Editorial

Failings of the purchaser–provider split

Strategy and implementation

Health authorities have been working hard on developing health strategies and health programmes. Much of this work can come to naught. Towards the end of the financial year the contracting process takes over. Large sums of money are exchanged between purchasers and providers without explicit or detailed cognisance of the health strategy or programmes. Similarly, general practitioner (GP) fundholders are negotiating to resolve minor operational issues for their patients and are not necessarily working towards the same strategic objectives as health authorities are. To a certain extent there is an inevitability about this. The people who do the implementation should also be responsible for the strategy formulation. This is not necessarily the case within health authorities, GP fundholders or Trusts.

Acute sector funding pressures

The current contracting arrangements allow National Health Service Trusts several attempts at establishing their contracting revenues for the subsequent financial year. Initially, they formulate first-cut prices, and they then enter detailed negotiations with health authorities and GP fundholders. These run to the deadline for signing. Last-minute negotiations can see considerable sums of money switching between provider and purchaser with no explicit relationship to strategic needs or the ‘cost equals price’ maxim. The emphasis is only on signing the contract by the set deadline. While these negotiations are being undertaken, second-cut prices are produced to maintain an expected revenue for Trusts. Some providers still assume that cost pressures can automatically be passed on to purchasers with no notice before the start of the financial year. If providers are dissatisfied with the proposed settlement with purchasers, they still have recall to regional conciliation. If this conciliation has a record of arbitrating 50/50, then one could say it is in Trusts’ best interest to go forward to conciliation to maximize their expected revenue. Indeed, this process could lead to the inflation of an opening figure for contract negotiation from Trusts. Such regional conciliation does not necessarily seem to take account of the fact that the resource envelope for health authorities is limited. Conciliation in favour of providers creates overspends for health authorities who, just like Trusts, also have financial duties to satisfy, such as ensuring that expenditure does not exceed cash limits.

Clinical practitioner involvement

The amount of involvement of clinical practitioners in these contracting negotiations is slight. There is also a varying amount of input by clinicians into the proposed service agreements and monitoring arrangements. The net result is that the financial and administrative arrangements are divorced and uncoupled from clinical practice. It is not therefore surprising that problems tend to perpetuate themselves. The purchaser–provider split has opened into a chasm. The divide created between purchasers and providers has in too many cases led to confrontation rather than collaboration. It has been particularly unhelpful for public health physicians, whose function and duties span the divide and who strive to ensure that clinicians work harmoniously within the National Health Service, whether in the secondary or primary care sector.

GP fundholding

The multiplicity of GP fundholding has led to massive increases in transactional costs. However, two good developments have emerged. Fundholders have in some areas changed the delivery of hospital services for the better in a way that health authorities had failed to do. The other major benefit of fundholding is that it has put resource allocation and equity firmly on the policy agenda for everyone, including GPs.

GP commissioning

The future has to lie in a more refined and less confrontational approach to GP commissioning. This would be an extension of the developments with GP fundholding where health authorities would support and help develop primary health care teams in this role of GP commissioning. Primary health care teams would have financial allocations and be monitored by health authorities in their performance. Health authority staff, including those in finance, public health, information, and planning, would support primary health care team members in this role. The primary health care team would formulate a strategy for its practice population and be responsible for delivering that strategy operationally. Not all GPs and primary health care teams will of course subscribe to this vision, so any new arrangements will need to cover the variety...
of approaches to GP commissioning that currently exist. This will be the challenging new role for health authorities. This vision is similar to arrangements in place before the 1989 NHS White Paper changes. There are, however, three major developmental differences. First, there would be the equitable allocation of resources to small populations. Second, there would be much increased support to primary health care teams to help them take on their wider role. And third, there would be the performance management of the primary health care team in its delivery of services and commissioning role.

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