government is committed to retaining the purchaser:provider split in the NHS. However it has also announced its intention to reform the purchasing function, with a move towards what it calls 'locality commissioning'. Although not fully developed, the principal features of this policy are: a change of focus in the purchasing function, away from the single general practice and the health authority, towards intermediate geographical 'localities' serving between 50,000 and 150,000 people; a change of emphasis from purchasing to commissioning; and an emphasis on time horizons longer than the current one year contract cycle. The stated policy objectives are: to restore fairness between patients; to reduce bureaucratic costs; and to ensure high quality care for patients.[2]

The purpose of this paper is to examine the implications of different models of purchasing in the light of experience in the NHS to date. In an attempt to avoid descent into fruitless semantic exegesis, the paper continues to use the expression 'purchasing' to describe the process of securing desired health services from providers at an agreed price. The paper starts with a brief survey of purchasing since the 1991 reforms. It concludes that the key managerial instrument for securing

devolution of purchasing responsibilities is the budget. It is argued that without a workable budgeting system any initiative designed to devolve health care purchasing responsibility will founder. The remainder of the paper therefore examines the implementation of budgeting arrangements for purchasers within the NHS. The paper ends with a summary and an examination of the issues arising from the discussion.

ABSTRACT

There is a clear move within the National Health Service towards devolving responsibility for purchasing health care towards individual general practices. The principle of devolution is embodied in the previous Conservative government's policy of general practice fundholding and the current Labour government's policy of locality commissioning. This paper highlights the key issues that are likely to emerge in seeking to move towards a devolved model of NHS purchasing. It claims that the principal managerial device for securing successful devolution of purchasing powers is the budget. It then examines the history of setting devolved budgets in the NHS, and highlights the principal issues that arise when seeking to design a budgetary system. The paper concludes that the most appropriate system is likely to be heavily influenced by political priorities and local circumstances. It therefore recommends retaining flexibility in any future system of devolved purchasing.

DEVOLVED PURCHASING IN THE NHS

The fundamental innovation of the 1991 National Health Service reforms was the separation of purchasers from providers.[3,4] In the first instance, purchasers were the 100 or so local health authorities, which receive an annual budget from the central government with which they are expected to purchase all the hospital and community health services needed by their population. Health authority budgets are based on a formula which weights the local population for age structure, health care needs and input prices. A typical health authority population is 500,000. The budget is used to purchase services from NHS providers in accordance with annually negotiated contracts.[5]

As documented by the Audit Commission,[6] health authorities have been devolving an increasing proportion of their hospital and community health service (HCHS) budgets to those general practices that have chosen to become fundholders. Under the standard fundholding scheme, general practices with more than 5,000 patients are able to negotiate their own contracts with providers for a specified range of elective procedures and services within a budget fixed by the health authority.[7] This element accounts on average for 55% of the fundholder's budget. In addition, the standard GP fundholding budget encompasses prescribing costs (38% on average) and the wages of non-medical practice staff (7%). In 1996, standard fundholding covered about 50% of the population, and accounted for 11% of all HCHS expenditure.[8] Any audited savings can be retained for up to four years by a fundholding practice for spending on patient services (which include capital development of practice premises).

In the early years of the fundholding scheme, budgets were generally based on past patterns of referral practice, and were frequently set at relatively generous levels.[9] It was therefore unusual to find fundholding practices encountering major budgetary difficulties.

However, as the fundholding scheme has become more extensive, it has become increasingly important that fundholder budgets are set equitably in relation to both other fundholders in the area, and also to non-fundholding practices. To that end, the NHS Executive[10] has recommended the adoption of formula funding for setting fundholder budgets.

The fundholding scheme has been augmented by the introduction of 'community fundholding', covering a more limited range of services than the standard scheme, and 'total fundholding', potentially encompassing virtually all HCHS activity. Community fundholders can have as few as 3,000 patients, and assume responsibility for prescribing costs, community services and staff wages, but not hospital services. Total fundholding encompasses virtually all HCHS, including emergencies, and usually involves coalitions of several practices.

Fundholding practices receive management allowances with which they are expected to provide the management support to manage the budget they are allocated. Many practices have become members of 'multifunds', to which they contribute a proportion of their management allowances, and which provide support for routine administration and some purchasing activities.[11] However, the health care budgets of the constituent practices are not pooled, remaining the responsibility of the individual practices.

A further reform introduced in 1991 was the introduction of 'indicative' prescribing budgets for all general practitioners. Although there are no sanctions associated with breaches of such budgets by non-fundholders, the scheme is intended to identify GPs with atypical prescribing patterns. More recently, a modest Prescribing Incentive Scheme has been introduced to encourage reductions in prescribing expenditure.

DEVOLVED PURCHASING IN THE NHS

The inspiration behind the standard fundholding scheme was clearly the theory of markets underlying neo-classical microeconomics. The general practitioner was to act as an informed agent on behalf of the patient, and providers would compete for business from a large number of such purchasers. The inefficiencies associated with monopoly purchasers (and providers) would thereby be eliminated. Standard fundholding was therefore intended to sharpen the link between providers and general practitioners. Participating practices would be given the incentive to offer more effective purchasing than non-fundholders, and providers would be given the incentive to respond more sensitively to the requirements of fundholding practices. However, definitive evaluation of the standard fundholding scheme has proved elusive, not least because 'no detailed objectives for the fundholding scheme have been set by the NHS Executive'.[6] Research evidence is not always reliable, and sometimes contradictory.[12-17] However, amongst the more important consequences of fundholding noted by commentators have been:

- evidence of improved services to patients in many fundholding practices, particularly in relation to waiting times;
- an emphasis on quality of services rather than price in the choice of provider;[18,19]
- evidence of heightened awareness of cost issues amongst fundholders;
- some reduction in prescribing costs in fundholding practices;
- high management costs associated with the scheme;[20]

- variable levels of managerial competence amongst participating practices;[6]
- evidence that some providers offer higher priority to fundholding than to non-fundholding patients (in the form of shorter waiting times).

In addition, the fundholding experiment has given rise to a number of less measurable concerns, of which some of the most important are:

- a concern at the lack of accountability for public money spent by fundholders (particularly relating to the use of budget underspends);
- a concern about the lack of co-ordination in health service provision brought about by fragmentary purchasing;
- a concern that fundholding practices might 'cream-skim' healthier patients;
- a concern that standard fundholders may have an incentive to refer elective patients to hospitals as emergencies, which lie outside their budgetary responsibility (refuted by Toth *et al*);[21]
- concern at unfairness between practices in the budget-setting process;
- a concern that patients in non-fundholding practices may be disadvantaged by the fundholding scheme.

In contrast to standard fundholding, the total fundholding scheme entails a collaborative venture between health authorities and participating practices. Moreover, the scheme has been the subject of a

thorough evaluation.[20] The first wave of total purchasing involved 62 distinct sites, each site containing on average three general practices and populations of 33,000 patients. The principal aims of the scheme are to secure better relationships between GPs and service providers and the provision of services more closely aligned to patient needs. Furthermore total fundholding appears to offer more flexibility than standard fundholding, in the sense that it allows sites to 'block back' certain services to the higher level budget holder (the health authority) or to devolve other services to a lower level budget holder (the general practice). The most serious disadvantages emerging to date are the associated increase in managerial costs and the difficulty of identifying a 'fair' budget for total fundholding sites.[20]

Fundholding of all types involves a formal delegation of part of the health care budget to individual practices, and gives those practices the freedom to negotiate their own contracts with providers. Under standard fundholding, the statutory 'fundholder' is the general practice, which is able to retain any surplus on its annual budget. Sanctions for overspending the budget vary from area to area. Approximately 20% of standard fundholders overspend, and health authorities are responsible for meeting overspending fundholders' financial obligations. In practice, 75% of overspends are covered using health authority funds.[6] Thus there is an asymmetry in the standard fundholding budget-setting: surpluses accrue to individual practices while deficits are met mainly from a central pool.

Under total fundholding, participating practices continue formally to hold their own budget for standard fundholding procedures and prescribing, and the health authority retains responsibility for the remainder of HCHS expenditure. However, health authorities give total fundholding sites firm global budgets within which they are

expected to restrain expenditure, and the architects of the scheme envisage that the formal budget holder for all expenditure will eventually be the total fundholding site.

The two principal types of purchaser envisaged in the 1991 reforms were the fundholding practice and the health authority. However, in seeking to ensure that their purchasing plans are sensitive to local preferences, many health authorities have entered into active dialogue with both fundholding and non-fundholding general practices. This sort of involvement of general practitioners has become known as 'commissioning', a process which is generally considered to be broader than purchasing, tending to embrace longer-term planning, and offering the potential for influencing services for which the commissioner does not necessarily have a budget.[22-26] Within the NHS the role of 'commissioning' has at times become particularly associated with non-fundholding general practitioners, and has often been contrasted with the purchasing role of fundholders. This paper does not make such a distinction, and considers all activities designed to secure desired services from providers at an agreed price to be encompassed by the expression 'purchasing'.

Broadly speaking, the NHS commissioning process entails involving all general practitioners in the development of the authority's purchasing plans, and co-ordinating health authority plans with fundholder purchasing. In fulfilling their commissioning role, health authorities have adopted a wide range of strategies, so that what Mays and Dixon[27] call a 'plurality of purchasing models' is emerging. Some of the most important developments from the original health authority/fundholder dichotomy are:

- fundholding multifunds, in which a number of fundholding

practices, covering say 50-80,000 patients, combine their management allowances (but not their purchasing budgets), principally in order to economise on transaction costs;

- fundholding consortia, more informal alignments of fundholding practices, which co-ordinate local purchasing intentions;
- total purchasing pilots, usually based on groups of practices;
- locality commissioning, in which a group of non-fundholding GPs (covering say 50,000 patients) collaborate to advise the health authority on preferred future purchasing developments;
- GP commissioning, in which a non-fundholding practice (or group of practices) is given a more formal role in purchasing, perhaps being given an indicative budget and involvement in the purchasing activity;
- formal GP purchasing advice by appointment of GP representatives to the health authority.

The importance of these initiatives varies around the country, and details of implementation also differ. However, it is possible to identify a number of themes common to all the developments:

- alignment of purchasing or commissioning into organisations which lie between the general practice and the health authority level;
- involvement of non-fundholders as well as fundholders (although not necessarily under the same umbrella);

- an increasing emphasis on longer-term commissioning rather than short-term purchasing;
- increased dialogue between the health authority and general practices;
- a move away from the narrow ambit of the standard fundholding list of services towards consideration of almost all health services;
- attempts to set 'fair' budgets for both fundholding and non-fundholding general practices;
- an interest in the development of the 'provider' role of general practice.

The development of purchasing models described above has taken place in the context of reforms put in place in 1991 by a Conservative government. On 1st May 1997 the Labour Party was elected to power. The new government has a commitment to retaining the separation of purchaser and provider within the NHS, albeit with an emphasis on commissioning rather than purchasing.[28] However, there is an intention to move "power, decision-making and cost both upwards from single practice level and downwards from health authority level".[2] The principal focus of commissioning is intended to be GP-led commissioning groups covering distinct geographical areas with populations of between 50,000 and 150,000. Unlike most existing locality groups, such commissioning groups will have 'real' budgets, and should in time replace the existing system of fundholding.

Thus in many respects the intentions of the incoming government appear to reflect many of the developments that are already taking place at local level. The major policy changes appear to be:

- the involvement of all GPs in the commissioning process;
- a move away from annual contracting towards 'health care agreements' lasting three to five years;
- an emphasis on geographical areas (rather than alignment of like-minded GPs);
- the phasing out of individual practice fundholding.

The policy objectives are to secure fairness between patients, to reduce bureaucratic costs and to ensure high quality care for patients.[2]

SETTING BUDGETS IN THE NHS

Successful implementation of fundholding depends on many factors, such as the vision, motivation and managerial expertise of participating general practices, and their ability to implement new approaches to patient care. However, one issue that is clearly of central importance is the process of setting budgets for general practices. In the NHS, the receipt of a budget signals command over resources, and therefore the budget has important symbolic as well as practical implications. This section examines the implications of devolving budgets to local levels in the NHS.

Budgets are ubiquitous in the modern enterprise, and are perhaps the most important formal mechanism for securing managerial control. Emmanuel, Otley and Merchant[29] set out five roles that budgets usually play:

- authorisation of actions;
- a means of forecasting and planning;
- a channel of communication and co-ordination;
- a means of motivating organisational members;
- a vehicle for performance evaluation and control.

Elements of all five purposes can be discerned in most budgetary systems. Unfortunately, a common finding is that budgets designed to serve one purpose (say motivation) may be less effective when serving other purposes (say performance review). However it is very rare to find different budgets being set for different purposes.

Even before the 1991 reforms, the NHS was no stranger to budgets. For decades the central government sought to restrain HCHS expenditure within strict cash limits. Setting cash-limited annual

budgets for individual health authorities was central to this objective. Of course such budgets could have been set on the basis of crude criteria, such as a fixed *per capita* sum, or last year's expenditure plus *x*%. However, major efforts have been made to make health authority budgets as equitable as possible. It is almost certainly the case that the attention to equity has helped to make acceptable the imposition of frequently severe cash limits.

Health authorities are responsible for restraining HCHS expenditure within their annual budgets. In this respect, they face a problem in the sense that HCHS expenditure is heavily influenced by the referral practices of a large number of individual GPs, over whom health authorities have little direct control. Until the advent of fundholding, the major restraining influences had been supply-side restraints, in the form of waiting lists for elective procedures and (in extreme cases) a refusal to undertake certain procedures. Nevertheless, even before the 1991 reforms, health authorities were generally successful in keeping within budget limits. This success could not have been achieved without the widespread acceptance by GPs of the need to restrain health care expenditure.

The introduction of fundholding has allowed health authorities to devolve an average of 15% of their HCHS budget to general practitioners. As noted above, this devolution does not necessarily absolve the health authority of all responsibility for that element of their budget, as the majority of any overspend is likely to be met by the health authority. Nevertheless, it is clearly hoped that the devolution will offer GPs a concrete incentive to restrain expenditure. In the same way, indicative prescribing budgets are intended to "place downward pressure on expenditure on drugs".[3]

In many ways the move towards a primary care-led NHS has made the distinctions between service headings such as prescribing and fundholding procedures irrelevant and unhelpful, as a principal objective of the initiative is to encourage GPs to secure the best health care for their patients subject to budget constraints, regardless of the service heading under which the care is found.[30] In principle, a global budget for all health care would allow GPs to switch freely between (say) hospital treatment and drugs. Any separation into separate budgets runs the risk of artificially constraining GP freedom in this respect. Furthermore, a global budget offers no opportunity for GPs to shift expenses to services not covered by their budget. Thus, for example, the standard fundholding scheme embraces only routine elective surgery, which accounts for just 20% of HCHS expenditure. There is therefore an incentive for fundholding GPs to refer patients as emergencies, which lie outside the ambit of their budget, thereby transferring financial liability to the health authority. In short, GP treatment decisions can only be made in an undistorted way if (a) budgets capture all expenditure caused by GP decisions and (b) GPs have complete freedom to switch between expenditure headings – that is, separate budgets are not set for specific services.

In practice, there may be many reasons why this counsel of perfection is neither attainable nor indeed desirable. Amongst the most important reasons for caution are:

- it may be very difficult to set what are perceived to be equitable budgets;
- at a strategic level it may be perceived that certain functions (say preventative medicine) could be squeezed out by more urgent health care demands, in which case there may be a

case for 'ring-fencing' the associated budget to ensure that GPs do not neglect the service;

- it may be unreasonable to expect general practices to take on certain health care risks (such as, for example treatment of HIV/AIDS), for which the associated budget might be held at the health authority or even the national government level;
- more generally, the unpredictable variation in local health care needs may be very high, rendering any budgets meaningless;
- GPs may not have the available information or the decision-making skills to make the 'rational' decisions demanded by the unconstrained budget;
- the management costs associated with devolution may be very high;
- it may be impossible to design satisfactory rewards and sanctions for underspending or overspending budgets.

These considerations are now considered under four headings: setting equitable budgets, handling variations from budget, managerial costs, and sanctions and rewards.

Setting equitable budgets

As noted above, the belief that NHS budgets are in some sense 'fair' is vital to securing the rigid expenditure control that is a feature of the NHS. The pursuit of such equity was one of the cornerstones inspiring the establishment of the NHS, and continues to be of central importance. There has been some debate about the precise concept of

equity that the NHS seeks to promote. For example, Mooney[31] offered seven possible interpretations of what is meant by equity:

- equality of *per capita* expenditure;
- equality of *per capita* inputs;
- equality of input for equal need;
- equality of access for equal need;
- equality of utilization for equal need;
- equality of marginal met need;
- equality of health outcome.

In practice, elements of all of these concepts can be found within the NHS. However, the most operationally practical (and therefore most used) concept is that of equality of access for equal need, notwithstanding vagueness in the definitions of both 'access' and 'need'. Pursuit of this concept has since 1977 been central to the budgeting system for HCHS. National funds have been distributed to health authorities on the basis of a variety of capitation formulae which seek to offer health authorities equal funds for equal population needs.[32]

Of course, even if the capitation formulae were perfect (which they are not) there is no guarantee that health authorities would be able to use their funds in an equitable fashion. In particular, different GPs might have very different referral patterns, and therefore offer very different levels of care. For example, Le Grand[33] estimates that, for equal levels of illness, the richest one fifth of the population obtained about 40% more NHS expenditure than the poorest fifth, suggesting that at the

time of his study (the 1970s) there may still have been some way to go before full equality of access was secured. Similarly, there is substantial evidence to suggest that, other things being equal, patients in urban areas receive more health care than patients in rural areas.[34]

The 1991 reforms, with their emphasis on competition and efficiency, paid scant attention to equity considerations, and have exposed features of the NHS which severely undermine its claim of offering equitable treatment. In particular, the favoured treatment given to patients of GP fundholders in some areas has led to clear differences in access. Whether the reforms have exacerbated or merely brought to light such inequalities must remain a matter for conjecture. However, within a market system, there is clearly an incentive for providers to favour patients from:

- purchasers who have larger *per capita* budgets;
- purchasers who can more readily transfer their contracts to other providers;
- purchasers who offer cost per case rather than block (fixed price) contracts;
- purchasers who are in direct control of the budgets and contracts.

On all counts, these criteria are more likely to apply to patients of fundholders than to patients referred by non-fundholders under health authority contracts. It would therefore hardly be surprising if patients from GP fundholding practices had been given favourable treatment by providers.

The methodology for setting HCHS budgets for health authorities has

been developed and refined over a twenty year period. The general principle is known as weighted capitation, in the sense that a capitation allocation for each citizen is weighted for a number of relevant factors.[35,36]

In contrast to the mature budget setting process for health authorities, setting budgets for general practitioner fundholders is still in its infancy. An early attempt to develop a needs index for fundholding procedures failed.[37] Subsequent guidance from the NHS Executive.[38] urges health authorities to use some sort of formula to set fundholder budgets, and to ensure that fundholders and non-fundholders are treated equitably. The Executive recommends use of an adjusted form of the HCHS acute sector index.[39]

Setting budgets for fundholders poses formidable problems. Amongst the most important are:

- there is very little systematic and reliable information collected about individual patients – in most areas it is limited to age, sex and postal address;
- in some areas databases of patients are unreliable, giving rise to the problem of 'list inflation', which averages 5.9% across the country;
- traditionally the NHS has used the characteristics of areas rather than those of patients as the basis for estimating needs – yet in general, patients attending a particular practice may not be representative of the area in which they live, even if that area is very small.

In the long run, as patient databases become more reliable and comprehensive, such problems may be overcome. However, they

present profound obstacles to setting equitable GP budgets in the foreseeable future.

Handling variations from budget

Annual health care expenditure on individuals is highly variable and unpredictable. Such variation can be considered under five headings:

- variation that is predicted by the relevant capitation formula;
- other variation which is predictable (given the individual's characteristics) but which is not captured by the current formula;
- variation which is due to clinical practice;
- variation which is due to local health care prices;
- variation which is random (that is, entirely unpredictable).

Only the first of these sources of variation is captured by the budget. The remainder are potential sources of variation from the budget. For an individual patient, variations from the annual capitation implied by his or her needs rating are likely to be massive. However, as patients are aggregated into populations, positive and negative variations will start to balance each other, so that the *per capita* variation from the capitation budget becomes smaller. Such aggregation is known as risk pooling.

At the level of the health authority, with a typical population of 500,000, budget risk is unlikely to be a major consideration. However, at the level of the general practice, with typical populations of (say) 6,000, a number of authors have shown that budget risk is likely to be

very large.[40] Martin, Rice and Smith[41] suggest that, assuming cost per case contracts are used, a typical fundholding practice (population 10,000) has a 1 in 3 chance of incurring expenditure more than 10% away from its budget, compared to 1 in 400 for a population of 100,000.

Thus in any year, the actual expenditure incurred by a general practice is very likely to vary substantially from its budget. This might have a number of serious consequences, such as:

- low spenders might 'spend up' to seek to justify their budget;
- high spenders might impose unjustified constraints on treatment and react with hostility to the budgeting system;
- patients with identical needs in different practices might be treated differently;
- patients with identical needs in the same practices might be treated differently depending on the time of year they present;[42,43]
- fundholding practices might negotiate block contracts, thereby transferring the risk to providers;
- fundholding practices might take out insurance with a third party, resulting in an unproductive outflow of funds from the NHS.

Yet variations from budget might be for some or all of the following reasons:

- the referral and treatment policies of the practice differ from the average assumed in the budget formula;[44]
- the practice has negotiated contract prices which differ from

the average assumed in the budget formula;

- the pattern of disease amongst practice patients differs from the needs-adjusted average assumed in the budget formula;
- the budget formula is faulty.

The managerial implications of the four sources of variation are clearly very different. Martin *et al* argue that unpredictable variations in health care needs (which are beyond the control of the GPs) are likely to be the dominant source of variation, suggesting that careful audit of such variations is essential before any action is taken.

It might be thought that improvement in the capitation formula could offer some hope of reducing the problem of such random health needs variation. Evidence from the US suggests that the major way of improving the predictive power of the English capitation formulae would be to incorporate data concerning pre-existing clinical conditions and past health care use of individual patients. Two major difficulties would be associated with such innovations. First, they necessitate the development of objective measures of health status which do not depend significantly on clinical judgement. In practice, this may imply reliance on previous health care expenditure. Second, they may offer a perverse incentive for GPs to increase expenditure on individuals in order to secure a higher capitation fee in the future.

It is therefore important to recognise that, although the use of a capitation formula is essential, and that some improvement in capitation formulae can be envisaged, no formula – however refined – can capture all the random variations in health care utilization. That being the case, some form of risk pooling will always be needed if budgets are to serve any useful purpose. Hitherto, the dominant risk

pool in England for HCHS has been the health authority. GP fundholders have also operated as limited risk pools for some aspects of expenditure, although in practice the health authority has continued to be the insurer of last resort, thereby to some extent blunting the incentive effect of the fundholder's budget. The nation has served as the risk pool for non-cash limited expenditure, such as prescribing, with the national government acting as insurer.

Clearly there is no reason why other mutual insurance arrangements should not be used (although legislation may be needed to permit some of these developments). For example, a number of general practices could agree to pool budgets. Such consortia might be based on geographical proximity (as in the locality purchasing model), but might instead be based on other criteria, such as agreement to follow certain clinical guidelines, or experience of similar population characteristics. The important point is that, by joining such consortia, GPs would have to agree to share budget surpluses and deficits. Within a consortium there would therefore have to be a strong degree of mutual trust and support amongst the participating GPs. A further advantageous aspect of such consortia would be that – particularly if based on locality – they could serve as administrative units along the lines of multifunds, allowing participating practices to economise on the costs of negotiating and monitoring contracts. The principal disadvantages of consortia would be the associated co-ordination costs, and the reduced focus on the treatment patterns of individual GPs.

As well as pooling practices, Martin *et al* suggest a number of other managerial strategies for handling the inevitable fluctuations in health care expenditure experienced for small populations:

- setting budgets for a period longer than one year, so that to some extent deficits and surpluses in successive years can be offset against each other;
- excluding certain expensive treatments from the budget – this is already done in the standard fundholding scheme (in which costs in excess of £6,000 in a year for a single patient are transferred to the health authority) and in total fundholding (for those services that are 'blocked back' to the health authority);
- excluding certain predictably expensive patients from the budget – this might require independent verification of the patient's health status;
- experimenting with contractual form – we have already noted that a block contract would eliminate risk for the budget holder, a cost and volume contract would introduce an element of risk sharing between purchaser and provider;
- establishing a contingency reserve at health authority level to accommodate overspends.

It is likely that a judicious mixture of these strategies is likely to avert some of the worst consequences of excessive risk to the budget holder. Yet it is important to bear in mind that the existence of some element of risk is important if budgets are to exert their discipline. There is therefore likely to be a trade-off between risk management procedures and the incentives given to individual budget holders.

Managerial costs

There is a belief implicit in many recent public sector reforms that 'we are all managers now'. In particular, it is presumed that front-line workers, such as teachers and doctors, can assume a managerial ethos without detriment to their professional skills. Yet this may simply be unreasonable. There is ample evidence, especially from the education, social work and health care sectors, that many professionals have neither the skills, time nor inclination to become involved in the managerial issues necessitated by the new public sector management. In particular, the devolution of budgets – and with them responsibility – appears to be imposing immense strains on many professionals whose training leaves them ill-equipped to deal with the new challenges.

Within the NHS, a common theme emerging from a variety of studies of fundholding and commissioning is that substantial managerial expertise is required to make devolved purchasing work.[6,20,45,46] In particular, the Audit Commission raises serious doubts about the ability of general practice to handle the managerial tasks associated with devolved budgeting. Even amongst advisory commissioning groups, success depends heavily on adequate managerial support.[47] The managerial requirements arise amongst providers (who must deal with a multiplicity of purchasers) and health authorities (who must seek to co-ordinate purchasing plans) as well as amongst fundholders and other local purchasers. Furthermore, managerial costs may be indirect (for example, in the efforts required to retain stability in the supply of local services) as well as direct (for example, in the negotiation and monitoring of contracts).

Many commentators noted that the key unknown factor which would determine the success or otherwise of the 1991 reforms would be their information requirements and more generally transaction costs.[48] As responsibility is devolved, so the necessary information flows and associated managerial requirements multiply. Few reliable estimates are available. However, all the indications are that managerial costs in the NHS have increased enormously since 1991,[49] and that managerial skills are highly variable within general practice.[6]

It is important to recognise that the managerial demands associated with the early years of the reforms are unlikely to be a transitional phenomenon. They are intrinsic to the market mechanism, and any evaluation of the reforms must weigh the costs of managing the system against any improvements in patient care, efficiency or equity that arise from the reforms. In this respect, the development of localities may represent a happy medium between low managerial costs but low sensitivity to patient needs associated with health authority purchasing and high managerial costs and high sensitivity to needs associated with general practice purchasing. They may permit some economies of scale in managerial activities, yet permit general practitioners to retain some personal interest in the commissioning and purchasing function.

It is impossible to examine the managerial costs of purchasers without considering the nature of the contracts and longer-term agreements they negotiate with providers. In the extreme, if purchasers negotiate only block contracts with their providers, then (at least in the short term) they experience none of the financial pressures associated with fixed budgets, as the marginal charge to their budget of an extra referral to a provider is zero. Thus the budgetary system becomes immaterial once contracts have been negotiated, and the managerial function may be largely administrative in nature. On the other hand,

as noted above, use of cost per case contracts may expose the purchaser to substantial risk, with its potentially dysfunctional consequences, and may induce financial uncertainty in providers, with consequences for the stability of local services. In the same way, the time scale of contracts and agreements has clear implications for purchaser behaviour and provider stability. There is therefore a compelling case for a much more careful examination than hitherto of the link between purchaser size and functions and the contracts they negotiate.[27]

Sanctions associated with budgets

In spite of the difficulties set out above, it is difficult to argue with the claim that setting general practice budgets for most health care services is in principle a desirable objective. The major impediment remains the cost to management of setting equitable budgets and monitoring GP expenditure against those budgets. Much more problematic is consideration of the rewards (or sanctions) associated with any underspend (or overspend) against a budget. At one extreme, budgets might be purely notional, in the sense that no consequences of any materiality arise from any divergence in spending from budget. At the other extreme, an annual budgetary regime may be so rigid that any overspend will have severe consequences for the budget-holder, perhaps even leading to loss of livelihood. Clearly, the behaviour of the budget-holder is likely to be quite different in these two circumstances. In particular, the referral and prescribing patterns of general practices are likely to be heavily influenced by the rewards or sanctions implicit in the budgetary regime chosen by the health authority – in short whether any budgets are 'soft' or 'hard'.

There has been a tendency within the NHS to consider fundholding budgets to be hard, and any indicative budgets received by non-fundholders to be soft. Similarly, purchasing has assumed a connotation of hard budgets, while commissioning budgets (if they exist) are considered soft. In many ways these distinctions are misleading. Fundholding budgets have many soft elements, not least the limited liability of fundholders for any overspend, and the possibility that current overspends might serve to boost future budgets. Conversely, indicative budgets might have some distinctly hard elements, such as preferential treatment for general practices that restrain expenditure within budgets. Therefore no budget system can be characterised as entirely hard or soft, and there is in practice a continuum between the two extremes.

The discussion on risk in health care expenditure suggests that, whatever reward system is implemented, variations in expenditure from GP budgets will have to explored with some care and sensitivity to local circumstances. In particular, it will almost certainly be necessary to specify some tolerance within which actual expenditure might be allowed to vary without serious consequence. Empirical results suggest that this tolerance may have to be quite large. It should be noted that tolerance limits should be greater for smaller practices than larger practices. An associated issue is the size of any contingency reserve the health authority might choose to set up.

Attention will inevitably focus on large overspends. In the first instance, every effort should be made to explore the reasons for the overspend. Preliminary questions to be asked might include:

- do referral or prescribing practices appear to be out of line with those in comparable practices?
- do contract prices appear to be reasonable?
- are there special circumstances that make the capitation formula inappropriate?
- is there a history of overspending?
- does the practice have adequate managerial and financial control mechanisms in place?

Even if there is a history of overspending, this is no guarantee that the practice is behaving unreasonably, given the evidence that a great deal of excess health care needs persist over a long time horizon. Only after careful scrutiny will it be possible to make some judgement regarding appropriate action.

If it is judged that an overspend is beyond the control of the practice, then – as is currently usually the case – the health authority might make good the deficit, either from a pool created from previous surpluses retained by the practice or from a contingency reserve held back from the authority's HCHS allocation. If the overspend is considered to be wholly or in part the consequence of the practice's actions, then sanctions might include a requirement for the practice to implement improved managerial control mechanisms and to submit to some sort of peer review. Reducing budget allocations in future years is likely to be an unfeasible option,

as it will disadvantage patients rather than discipline the general practice.

Attention should also be paid to the treatment of underspends. Clearly, budget holders should be given some incentive to spend below their budgets, and should therefore be allowed to retain a proportion of their savings. However, there is a case for encouraging practices to return a proportion of their underspend to the risk pool, either to insure against their own future overspends, or to fund current overspends in other practices.

Finally, an implicit reward for overspending in many budgetary systems is caused by basing future budgets on past outturn expenditure. This offers budget holders a perverse incentive to sustain high spending levels, and was the curse of the Soviet planning system.[50] Every effort should therefore be made to make budgets independent of past behaviour.

SUMMARY AND CONCLUSION

This paper has sought to highlight some of the issues that are likely to emerge in seeking to move towards a devolved model of purchasing within the NHS internal market. It has been suggested that there are numerous considerations in devolving responsibility for purchasing within the NHS. Amongst the more important are those given in Table 1. The table compares the likely performance of two extreme purchasing arrangements along six dimensions of performance: management costs; equity; sensitivity to local needs; cost restraint; stability amongst local providers; and accountability to local citizens. The 'centralised' arrangement can be thought of as health authority purchasing, while the 'devolved' arrangement might in the extreme involve the allocation of virtually the entire health authority budget to individual general practices. Table 1 suggests that there are likely to be important trade-offs between these criteria.

The paper has noted that many of the commissioning and purchasing developments evolving locally in the NHS appear to be converging towards a model which is consistent with the concept of locality commissioning, as embodied in government policy. Yet what is also evident is that there remains an enormous plurality of organisational forms to be found.[27] There are numerous dimensions along which differences between commissioning or purchasing groups exist:

- the size of the population covered;
- the range of health services covered;
- whether or not the group embraces all general practices within a geographical area;
- whether the group comprises fundholders, non-fundholders, or both;

- whether or not the group holds a budget;
- whether that budget is hard or soft;
- the extent to which any budget is devolved to constituent general practices;
- whether the group's role is advisory or executive;
- the extent to which the group considers longer term developments;
- whether or not the group negotiates and manages contracts with providers;
- the nature of such contracts;
- the extent of public consultation undertaken by the group;
- the organisational structure of the group;
- the administrative support for the group;

and so on. The local choice in relation to these issues should in principle be determined with reference to the performance criteria of the sort summarised in Table 1.

TABLE 1: The impact of devolving purchasing powers

Criterion	Centralised system	Devolved system
Management costs	Low	High
Equity	High	Low
Sensitivity to local needs	Low	High
Cost restraint	Low	High
Stability of providers	High	Low
Accountability to local citizens	?	?

Although other factors are also important, this paper has contended that the budget forms the central managerial instrument for devolving responsibility and securing participation from general practitioners. Two fundamental issues inform the budgetary framework: the breadth of health services covered, and the population covered. These two issues cannot be considered in isolation. We have already noted that, for the purposes of most health care risks, the health authority can be considered a self-insuring entity. The exception to this general principle might be emergencies or epidemics of serious diseases necessitating substantial expenditure, in which case the national government might be the insurer of last resort. As budgets are devolved by the health authority to commissioning groups, so it becomes important to examine with some care the limits to the health care services covered by the budget holder, and the limits to their liability.[27] Commissioning groups might then retain a portion of their budget, but might devolve some of their budget to their constituent general practices. Considerations of risk management then become very important.

Although the budgetary framework is a starting point, the discussion suggests that it must be considered in conjunction with the other issues noted above. If the purchasing group embraces all general practices in an area, this may throw together practices with fundamentally different priorities and styles.[51] Yet – particularly if the groups receive 'hard' budgets – there may be a need for a high degree of mutual trust and consensus amongst practices. This suggests that an element of voluntary association may be more appropriate, so that geographical proximity may be only one criterion for membership of a group. If membership is voluntary, this raises the issue of how to handle those general practices which choose to remain outside any

group. At the very least, it may be important to ensure that such practices implement some basic budgetary control systems.

The 'hardness' of any budgets is a central issue to any devolved purchasing arrangement. Many fundholders claim that it is only by having direct power over contracts and finances that they are able to exert real influence over providers. Yet we have also noted the potentially dysfunctional consequences associated with excessively hard budgets. Furthermore, the role of hard budgets in securing expenditure control may be overstated. The NHS enjoyed a large degree of success in containing expenditure before the advent of the internal market, to a great extent because of the widespread restraint of general practitioners. It is moreover noteworthy that hitherto standard fundholding budgets have not in practice been particularly hard, as budgets have often been based on past expenditure and the health authority has usually met the bulk of any overspend. Many of the enthusiasts amongst fundholding practices may therefore have been sheltered from the full rigours of a cash-limited budgetary system.

The issue of managerial costs permeates much of the debate. In this respect there are clear trade-offs between increased devolution, with its associated benefits of participation and sensitivity, and increased managerial costs. Similarly, the type and time scale of contracts negotiated by budget holders may have profound implications for the effectiveness and efficiency of any devolution. Finally, a perennially troublesome question for the NHS is how the views of constituencies other than health care professionals – most especially local citizens – can be brought into the commissioning process. Experience to date offers little advice in this respect.

TABLE 2: The implications of performance criteria for aspects of the financial regime

	Aspect					
Criterion	Population size	Range of services	Basis of groups	Nature of budget	Contract term	Nature of contract
Management costs	Large	Narrow	Geography	Hard	Long	Block
Equity	Large	Wide	Geography	Soft	Long	Block
Sensitivity to local needs	Small	Wide	Voluntary	Soft	Long	Cost-per-case
Cost restraint	Small	Wide	Voluntary	Hard	Short	Cost-per-case
Stability of providers	Large	Narrow	Geography	Soft	Long	Block

In summary, Table 2 indicates the type of financial regime implied by five of the six performance criteria noted in Table 1 (the accountability criterion is omitted not because it is considered unimportant, but because there is little evidence on which to base any clear judgement on the impact on accountability of devolved purchasing). Six important aspects of devolved financial arrangements are listed:

- the size of population covered by the devolved budget;
- the range of health services covered by the devolved budget;
- whether budgets are devolved on the basis of geography or voluntary association of general practices;
- the hardness of the budget;

- the time scale of the contracting process;
- the nature of contracts (block or cost-per-case).

The entries in the table indicate my judgement as to the preferred model if the associated performance criterion were considered paramount. Thus for example, an overriding concern with cost restraint might lead to devolution to *small* population sizes; based on a *wide* range of services; with general practices aggregated on the basis of *voluntary* association; *hard* budget constraints; a *short-term* contract cycle; and *cost-per-case* contracts. In most respects, concern with management costs would yield diametrically opposite policy conclusions. It should be noted that some judgements are easier to make than others, and that some conclusions are therefore rather speculative. However the results of this rudimentary exercise show that – if two or more performance criteria are considered – no one model is likely to dominate, so that technical and political judgements must be applied to determine the best trade-off between competing models.

In this respect, there is clearly much to be learnt from local initiatives and the total purchasing pilot projects. However, although some discernible trends are emerging, experience to date suggests that the optimal form of a commissioning group may be heavily contingent on local circumstances, such as:

- the history and culture of local health services;
- the attitudes of local authorities and other local statutory and voluntary organisations;
- the configuration of local health care providers;
- local geography and infrastructure;

- local population characteristics;
- the preferences and preoccupations of local individuals (in particular general practitioners) and organisations.

To ignore these issues would be to court disaster. However, at the same time, there is a growing body of evidence from which to learn, and the dissemination of good practice would be an important part of any new arrangements. The best way forward would therefore seem to be to retain maximum flexibility in arrangements, while ensuring that all areas and general practices are subject to some minimum involvement in NHS purchasing.

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There have been numerous experiments in the UK-NHS with the devolution of fixed annual budgets for purchasing and commissioning secondary care to general practitioners.

However, whilst devolution increases responsibility and risk to general practitioners and may secure improvements in the efficiency and quality of health care, it may also compromise the achievement of key NHS objectives such as ensuring that all patients are treated fairly and provider stability is maintained.

In this paper Professor Peter Smith explores these issues and suggests that the optimal way of devolving responsibility to general practitioners may depend on local circumstances and the priorities attached to the different objectives of the NHS.