

NHS White Paper proposals for GP commissioning: does size matter?

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Footnote *i* (p.4) which clarifies the role of the NHS Commissioning Board was missing from an earlier published version of this report. This was due to an editing error, for which we would like to apologise.

Executive summary

The Coalition Government's White Paper, *Equity and Excellence: Liberating the NHS*, proposes transforming the purchasing side of the English NHS: replacing 152 Primary Care Trusts (PCTs) with groups or 'consortia' of general practices that will have responsibility for commissioning the majority of health care for their local populations.

The size of the consortia has yet to be specified, but early indications suggest there will be a proliferation of commissioning organisations of a considerably smaller size than existing PCTs.

This report looks at the relationship between size and performance in commissioning (purchasing) organisations both in the NHS in England and internationally, by way of literature review and original analysis of data. It concludes:

- On balance, there is a good and plausible theoretical case for arguing that size matters to commissioning organisations: small commissioning organisations (especially those covering 100,000 people or fewer) are likely to struggle if they are responsible and carry the risk for commissioning the entire spectrum of health care for their populations.
- Data on the performance of commissioning organisations in the NHS (the Care Quality Commission's Annual Health Check and Department of Health's World Class Commissioning regime) shows little or no relationship between size of commissioners and their performance. This may be because there is no relationship, or because none is revealed due to there being little heterogeneity in organisational size; repeated reorganisations masking performance differences; and measures of performance lacking discriminatory power. Similar results are in evidence in the academic literature on commissioning in the NHS.
- In 10 European countries analysed, seven have seen a consolidation of commissioning organisations over the past 15 to 20 years, two have seen no change. In only one country (Spain, due to devolution) has the number of commissioning organisations increased. In all countries apart from Switzerland the average population coverage of a commissioner is above 300,000 people.

It is likely that GP consortia will cover smaller populations than existing PCTs: there is little, if any, theoretical or empirical evidence to suggest this reduction in size will lead to better commissioning – particularly given that the transition will be costly and almost certainly result in a dip in performance in the short-to-medium-term.

An alternative strategy, worthy of debate and more concordant with the evidence, would be to decentralise control over existing commissioning in the NHS by creating a permissive and flexible framework which would allow commissioning organisations (PCTs, practice-based commissioners) to change organisational arrangements for themselves. Further ideas – such as allowing people a choice of commissioning organisations – also could be tested.

Introduction

A crucial element of the Coalition Government's planned reform of the National Health Service in England is the transformation of commissioning.¹ The White Paper, *Equity and Excellence: Liberating the NHS*, proposes replacing 152 Primary Care Trusts (PCTs) with groups or 'consortia' of general practice that will have responsibility and carry the risk for commissioning the majority of health care for their local populations.¹ The size of the consortia has yet to be specified, but early indications suggest there will be a proliferation of commissioning organisations of considerably smaller size than existing PCTs.² Yet, it is only six years since the then Labour government merged many smaller PCTs to form the current organisations, arguing that they were too small to commission effectively.³ What's more, in certain areas such as London, Manchester and the North East, existing PCTs currently join forces in still larger confederations or alliances to commission health services, suggesting there are possible advantages or economies of scale in doing so.

So does size matter in healthcare commissioning? And what might be the impact of the Coalition Government's reforms if they do lead to the creation of smaller-scale commissioning organisations in the form of GP consortia? This briefing examines the evidence on size and performance in healthcare commissioning first in the UK and then internationally, by way of literature review and analysis of performance data. It concludes that the evidence does not support a move to smaller commissioning organisations, and more widely questions the wisdom of mandating a 'one size fits all' commissioning structure.

What does effective commissioning look like?

The development of commissioning in the NHS in England over the last 20 years has been something of a saga of great expectations and disappointing results. Despite experiments with a number of different organisational forms and structures (GP fundholding, total purchasing, primary care groups, primary care trusts and practice-based commissioning to name a few) and substantial investment in commissioning arrangements, research has shown marginal benefits at best.⁴ Research also suggests that promising results from experimental forms of commissioning have been difficult to replicate when experiments are rolled out across the NHS, with some researchers suggesting that the repeated reorganisation of commissioning arrangements has been part of the problem.⁵

Since 2006, the Department of Health has invested much effort in the ambitiously titled 'World Class Commissioning' (WCC) programme, which tried to define and measure the key competencies in commissioning that the current commissioners, PCTs, should possess.ⁱⁱ This initiative, and much

ⁱ The NHS Commissioning Board, a national body, will be responsible for commissioning general practice, pharmacy, dentistry, and national and regional specialised services, maternity services and prison health services.

ⁱⁱ There is some evidence that PCTs have been improving their commissioning skills, at least when measured against the WCC competency framework. Gainsbury, S., Taylor, A., Lewis, S., 'World class commissioning: PCTs raise the bar in final assurance test', *Health Service Journal*, 12 August 2010: <http://www.hsj.co.uk/topics/world-class-commissioning-scores-2010/world-class-commissioning-pcts-raise-the-bar-in-final-assurance-test/5018158.article>

of the commissioning debate over the last two decades, has revolved around issues of structure and process such as what kind of organisation is needed, what competencies it should have, how GP and other clinical involvement should be secured, how it should be made accountable, and so on. But what really matters is how well a commissioning organisation does its job: that is purchasing health services on behalf of the population it serves.⁶ This can be defined through the three classic dimensions of performance evaluation: efficiency, economy, and effectiveness:⁷

- *Efficiency* is how much a commissioning organisation spends on the administrative systems and processes for commissioning – staff, information systems, transactions with healthcare providers and patients etc. – to achieve what it does. It can be measured most simply as the annual cost of running the commissioning organisation per member of its population.
- *Economy* is how much the commissioning organisation has to pay for the healthcare services it buys from healthcare providers like hospitals, clinics, primary care doctors, and so on. Again, it can be measured, either by looking at the spending on health services per member of population or by looking at what is paid for particular services. Of course, a low cost commissioning organisation could be achieving that result by buying health services wisely and paying a low unit cost, or by not meeting the necessary clinical needs of its population.
- *Effectiveness* is how much the commissioning organisation is improving the health of the population it serves through the healthcare services it buys for them. This is much harder to measure than efficiency and economy, but it is possible to establish useful and practical indicators. For example, we can measure whether the commissioner is providing access to clinical therapies which are known to be effective (and whether it is not investing in therapies which are ineffective). For major disease areas like diabetes, stroke, heart disease or dementia, we can measure whether the commissioning organisation purchases services which meet national quality standards, and what outcomes are achieved for its population. We can also measure aspects of the health status, morbidity and mortality of its population which are known to be amenable to change (like rates of cancer survival, or avoidable deaths).

Any meaningful attempt to reform commissioning thus needs to demonstrate how it will bring about improvements in these three dimensions. Particularly in an environment of scarce resources, articulating a policy initiative to have smaller or larger commissioning organisations; or to involve GPs in commissioning; or to link healthcare commissioning more closely to social care commissioning; must be supported by plausible evidence that the policy initiative will improve commissioning *per se*.

Why might size matter for effective commissioning?

Three key elements to effective commissioning – efficiency, economy and effectiveness – have been identified. Here, we consider in turn how these elements might be affected by the core consideration of this report: a commissioning organisation's size.

Efficiency

There is a good case for arguing that larger commissioning organisations are likely to be able to achieve greater economies of scale and therefore greater efficiency than smaller such organisations. Many infrastructure costs, such as IT systems, contracts, office accommodation etc., are fixed or semi-fixed (i.e. do not vary much with population coverage) and so such costs are likely to drop in terms of unit costs as population coverage increases. To take a practical example, suppose a commissioning organisation which looks after 100,000 people has to negotiate contracts and manage transactions and payments to 20 healthcare providers (hospitals, treatment centres, clinics etc.) to provide care. If the commissioning organisation doubled in size, to look after a population of 200,000, the number of healthcare providers it used would probably go up, but not by much. It would then be able to spread the costs of contracting across a lot more people, and so would be more efficient in terms of unit costs.

Set against this is the argument is that there may be a plateau above which greater economies of scale are difficult to achieve and diseconomies of scale set in. For example, the larger the organisation, the more bureaucratic it may become. In addition, smaller commissioning organisations may also be able to achieve economies of scale in other ways, for example by contracting out back-office functions to a specialist provider, or by forming alliances or consortia with other commissioners.

Overall, however, it is likely a commissioning organisation responsible and carrying the risk for commissioning the entire spectrum of health care – as proposed with GP consortia – must be responsible for a significant number of people to achieve reasonable levels of efficiency.ⁱⁱⁱ

Economy

There is a strong case to make that larger commissioning organisations might also be more economical, because their size gives them greater leverage to negotiate prices with healthcare providers. For example, a commissioning organisation which buys 200 orthopaedic operations per year is more likely to be able to negotiate volume discount from a hospital than one which only buys 20 operations a year. Some healthcare providers, particularly acute hospitals, tend to be very large organisations with a lot of financial and political power, holding an effective monopoly in their local area.⁸ Small commissioning organisations dealing with large healthcare providers are unlikely to be able to set or negotiate terms and will often have to take the prices and conditions they are offered.

Set against this, however, is the possibility that a market led by a number of smaller commissioning organisations, rather than a few big ones, would lead to more dynamic and responsive providers, because the market would be shaped by many 'individual' purchasing decisions (as in the gas or telecoms market) rather than a few big contracts. For this benefit to emerge, however, it may be that

ⁱⁱⁱ Debate rages over roughly what this figure is, but it is likely to be approaching, or at least, 100,000 people. Given, R.S., 'Economies of scale and scope as an explanation of merger and output diversification activities in the health maintenance organisation industry', *J Health Econ.* 1996 Dec;15(6):685-713; Wholey D, Feldman R, Christianson JB, Engberg J., 'Scale and scope economies among health maintenance organisations', *J Health Econ.* 1996 Dec;15(6):657-84; Smith, P., 'Setting budgets for general practice in the new NHS', *BMJ* 318,776-779

commissioners would need to be competing against each other for custom, so as to minimise the effect of monopoly.

Effectiveness

The effectiveness of commissioning is perhaps the most important dimension and here the argument that size or scale matters is more nuanced. On the one hand, economies of scale apply once again, in that a larger commissioning organisation is likely to be more able to invest in specialist expertise to drive service changes that may improve effectiveness. For example, if a commissioning organisation has just a handful of stroke patients with stroke each year, designing a new stroke pathway and negotiating service changes with healthcare providers to improve access to specialist stroke units will be difficult. But a large commissioning organisation could afford to dedicate more staff resources to the redesign, and would have greater leverage with healthcare providers to get change.

The converse argument is that, as the White Paper seems to presume, smaller commissioning organisations might be closer to patients and their needs, and be more able to act quickly and responsively towards individual patients and their care – particularly when it comes to primary care and chronic disease management. They may also be able to take advantage of effective commissioning templates, if they exist, to mitigate the benefits of larger organisations in developing effective core pathways.

In summary, for all three dimensions of commissioning – efficiency, economy and effectiveness – there are plausible arguments which suggest that the size of commissioning organisation could impact on performance. On balance, it is reasonable to say theory suggests larger commissioning organisations – up to a point where diseconomies of scale set in and their size begins to quash competition – could well perform better.

Given this, the likely direction of policy towards establishing smaller commissioning organisations in the NHS is worthy of closer examination. In what follows, we do this by first exploring the available evidence from the NHS and then by taking a look at the international picture.

The relationship between size and performance in commissioning organisations in the NHS

Since the introduction of the ‘internal market’ in the NHS in England in the early 1990s there have been a variety of different commissioning organisations, of different sizes, with different degrees of autonomy and responsibility. In this section, we look first at the evidence on the relationship between size and performance in commissioners during the first attempt at a market in the NHS, 1991-97, and then during the second, from 2000 to the present.^{iv} The former is examined by way of a literature

^{iv} In the intervening period, between 1997 and 2000, primary care groups managed the purchasing of services, but they did not act as impartial, discriminating, commissioners in the true sense of the word: the emphasis was on rolling back the market.

review. The latter is examined by way of a literature review and original analysis of data on PCT performance.

The internal market, 1991-97

The 1991-97 market in the NHS encompassed three types of commissioning organisation: 100 district health authorities (DHAs), which held overall responsible for commissioning health care for geographically-based populations; voluntary single-practice GP fundholding schemes, which operated under DHAs with real budgets for purchasing elective care; and voluntary Total Purchasing Pilots (TPPs), single- or multi-practice GP-led organisations, which operated under DHAs but held larger budgets with greater responsibility for the purchasing of a greater variety of services. Average population coverage is found in Table 1.

Table 1.

Commissioning organisation	Average population coverage	Smallest population coverage	Largest population coverage
District Health Authorities ⁹	500,000	<100,000	>800,000
GP fundholder ¹⁰	10,000	3,000	50,000
Total purchasing pilots ¹¹	30,000	8,000	80,000

Literature searches^v revealed no evidence on the relationship between size and the performance of DHAs or GP fundholders. That said, it is worth noting evidence on the effectiveness of GP fundholders per se, given that they were small commissioning organisations. This suggests GP fundholding was associated with: improvements in speed, access and responsiveness of secondary care; reductions in waiting times; slight reductions in referral rates and costs; and widening the range of available services. However, GP fundholding failed to reduce costs as much as expected. One study found fundholding to be associated with lower patient satisfaction with services. Importantly GP fundholders were also self-selected volunteers and held commissioning budgets and responsibility for a relatively small subset of care: electives.¹²

There is some evidence on the relationship between size and the performance of TPPs. With regard to achieving clinical objectives, this suggests smaller pilots were initially stronger. In a study of achievement against self-reported objectives in the first 'live' year (which were mainly based around the development of primary care) it was found that single-practice and small multi-practice TPPs were more likely to have succeeded. No large multi-practice pilot was judged to be a 'high achiever'.¹³ However, in the second 'live' year large multi-practice pilots were more likely to be 'high achievers'.¹⁴ This was partly attributed to their development of more efficient organisational structures, but it may also have been related to political trends. It is argued that single-practice pilots may have been

^v Keywords and MESH terms used were: District Health Authority, GP fundholding, Total Purchasing Pilots, size, population, budget, performance, success, efficiency, and quality. The search terms were entered into NHS Evidence and PubMed databases.

undermined by New Labour’s shift away from fundholding upon their election in 1997, causing some DHAs to withdraw their support.¹⁵

With regard to managing budgets, smaller TPPs appear to have been more effective. In the 1996-97 fiscal year, 90% of multi-practice pilots found that actual spending differed from planned spending, compared to 30% of single-practice pilots; in addition, 40% of multi-practice pilots reported some kind of ‘financial crisis or difficulty’ compared to 9% of single-practice pilots.¹⁶ This was attributed to the integration of clinical and managerial roles being easier in single-practice pilots: lines of communication and organisational structures were already in place, whereas in the larger groups they were more difficult to establish.¹⁷ For the same reason, it was found that anticipated economies of scale in larger groups were not in evidence; neither was there a difference in the frequency of reporting problems from rare costly referrals between single and multi-practice pilots (theory would predict this would be more of a problem for smaller commissioning organisations because they have less people to spread risk across).¹⁸

It is, however, important not to overstate these findings. Firstly, the TPP scheme was only in place for a few years (c.1994-98): it may well be the case that if it had been given a longer time to bed in larger, multi-practice pilots would have the time to develop more effective management structures and realise benefits from economies of scale.¹⁹ Secondly, the lack of correlation between size and overspending on costly referrals may have been a result of chance.²⁰ And thirdly, the TPP scheme gave pilots the ability to choose which services they held budgets for. Most GPs stuck to familiar territory such as developing primary care services, with few tackling more unfamiliar areas such as specialist secondary care. Few succeeded in reducing hospital activity.²¹ TPPs, as with GP fundholders, did not hold responsibility or risk for the commissioning of the entire spectrum of health care, whereas GP consortia will.

The NHS market, 2000-present

The market in the NHS from 2000 to the present is led by two types of commissioning organisations: 152 primary care trusts, geographically based commissioners with overall responsibility for the commissioning of healthcare services for their local populations, and subsidiary practice-based commissioning groups with devolved but ‘virtual’ budgets for the commissioning of community healthcare services.^{vi} Average population coverage is found in Table 2.

Table 2.

Commissioning organisation	Average population coverage	Smallest population coverage	Largest population coverage
Primary Care Trust ²²	338,000 ^{vii}	90,800	1,300,000
Practice-based commissioners ²³	63,000	1,000	300,000

^{vi} The aim with practice-based commissioning was to make the commissioning process more targeted and localised and to incentivise clinicians to make more cost-effective treatment decisions.

^{vii} From 2006 when mergers took place. From 2000 to 2006, average population coverage was 170,000.

The first thing to emphasise with regard to PCTs is that since their establishment in 2002 many have been merged to form larger organisations: in 2006-07, 303 PCTs became 152 (223 were merged and 80 remained unchanged) as a result of central directive.^{viii} As previously mentioned, the mergers were seen as necessary by government in order to improve commissioning.²⁴

Literature searches^{ix} reveal only one study to have been conducted on the relationship between size and performance in PCTs. It found that size was only important in two of the 23 performance variables analysed: larger PCTs were more likely to have initiatives to extend the range of services available and more likely to have introduced initiatives in intermediate care.²⁵ On balance, the study found that PCTs with populations over 100,000 did not generate significant cost savings or improvements in performance compared with other, smaller, PCTs.²⁶ The literature search revealed no evidence on the relationship between the size and performance of practice-based commissioners.

The next stage of our research led us to analyse raw data on the performance of PCTs against their size. To do so, two sets of performance data were used: Healthcare Commission (now Care Quality Commission) 'quality of services' and 'use of resources' ratings compiled as part of the Annual Health Check (now Periodic Review);^x and the Department of Health's World Class Commissioning ratings on 'governance' and 'competency'.^{xi} As a proxy for size of PCT, Office for National Statistics data on population by PCT was extracted.^{xii} The years studied were 2005/06, 2008/09 and 2009/10 (available performance data for each year are found in Table 3).^{xiii}

^{viii} The figures in Table 2 reflect population coverage post-mergers.

^{ix} Keywords and MESH terms used were: Primary Care Trust, PCT, practice-based commissioning, size, population, budget, performance, success, efficiency, and quality. The search terms were entered into NHS Evidence and PubMed databases.

^x Until 2008/09, PCTs were assessed according to two criteria, 'quality of services' and 'use of resources', and given ratings of 'weak', 'fair', 'good' or 'excellent'. Between 2005/6 and 2007/8, the quality of services criteria judged performance against core standards, existing national standards and new national standards. The use of resources section assessed financial reporting, financial management, financial standing, internal control and value for money. In 2008/9, however, the Annual Health Check was changed to account for the separation of commissioning and care provision roles in PCTs. The new criteria were 'overall quality score', split between 'quality of commissioning' and 'meeting core standards' in care, and 'financial management'.

^{xi} The World Class Commissioning regime was introduced in December 2007 and aimed to enable PCTs to commission high quality and value for money services, that meet the needs of their local communities. Under the regime, PCTs are assessed annually against governance (board, finance and strategy) and against 11 competencies: locally leading the NHS; working with community partners; engaging with patients and the public; collaborating with clinicians; managing knowledge and assessing needs; prioritising investment; stimulating the market; promoting improvement and innovation; securing procurement skills; managing the local health system; and ensuring efficiency and effectiveness of spending. World Class Commissioning results were only published for 144 PCTs in 2009-10, and 148 PCTs in 2008-09 (out of 152). For sake of continuity, in our analysis we used the 144 PCTs from the 2009-10 in both years.

^{xii} We also ran the same analyses against budget. Similar, if not completely identical, results were found, due to there being a high correlation ($R_{sq} > 0.9$) between population coverage and budget (the DH allocates funds to PCTs based on population, adjusted for various indicators of healthcare need). The 2005-6 population figures from the Office of National Statistics had been changed to fit the 152 PCTs operating after the merging in 2006, and therefore were no longer relevant. Instead, we used 2001 population figures for the 303 PCTs operating in 2005/06. 2008/09 PCT population figures were used for the years 2008/09 and 2009/10, as 2009/10 population data was not available.

^{xiii} We began with 2005/06 because this was the first year in which the Healthcare Commission's Annual Health Check was published for PCTs (before that, little reasonable comparative data is available) and did not analyse the years 2006/07 and 2007/08 as a recent study by Civitas showed the performance of PCTs was significantly affected by whether or not they were merged: to isolate any effect of size would be improbable. Gubb, J., *Civitas Data Briefing: Government plans to transfer commissioning responsibility from PCTs to GPs*, London: Civitas, 2010 http://www.civitas.org.uk/nhs/download/civitas_data_briefing_gpcommissioning.pdf

Table 3.

Year	Performance measures available
2005/06	Annual Health Check
2008/09	Annual Health Check & World Class Commissioning scores
2009/10	World Class Commissioning scores

As shown in Figs. 1-6, in all years and on all available measures no relationship was found between the size of a PCT and performance. This held true, also, when World Class Commissioning scores were disaggregated into individual ‘competencies’: no relationship was found between PCT size and performance on any given competency.

2005-06

Fig. 1. The correlation between PCT size and Annual Health Check ‘quality of services’ rating (2005/06)

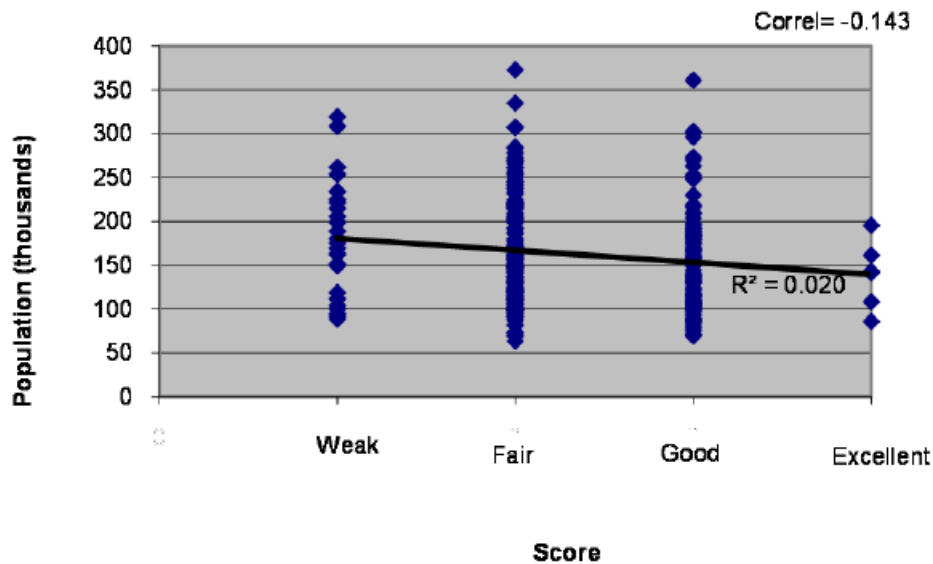
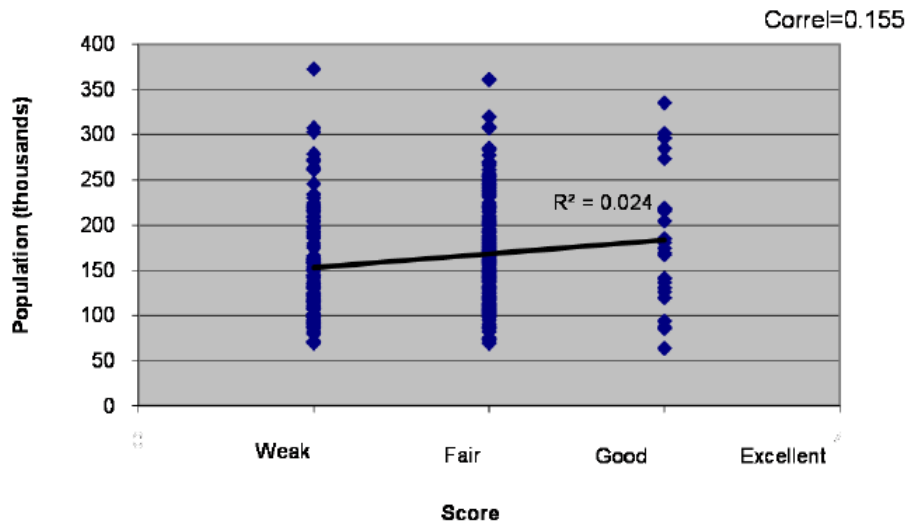


Fig. 2. The correlation between PCT size and Annual Health Check 'use of resources' rating (2005/06)



2008-09

Fig. 3. The correlation between PCT size and World Class Commissioning score (2008/09)

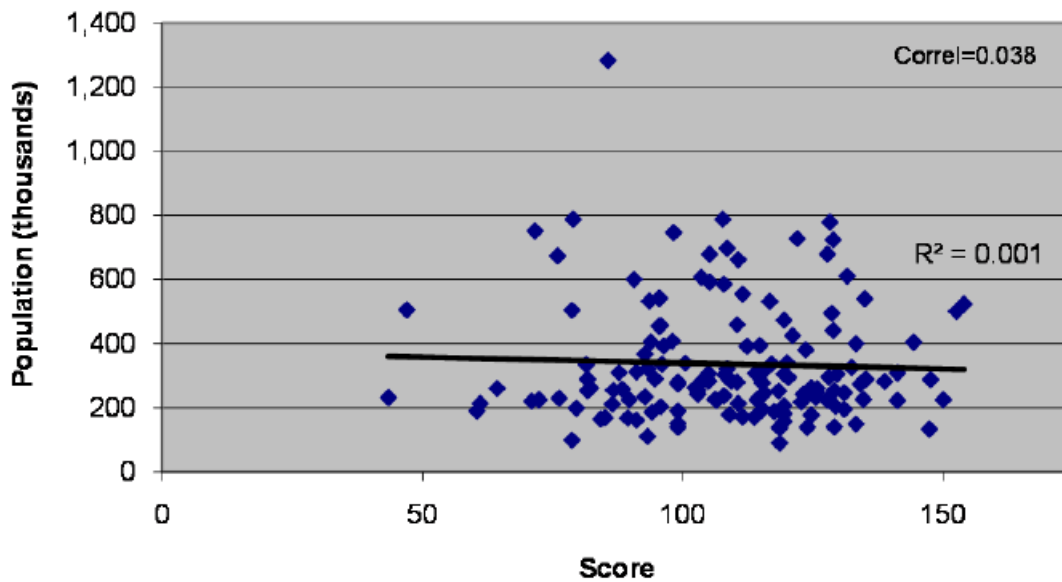


Fig. 4. The correlation between PCT size and Annual Health Check 'quality of services' rating (2008/09)

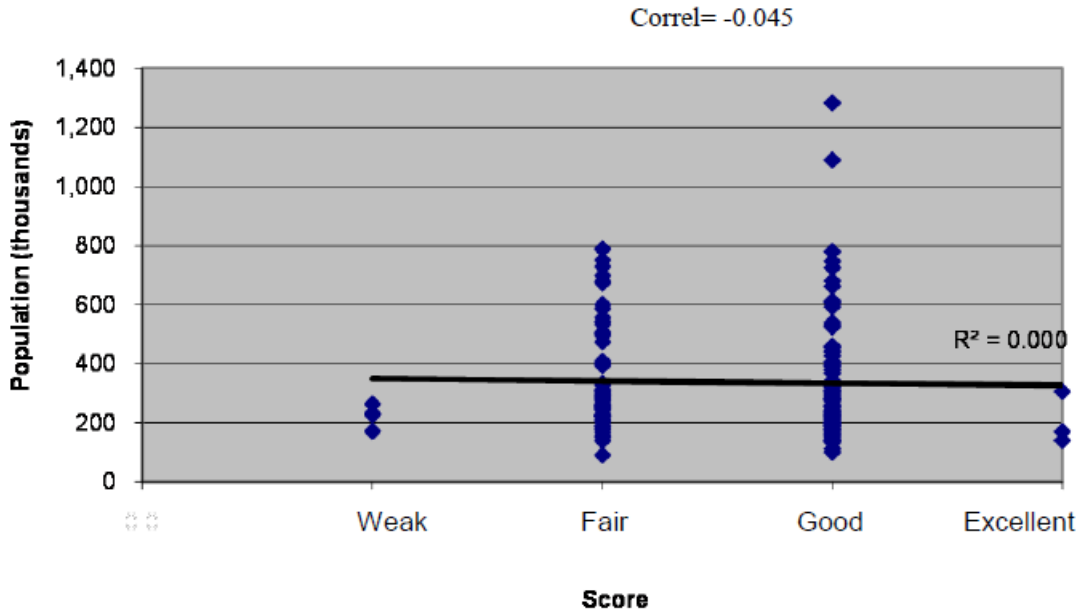
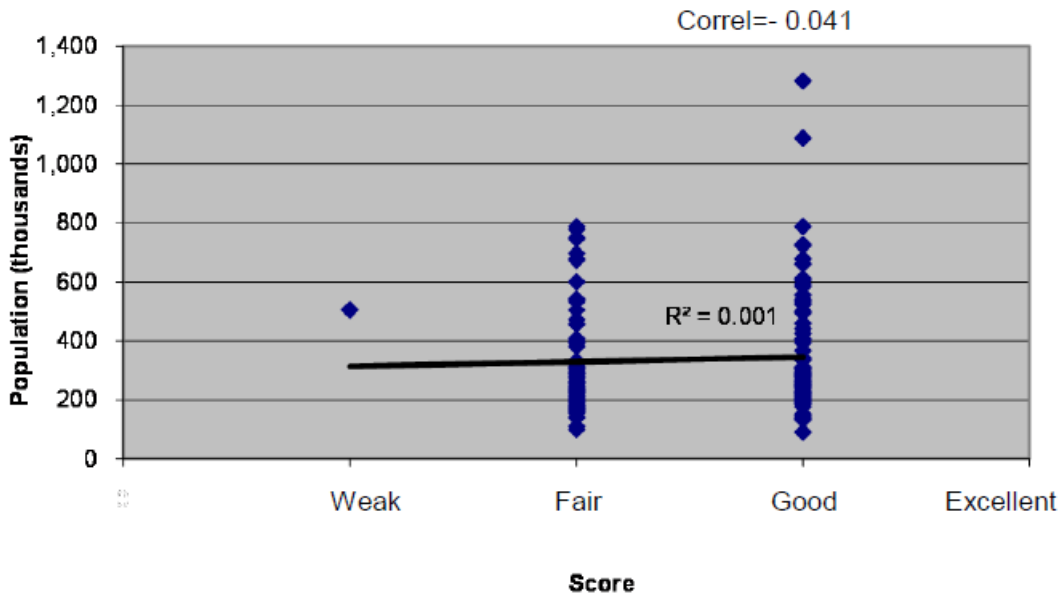
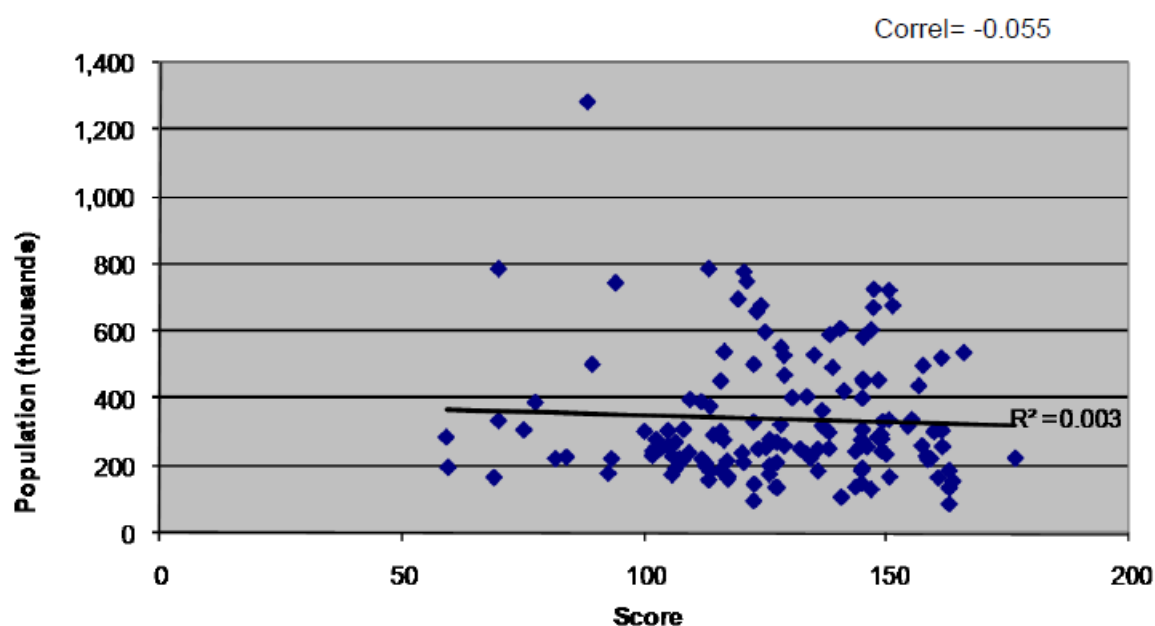


Fig. 5. The correlation between PCT size and Annual Health Check 'use of resources' rating (2008/09)



2009-10

Fig. 6. The correlation between PCT size and World Class Commissioning score (2009/10)



The findings presented in this section – the literature review on commissioning organisations throughout the NHS’s history and original analysis of PCT performance data – show two things: first, that there is a dearth of evidence in the literature on the association between size and performance in commissioning organisations in the NHS. Aside from that on TPPs, which were in existence for too short a time to draw reliable conclusions and bore responsibility for only a sub-section of care, overseen by health authorities, there is little of note.

The second is that, from our original analysis of data on PCT performance in 2005/06, 2008/09 and 2009/10, however we measure it, there is little or no apparent association between PCT size and performance. At first sight, it seems then that the size of commissioning organisations does not appear to matter much. Neither the theory that larger commissioning organisations are likely to be more efficient and economic, nor the theory that smaller commissioning organisations may be more effective in delivering improved clinical outcomes are supported by the data.

Our results should, however, be interpreted cautiously, for three reasons. First, because PCTs were created and then reorganised through central directives from the Department of Health, there has been relatively little variation in organisational size. In 2009/10, while the largest PCT served a population of 1,300,000 (Hampshire PCT) and the smallest a population of 91,000 (Hartlepool PCT), half of PCTs covered between 200,000 and 400,000 people (interquartile range). When size does not vary much, it is inevitably difficult to see any relationship between size and performance. We can, for example, say little of the likely effectiveness of very small commissioning organisations outside the

range of coverage in PCTs (i.e. below 100,000) taking on risk and responsibility for commissioning all health care, as may be the case with GP consortia. Our results, also, may have been distorted by the fact that many of the smallest PCTs, such as Hartlepool PCT and Darlington PCT (the two smallest) have formed larger commissioning clusters.

Secondly, the performance data used does not have much discriminatory power – in other words, most PCTs obtained fairly similar performance ratings. For example, in 2005/06, 90% of PCTs got ratings of ‘fair’ or ‘good’ for quality and 92% were rated ‘weak’ or ‘fair’ for use of resources. Almost none were rated excellent in either category, very few were rated ‘weak’ on quality of services and very few ‘good’ on use of resources – so the performance rating was effectively only a two point scale. The World Class Commissioning scores are more variable, though it is still true that half of PCTs scored between 112 and 146 (interquartile range).

Thirdly, as already has been noted, PCTs were subject to rapid and multiple reorganisations over this period (from 2005 onwards) – as was the rest of the NHS. Their performance data may be more affected by external factors such as the local and national pace and scale of change (and its often adverse effects on performance) than by internal factors to do with the PCT itself, including the issue of organisational size.

What can be said, however, is that the evidence from both the literature and our analysis of PCT performance data does not justify the Coalition Government’s move to what will in all likelihood be smaller commissioning organisations.

International evidence on the size of commissioning organisations

The lack of evidence and inconclusive results on the relationship between commissioner performance and size in the NHS makes it doubly important to look internationally for points of learning. What is noticeable here is that 1) other countries with a purchaser/provider split tend to favour a relatively small number of purchasing organisations serving quite large populations, and 2) the trend over recent years has been towards consolidation with mergers or acquisitions resulting in there being fewer, larger commissioning organisations.

Table 4 shows that of ten countries in Europe where data is available,^{xiv} seven (Austria, Czech Republic, Estonia, Germany, the Netherlands, Sweden and Switzerland) have seen a reduction in the number of purchasing organisations in the last 20 years; in two (France and Italy) the number has remained unchanged; and in just one the number has increased (in Spain, due to devolution). In five of the seven countries where the number of commissioning organisations has fallen, the consolidation has predominantly come about through mergers motivated by commercial decisions

^{xiv} We looked only at health systems where there is a purchaser/provider split, and where regionally-based or competitive health insurers are responsible for commissioning the entire spectrum of health care, as is proposed with GP consortia. We contacted the OECD and the European Observatory on Health Systems and Policies, but no comparative international data on purchasers was immediately available. We compiled Table 4 largely using data contained in the Health in Transition reports published by the European Observatory.

(or health insurers going out of business). In the other two (Estonia and Sweden) consolidation has resulted from policies set at a national level by government.^{xv}

Table 4: Purchasing markets in European health systems

Country	Nature of purchaser/ provider split	Number of purchasers c.20yrs ago	Number of purchasers c.2008	Mean population coverage (c.2008)
Austria	Mandatory social insurance	22 (regional/ occupation-based funds) ^{xvi}	19 (regional/ occupation-based funds)	347,000
Czech Republic	Mandatory social insurance	27 (regional/ occupation-based funds) ^{xvii}	10 (regional/ occupation-based funds) ^{xviii}	1,158,000
Estonia	Publically-funded insurance	22 (regional funds) ^{xix}	4 (regional funds)	335,000
France	Mandatory social insurance	14 (occupation-based)	14 (occupation- based) ^{xx}	4,448,000
Germany	Competing health insurers	1146 ^{xxi}	202	351,000
Italy	Publically-funded insurance	20 (regional funds) ^{xxii}	20 (regional funds)	303,000
Netherlands	Competing health insurers	118 ^{xxiii}	32 ^{xxiv}	514,000
Sweden	Publically-funded insurance	26 (regional funds) ^{xxv}	21 (regional funds)	438,000
Spain	Publically-funded insurance	10 (9 regional funds, plus government) ^{xxvi}	17 (regional funds)	2,675,000
Switzerland	Competing health insurers	207 ^{xxvii}	89 ^{xxviii}	81,000

^{xv} Trends towards consolidation are particularly strong in countries where universal health coverage is provided through private/state-backed insurance (subsidised by the state for those who cannot afford it). In the Netherlands, the number of insurers fell by 58% between 1985 and 2005, and after the 2006 reforms they fell further from 57 to 33 due to mergers. At present, the four biggest insurance concerns hold approximately 89% of the market share. In Switzerland, the number of insurers has fallen from 118 to 87 in the last 10 years.

^{xvi} Pre-2006

^{xvii} 1995

^{xviii} In 2005 the largest fund, the General Health Insurance Fund, covered 71% of the population.

^{xix} 1992

^{xx} Around 84% are covered by the main scheme, Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, or CNAMTS, which has a number of regional offices.

^{xxi} 1994

^{xxii} 1992

^{xxiii} 1990

^{xxiv} In 2008 four large insurers had 88% of the market.

^{xxv} 994

The reasons behind the international trend towards larger commissioning organisations covering larger numbers of people are unclear. It could be the result of: a drive to achieve greater profitability or protection from risk; a desire to achieve economies of scale; managerial preference; or other factors.²⁷ Neither is there much in the way of evidence as to whether the larger commissioning organisations have been more efficient, economic or effective – although studies do suggest that organisations with population coverage of less than 100,000 are likely to struggle.²⁸

The important thing to note with regard to the White Paper's proposed reforms to commissioning in the NHS is that if these reforms lead to a larger number of smaller commissioning organisations, this will go against the international trend: both markets and governments are moving towards fewer purchasing organisations rather than more.

Conclusion

This briefing contains three findings which are relevant to the Coalition Government's plans to transfer risk and responsibility for commissioning in the NHS from PCTs to new organisations – GP consortia – from 2013.

First, on balance, there is a good and plausible theoretical case for arguing that size matters to commissioning organisations: that, up to a point where they may become excessively bureaucratic and monopolistic, larger commissioning organisations could well perform better. Small commissioning organisations (especially those covering 100,000 people or fewer), by the same token, are likely to struggle if they are made responsible and carry the risk for commissioning all health care for their populations.

Secondly, the data on commissioning organisation performance in the NHS shows little or no relationship between size and available measures of performance. This may be because there is no relationship, or because none is revealed due to there being little heterogeneity in organisational size; repeated reorganisations masking performance differences; and measures of performance lacking discriminatory power. Similar results are in evidence in the academic literature on commissioning in the NHS.

Thirdly, the international evidence suggests that in nearly all countries with a purchaser/provider split, commissioning organisations or purchasers serve larger populations than those likely to be covered by GP consortia. The last decade also has seen a trend towards a smaller number of larger commissioning organisation: the opposite to what is likely to happen in the NHS.

In summary, although size of commissioning organisation is clearly not the only factor influencing the proposed shift of commissioning responsibility from PCTs to GP consortia – much, for example, is made of the importance of increased GP and clinical input – the evidence presented here does not provide a strong basis for the Coalition Government's proposed reforms. It is likely that GP consortia

^{xxvi} Up to 2002

^{xxvii} 993

^{xxviii} In 2007, 17 insurers had 80% of the market.

will cover smaller populations than existing PCTs: there is little, if any, theoretical or empirical evidence to suggest this will lead to better commissioning – particularly when coupled with recent studies that suggest the transition will be costly and almost certainly result in a dip in performance in the short to medium term, regardless of whether any intended longer term benefits may be achieved.²⁹

For at least three decades, governments have engaged in successive top-down reorganisations of the NHS which have often failed to deliver the promises of policy rhetoric.³⁰ If anything, central control of the NHS by the Department of Health in Whitehall has grown, despite many reorganisations promising decentralisation, devolution and localism. There is a certain obvious irony in the Coalition Government titling its White Paper *Liberating the NHS*, and claiming to be promoting greater devolution and increased localism, but in reality introducing yet another centrally planned reorganisation of the NHS akin to those initiated by previous governments, in which a particular organisational form (in this case GP commissioning consortia) is mandated, and a centrally imposed timetable for its implementation is imposed.

An alternative strategy, worthy of debate and more concordant with the evidence, would be to decentralise control over commissioning in the NHS by creating a permissive and flexible framework which would allow commissioning organisations to merge or demerge, and to change organisational arrangements for themselves. The NHS Commissioning Board could oversee this process, which would start from the existing structure of 152 PCTs. It could establish a robust set of measures of commissioning performance, which focus on the results of commissioning rather than on structures and processes, and those commissioning organisations which perform poorly could be encouraged or supported to change, with less successful organisations taken over by better performers through mergers, split up through demergers, or taken over by entrepreneurial groups of health professionals including GPs. Organisational change then could be evolutionary, locally initiated, and more responsive to local performance and contextual factors. Over time, we would learn whether larger or smaller commissioning organisations performed better. Further ideas – like allowing people a choice of commissioning organisations – also could be tested out.

Notes

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