Locality commissioning: how much influence have general practitioners really had?

CATHRYN HUDSON HART

NEIL DRUMMOND

MERYL DEANE

RAKESH CHOPRA

SUMMARY

This paper investigates the various models of locality commissioning in relation to the participation of general practitioners (GPs), and explores the perceived successes of locality commissioning in the 15 health boards in Scotland and 13 health authorities in the Northern and Yorkshire Region of England. A postal questionnaire was sent to 190 individuals involved in commissioning, and semi-structured interviews with GPs (n = 31) and health authority managers (n = 41) were undertaken in each of the 28 health authorities. Seventy-five per cent of the health authorities had introduced some form of locality commissioning. Five types of locality commissioning organization were identified on the basis of the level of GP influence over decisions. All GP responders identified benefits resulting from their involvement in the process but only 27% of health authority responders did so. Most benefits related to improved professional relationships, not to service changes. On the whole, locality commissioning does not appear to have resulted in major changes to contracts or services.

Keywords: locality commissioning; semi-structured interviews; health authorities.

Introduction

THE development of primary care groups and trusts indicates that locality models of commissioning are favoured for future health service development in Britain.[1,2] One of the key elements in this development is the participation of general practitioners (GPs) in the belief that this will improve the quality of care. The aims of this paper are to identify the influence GPs have had in locality commissioning initiatives so far and to assess the latter's relative effectiveness in achieving service change.

Method

Data were collected between October 1995 and March 1997 in the 28 health authorities in Scotland and the Northern and Yorkshire Region. Questionnaires were sent to all health authorities to identify key people involved in 'locality initiatives for purchasing health care'. In order to gather substantive information about locality commissioning a second questionnaire was sent to all those so identified. A purposive sample, consisting of at least one senior manager (usually at director or public health consultant level) responsible for the conduct of locality-based commissioning, and at least one GP participating in the process, were interviewed. Interviewees were selected on the basis of their demonstrating particular knowledge of their local commissioning arrangements.

Results

A total of 190 key individuals were identified and sent a postal questionnaire, with a 74% and 70% response rate in Scotland and in the Northern and Yorkshire Region respectively. Thirty-one GPs and 41 managers were interviewed, representing all 28 health authorities.

Locality commissioning initiatives had been introduced in 21 of the health authorities under survey. Of those not reporting locality commissioning, three were Scottish island health boards, while the four mainland health authorities practising area-wide commissioning nevertheless reported the inclusion of both fundholding and non-fundholding GPs in the process, indicating overall compliance with the recommendation that GPs should be involved in the commissioning process.[3]

Five general organizational structures were identifiable with respect to locality commissioning, on the basis of the level of GP influence over purchasing decisions (Table 1).

In considering the success of the various types of locality commissioning a key issue is the extent to which their implementation has created changes to service provision. Table 1 includes examples of the changes reported. In the main these related to the enhancement of existing community services or the speed of access to existing secondary care facilities. It also suggests that, overall, the number of changes has been relatively few: 69 separate changes were attributed to locality commissioning and GP involvement across all 28 health authorities since 1992.

All GP interviewees attributed positive outcomes following the implementation of locality commissioning, but 26 (63%) of the health authority responders identified no beneficial outcomes. Benefits that were identified, both by GPs and their health authority colleagues, mainly concerned improved relationships and attitudes (including those between fundholders and non-fundholders).

Discussion

These findings suggest an important dichotomy between the views of GPs involved in the commissioning process and their health authority colleagues, with the former being substantially more positive than the latter. This lack of agreement implies that GPs may have had less influence across the totality of the locality commissioning process than they believe they have. It appears that no individual type of locality commissioning has been particularly successful at achieving service reconfiguration, implying that even the more profound levels of GP participation may not lead to radical service development.

This may be partly attributed to the relatively recent development of the practice. Another factor may be a reluctance to put into effect changes that might be detrimental to the overall distribution of services. Evaluations of fundholding reported a similar

C Hudson Hart, BSc, MSc, research fellow, Public Health Research Unit, University of Glasgow, Glasgow. N Drummond, BA, PhD, director of research, community programme, Sunnybrook and Women's College Health Science Centre, Ontario, Canada. M Deane, MBBS, DA, MFPHM, consultant in public health medicine, Tees Health Authority, Teesside. R Chopra, MRCGP, DRCOG, general practitioner, Ashington.
Submitted: 14 August 1998; final acceptance: 7 April 1999.

Table 1. Types of locality commissioning.

Type	Description	Number of health authorities	Percentage served by GP fundholders [mean (range)][a]	Duration of GP participation [mean (range)]	Number of service changes per health authority [mean (range)][a]	Examples of changes
1	Locality-based, GP-dominated, devolved budgets	1	100	5	3	Family planning, school health services, methadone prescribing
2	Locality-based, GPs directly involved in purchasing decisions	10	52 (35–70)	3.71 (1–6)	3 (1–11)	Direct access to diagnostic services, district nursing reorganization, counselling, vaccine delivery, chiropody, health visiting, specimen uplift
3	Locality-based, GPs advise on purchasing decisions	10	56 (37–75)	3.5 (2–6)	2 (0–6)	Termination of pregnancy, physiotherapy, diabetes services, access to diagnostic services, drug and alcohol services, dietetics, reduced waiting times
4	Island health authorities, GPs either advisory or directly involved in purchasing decisions	3	9 (0–26)	2	1 (0–2)	Minor surgery and ENT outpatients transferred to local district general hospital
5	Health authority-wide, GPs advise on purchasing decisions	4	45 (16–60)	0.75 (0–2)	1 (1–2)	Cardiology, cancer, orthopaedic services reorganized

[a]Figures rounded to nearest integer.

lack of evidence for significant service change,[4] as did a case study of locality commissioning.[5] There is evidence that GP influence successfully changed quality targets, but not on a locality basis.[6] A study of locality commissioning in a single health authority identified 20 service changes over a 32-month period, but it is unclear how many of these consisted of significant changes to contracts, rather than marginal changes within existing contracts.[7] It also reported attitudinal benefits which were largely in agreement with those identified here.

Thus the evidence suggests that, while locality commissioning has improved relationships between GPs and their health authority colleagues, it appears to have not yet resulted in widespread revision of services with a locality focus. This finding should temper expectations of local sensitivity and accountability associated with the establishment of primary care groups and trusts.

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Acknowledgements

We thank Pam Hayes, Irene Young, and Roisin McGrath for their help in data processing and in preparing this paper. The study was supported by the National Research and Development Programme in the area of the primary–secondary care interface and by the Scottish Office Department of Health Chief Scientist Office. The views expressed herein are those of the authors alone. There are no conflicts of interest.

Address for correspondence

Dr Neil Drummond, Director of Research, Community Programme, Sunnybrook and Women's College Health Science Centre, Room E349A, 2075 Bayview Avenue, Toronto, Ontario, Canada M4N 3M5. E-mail: neil.drummond@swchsc.ca