

viewpoint

GP commissioning in the NHS in England: Ten suggestions from the United States

Lawrence P. Casalino / New York

Contents

1	About the author
2	Foreword
4	Summary
8	Introduction
10	Four models of physician contracting with health insurance plans
11	Three models of risk contracting
14	A capsule history of risk contracting in the US
19	Ten suggestions for GP commissioning
33	Conclusion
34	References

Nuffield Trust Viewpoints provide a platform for UK and international health leaders to explore, discuss and debate critical health care reform issues. The views expressed are the authors' own, and do not necessarily represent those of the Nuffield Trust.

This Viewpoint forms part of the Nuffield Trust's work programme on commissioning and our comparative work on UK and international health systems. We are examining reforms to commissioning and how this vital function can be strengthened to improve patient care. As part of this, we are examining established practice overseas and aim to bring the benefits of international experience to inform policy-making and practice in the UK. Our new website, to be launched in mid-June, will bring all our related research and analysis on commissioning together in one section at www.nuffieldtrust.org.uk/commissioning, while our wider UK and international research programme will be accessible from www.nuffieldtrust.org.uk/international-comparisons

Our most recent publication on commissioning, *GP Commissioning: Insights from medical groups in the United States*, can be downloaded from www.nuffieldtrust.org.uk/publications

About the author



Lawrence P. Casalino

Lawrence Casalino is the Livingston Farrand Associate Professor of Public Health and Chief of the Division of Outcomes and Effectiveness Research at Weill Cornell Medical College. Previously he worked as a community organiser; was a full-time family physician in a small private practice in California for 20 years; served as Vice President of a large Independent Practice Association; obtained a Ph.D in Health Services Research at the University of California, Berkeley; and served as an Associate Professor at the University of Chicago.

He has served as Chair of the Academy Health Annual Research Meeting and on numerous national committees. He has worked with the Federal Trade Commission and with provider organisations on anti-trust issues related to clinical integration. Dr Casalino is the recipient of an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation; he is currently a member of the National Advisory Committee for this programme.

Dr Casalino's work focuses on the ways in which physician and hospital practice is organised – with 'organisation' taken to mean both organisational structures and the processes that physician groups and hospitals use to improve the care they provide. He is particularly interested in the effects of public and private policies on physician and hospital organisation, and thus on the quality of health care. He seeks to understand the effects of policies on racial/economic and social class disparities in health care delivery, as well as other unintended consequences.

He has published numerous articles on issues related to medical groups, risk contracting, physician-hospital and physician-health insurance plan relations, pay for performance, and Accountable Care Organisations. Dr Casalino uses a variety of research methods, including surveys, chart reviews, interviews and case studies, and analyses of large databases.

The Nuffield Trust designated Dr Casalino as the 2010 John Fry Fellow, part of which has included his writing of this Viewpoint.

Foreword

The NHS in England is embarking on a major programme of reform following the election of a Conservative-led coalition Government in May 2010. The centrepiece of the reforms is the proposal to shift the responsibility for commissioning most NHS services from managerially-led primary care trusts (PCTs) to new groups led by general practitioners (GPs), known as GP commissioning consortia. The Government's expectation is that putting GPs in charge of health budgets will result in higher quality and more efficient health services, because doctors have a better understanding of their patients' needs and will be more motivated than PCTs to purchase (and provide) better health care.

These reforms to commissioning, announced in July 2010, have been highly controversial, with opponents of reform claiming that GPs are neither equipped nor willing to take on this role and that shifting budgets to inexperienced commissioners at a time of financial constraint in the NHS is risky. The Government has countered that these reforms are not revolutionary but evolutionary, and draw on two decades of GP experience of handling commissioning budgets, from the fundholding programme of the 1990s to practice-based commissioning more recently.

Although there is encouraging evidence from GP fundholding in its various forms in the NHS, it may only be a partial guide to the success of the proposed GP consortia. The degree of financial risk that will be faced by GP commissioning consortia, for most kinds of hospital and community care, is much wider in scope than anything seen so far in the NHS. It is, in fact, much closer to the scope of risk that has been held by some doctor-led networks and groups in the United States (US), which have contracted with insurance plans to manage the care of patients within a fixed annual budget.

This Viewpoint offers a distillation of the learning from these doctor-led groups in the US by one of their foremost scholars: Dr Lawrence P. Casalino. In Summer 2010, the Nuffield Trust was delighted to award our John Fry Fellowship to Dr Casalino, Chief of the Division of Outcomes and Effectiveness Research, and the Livingston Farrand Associate Professor of Public Health, at Weill Cornell Medical College. Dr Casalino spent six weeks exploring commissioning in the NHS in England in the light of the US experience: these are his personal reflections on the lessons that the NHS could learn from across the Atlantic.

Jennifer Dixon, Director, Nuffield Trust, June 2011

Summary

Suggestion 1.

GP commissioning consortia and NHS policy-makers should seek to learn from US independent practice associations (IPAs), not just from US integrated delivery systems (IDSs)

As the NHS prepares to transfer responsibility for commissioning health services to groups of GPs acting together as commissioning consortia, there are important lessons to be learned, particularly from the experience of IPAs in the US. IPAs are networks of independent physicians who come together to hold a budget from insurance companies, but maintain their status as independent businesses. GP consortia will be much more like IPAs than like the IDSs with which the NHS has been more familiar, such as Kaiser Permanente. [Page 19](#)

Suggestion 2.

To succeed, GP consortia will have to invest heavily in leadership, management and infrastructure

Within the past two decades, the great majority of US IPAs and medical groups failed at risk contracting, including a number of high-profile bankruptcies that disrupted care and cost health insurance plans many millions of dollars. The failures occurred because most IPAs were loosely structured organisations that lacked strong physician leadership, drastically under-invested in management and infrastructure, and failed to gain physicians' cooperation.

To succeed, GP consortia will have to invest heavily in leadership, management and infrastructure. Left to themselves, most GP consortia are likely to under-invest in these capabilities. In the early years, the NHS should provide GP commissioning consortia with generous, ring-fenced budgets to invest in leadership, management and infrastructure. [Page 19](#)

Suggestion 3.

Provide training for GP leaders

Highly skilled, full-time non-physician managers will be necessary for consortia, but not sufficient – skilled clinical leaders who spend most of their time on consortium activities will be required as well. The experience of successful IPAs in the US suggests that a consortium with 100,000 patients will need at least two physicians who spend the great majority of their time leading the consortium. Contracting with external organisations is likely to be helpful for GP consortia, but only if the consortia have strong leadership. External organisations cannot substitute for this leadership. [Page 20](#)

Suggestion 4.

Balance quality, patient experience and cost incentives

If GP commissioning is perceived to be focused primarily on cost, it will likely generate a strong physician and patient backlash. The NHS should provide consortia with balanced incentives. That is, the consortia should receive financial benefits (or penalties, if performance is poor) based not just on their performance in controlling the overall costs to the NHS of care for their population of patients, but also for the quality of care and for patient experience.

The NHS and the Government should take care that communications about the programme to the public and to physicians make clear that it is not just about reducing costs, but also about improving the quality of care and patient experience. [Page 21](#)

Suggestion 5.

Incentives for GP consortia to generate cost savings for the NHS should neither be excessively strong, nor excessively weak. GP consortia should have the ability to use meaningful incentives for their member practices

Each GP consortium must be ‘at risk’ in some meaningful way for the cost of care provided to the consortium’s patients; and the individual GPs within the consortium must have something ‘at risk’ as well. However, the risk should be for costs that the consortium can reasonably be expected to control, and should not be so large that it is likely to lead to under-treatment or avoiding the sickest patients. To succeed, GP consortia must be able to distribute savings and quality bonuses received by the consortium differentially to members based on their performance. [Page 23](#)

Suggestion 6.

The consequences for poorly performing consortia should be made clear in advance and should be consistently enforced

There should be financial consequences, at least to some extent, for the GPs in a consortium that persistently fails. [Page 25](#)

Suggestion 7.

To the extent possible, minimise the ‘insurance risk’ that consortia bear

GP consortia’s exposure to ‘insurance risk’ should be minimised by requiring that they have a minimum size (probably 100,000 patients or more); by adequate risk adjustment; by requiring consortia to purchase reinsurance (‘stop-loss’ insurance which is initiated when a claim reaches the threshold) to cover outlier cases with extremely high costs; and by excluding high-cost, low-frequency illnesses from the consortia’s commissioning responsibilities. [Page 26](#)

Suggestion 8.

Either ‘real’ or ‘virtual’ budgets can work, but details matter

Giving consortia real rather than virtual budgets – that is, actually giving consortia the funds budgeted – has advantages, but is a high-risk activity. Whether budgets are real or virtual, it is critical that both the NHS and GP consortia have timely and accurate information about expenditure, and that consortia are able to keep track of services that have been provided, but for which payment has not yet been made. [Page 27](#)

Suggestion 9.

Encourage hospitals and specialist physicians to cooperate with GP consortia and remove barriers to cooperation

For GP commissioning to succeed, the NHS must find ways to give hospitals and specialist physicians incentives to cooperate with GP consortia. In addition, it would be helpful if the NHS made it more feasible for specialists to leave hospital employment and work as members of commissioning consortia. [Page 28](#)

Suggestion 10.

Assume that, even if the NHS creates perfect incentives, it is likely to take many years for most consortia to become highly competent

Even if the NHS creates perfect incentives, it is likely to take five to ten years for most consortia to become highly competent. The Government should plan accordingly. Experience in the US suggests that organised processes of care and a collaborative group culture are essential for physician groups to function effectively; by definition, these take time to develop. [Page 30](#)

Dr Casalino spent six weeks exploring commissioning in the NHS in England in the light of the US experience: these are his personal reflections on the lessons that the NHS could learn from across the Atlantic.

Introduction

The NHS in England is preparing to transfer responsibility for 70 per cent of its budget to groups of primary care doctors, known as GP commissioning consortia. These consortia will be responsible for contracting with providers of hospital and community services to meet the needs of their patient population. GPs will continue their primary care practices (mostly as independent contractors with the NHS), but they will also be required to belong to a commissioning consortium, which will be led by GPs and will be accountable to a new national NHS Commissioning Board, outside of the Department of Health. Consortia will formally begin operating in April 2013, although many are being encouraged to start sooner and act as ‘pathfinder’ pilots to generate evidence ahead of the final roll-out (Department of Health, 2010a).

70%

responsibility of the English NHS budget transferred to groups of primary care doctors, known as GP commissioning consortia.

The Government argues that doctors will make better decisions about the care needed by their patients than the managers whom they will replace; partly because they have better knowledge of their patients’ needs, but also because they will have stronger incentives to purchase or commission more appropriate care. Overall, GP commissioning as an idea has the potential to improve the quality and reduce the costs of health care. Some GP leaders are enthusiastic about GP commissioning, and their enthusiasm should be encouraged. But there will be a great many ways to get GP commissioning wrong, and very few ways to get it right – and the consequences of failure would be significant.

Something like this idea has been tried before – in the US. Twenty-five years ago, physician groups in a number of US states, most prominently, but not exclusively, in California, were given responsibility for most medical costs for their patients. By the early 1990s, it was thought that this ‘global risk contracting’ model would sweep across the nation (Fine, 1998). However, it failed to do so, and by 2000 it had been trimmed back even in the states in which it had been most successful.

What went wrong? What can be learned from the US experience, and are these lessons relevant for GP commissioning in England? Two recent articles have thoughtfully addressed this question from the perspective of the NHS (Ham, 2010; Thorlby and others, 2011); I will attempt to draw out some broad lessons based on my reflections from two decades of study and interaction with US physician groups, from 20 years as a family physician in private practice, and from many years as a leader of an IPA.

To begin, I will briefly describe US models of physician contracting with health insurance plans and of risk contracting, and provide a brief history of risk contracting in the US. I will then make ten suggestions for GP commissioning, based on experience in the US. These suggestions are not intended to comprehensively address all major issues raised by GP commissioning in England – for example, they do not address the critical questions of the role of PCTs during the transition to commissioning, or the development of effective accountability to the public and local government.

Four models of physician contracting with health insurance plans

Physicians in the US contract with health plans through one of four models (Burns and Wholey, 2000; Gold and others, 2001; Robinson, 1999):

1. They may contract as individuals. This was, and is, fairly common, but is not relevant to the GP commissioning model planned for the NHS and so will not be discussed further.
2. Physicians may contract through an IPA: networks of small, independent physician practices formed specifically for the purpose of contracting with health plans (Robinson and Casalino, 1996). A typical IPA includes more than 100 practices and 250 to 500 physicians; some are much larger.
3. Physicians may contract as members of a large medical group that includes between 50 and several hundred physicians or more. Large medical groups usually have multiple and relatively large clinics within a geographic area; unlike the physicians in an IPA, medical group physicians are members of the same business, in other words, a single, large practice.
4. Physicians may contract with health insurance plans as members of IDSs, which include both physicians and one or more hospitals (and occasionally a health insurance plan) in the same organisation.

Virtually all IPAs, medical groups and IDSs include both primary care physicians and specialists.

It is important to realise that, although large medical groups and IDSs are best known in the UK, IPAs have been more common in the US. Critically, GP commissioning consortia will resemble IPAs because they bring together large numbers of small practices (that retain most of their independence) into a network that contracts with health insurance plans to provide care for patients. Unless GP commissioning consortia merge their practices, they will not resemble large US medical groups, and unless they integrate with hospitals, they will not resemble US IDSs.

Three models of risk contracting

In the most generic sense, 'risk contracting' refers to holding providers of health care accountable for all or part of the costs of their patients' medical care.

'Providers' in the US is a general term, referring primarily to both physicians (GPs and specialists) and hospitals, and will be used that way here; referring to IPAs, medical groups or IDSs.

There are three models of risk contracting with physician groups in the US that have the most potential relevance for the NHS in England (Casalino and Robinson, 1997):

1. Professional capitation with some risk for other services

This was, and is, the most common model in the US, although it remains relatively uncommon. In this model, health insurance plans contract with large medical groups or IPAs to provide services to their patients. Patients choose a primary care physician (PCP), and the medical group or IPA to which the PCP belongs becomes responsible for the population of patients who have chosen its PCPs. The medical group or IPA is paid a per-patient-per-month 'professional' capitation fee, intended to cover the cost of outpatient and inpatient services provided by PCPs and specialists (including specialists outside of the group). If the cost of the professional services provided by the physician group is lower than anticipated, the group is able to keep the savings. If the professional services cost more than anticipated, the group loses money.

The health plan also estimates the amount that will be spent on the group's patients for other services, which may include imaging, inpatient hospital services, laboratory services, and/or pharmaceuticals and other services. If the costs for these services are less than anticipated, the health plan gives the group a percentage of the savings; typically 50 per cent or more. If the costs are higher than anticipated, the group is responsible for a percentage of the additional costs.

Health plans typically withhold 10 to 20 per cent of the monthly capitation fee to cover higher than anticipated costs, should they occur. As discussed by Thorlby and others (2011), successful US IPAs and medical groups negotiate contracts with health plans that do not force them to take risks for services for which the IPAs and medical groups do not believe that they will be able to produce savings.

2. Global risk contracting with the health insurance plan paying claims

In this uncommon model, the provider organisation – medical group, IPA or IDS – is held responsible for nearly all of the health care costs incurred by its patients. Low-volume, high-cost services such as transplants are usually excluded. As in the professional capitation model just described, the health plan pays a monthly professional capitation fee to the provider organisation, withholding 10 to 20 per cent, and the plan creates a budget for the anticipated cost of other services (for example, hospital, pharmaceuticals, or specialists who are not members of the organisation). The plan pays the bills for these services. But in the global risk model, the provider organisation is responsible for a wider scope of services than in the professional capitation model, and has both more upside and more downside risk – that is, it will receive most of any savings generated, but is responsible for the majority of any costs over the budget.

3. Global risk contracting with the provider organisation paying claims

This model is similar to the previous model, with the critical difference being that the health plan gives the entire budget for health care services included in the contract to the provider organisation, which is then responsible for processing and paying all claims for these services. In many cases, provider organisations are also responsible for negotiating contracts with hospitals, laboratories and specialists, and other service providers outside the organisation.

During the 1990s, it appeared that this might become the dominant model of risk contracting in the US, but it is now quite rare – with the exception of California.

“Provider organisations that take more risk are typically delegated more responsibility for managing the utilisation of care.”

Regardless of the model of risk contracting, there are several general issues worth understanding. First, the provider organisation, not the health insurance plan, decides how to pay its physician members. IPAs typically capitate individual PCPs for their services and pay individual specialists via fee-for-service. Medical groups and IDSS typically pay their individual physicians a salary; that varies to a greater or lesser extent with the volume of services provided by the physician.

Second, part of any savings created by the provider organisation is usually invested into the organisation, and part – often the larger part – is given to its physician members, who may keep it as personal income. In integrated systems, hospitals also receive a share of the savings. When costs exceed the projected budget, the health plan keeps all or part of the ‘withhold’ (the cushion set up for unanticipated costs; see above). If costs exceed the withhold, the health plan tries to recoup the cost in other ways – for example, by taking it out of the following year’s payments to the provider organisation, although in some (uncommon) cases, the provider organisation has had to write a cheque to the health plan for the amount of the cost over-run. The withholds are returned to providers if costs do not exceed the budget.

Third, provider organisations that take more risk are typically delegated more responsibility for managing the utilisation of care (Kerr and others, 1995). That is, the IPA or medical group, rather than the health plan, creates utilisation management programmes to, for example, reduce unnecessary admissions and emergency department visits; reduce the length of patients’ stay in the hospital; or reduce unnecessary imaging. This was the origin of the term ‘the capitated/delegated model’. Provider organisations taking global risk often sought and received delegation to pay claims and to negotiate contracts with other providers as well (Casalino, 1997).

A capsule history of risk contracting in the US

Risk contracting began slowly in the US during the early 1980s, and grew rapidly during the 1990s (Hurley and others, 2002). Health insurance plans, through their rapidly growing Health Maintenance Organization (HMO) insurance products, initiated risk contracting as a way to limit and fix in advance their expenditure on health services in the contract, and as a way of giving physicians an incentive to reduce health care costs. Initially, physicians signed risk contracts reluctantly, as a defensive measure, because they felt they had no alternative. There appeared to be a surplus of physicians, especially specialists, and physicians who did not sign feared being left out of HMO 'provider networks', and thus unable to see the large and increasing number of patients insured by HMOs. Physicians perceived HMOs as distant, bureaucratic, intent on reducing physicians' autonomy and income, and interested in profit rather than patients' welfare (Donelan and others, 1997).

Risk contracting led to the creation of a new form of organisation, the IPA, and to a lesser extent to the creation of large multi-specialty medical groups and IDSs. Physicians in IPAs, large medical groups and IDSs could gain negotiating leverage to obtain better payment rates from HMOs; keep part or all of any savings they were able to generate, and be subject to their own utilisation management programmes (for example programmes that required physicians to obtain prior authorisation before ordering a referral to a specialist or hospitalising a patient), rather than those of HMOs. Some large medical groups and IDSs already existed – approximately 125 medical groups and 30 IDSs, although precise counts are not available; these numbers are likely to have doubled between 1980 and 2000. Large numbers of IPAs – 1,500 or more – were created during those years. IPAs could be created much more quickly and inexpensively than large medical groups or IDSs, and they made it possible for physicians to remain in the small, independent practices that many preferred.

Although few providers were ever enthusiastic about risk contracting, PCPs had the most to gain; specialist physicians and especially hospitals had the most to lose. It was obvious that most savings would be generated by reducing the volume of specialist and hospital services

“Most IPAs were loosely structured organisations that lacked strong physician leadership; drastically under-invested in management and infrastructure; and failed to gain physicians’ cooperation.”

provided to patients. Plus, HMOs required all patients to access specialists and hospitals through PCPs (whom the HMOs labelled with the unfortunate name of ‘gatekeepers’) (Bodenheimer and others, 1999). There was a surplus of specialists and hospitals, so it was possible for IPAs and medical groups to choose some specialists and hospitals rather than others. As a result, specialists and hospitals suddenly became interested in establishing close relations with PCPs (Casalino and Robinson, 2003). Specialists, most of whom worked in independent practices rather than being employed by hospitals, became eager to join IPAs and multi-specialty medical groups, and many hospitals purchased PCP practices; paying high prices for the practices and guaranteeing relatively high incomes for the PCPs, who became employees of the hospital (Burns and Pauly, 2002).

Until the mid-1990s, a minority of medical groups and IPAs, most but not all of which were located in California, were able to generate substantial savings and thus found risk contracting to be quite profitable. Most of the savings came from reducing the number of hospital admissions and the average length of stay in hospital. The most effective physician groups reduced hospital days per thousand by more than 50 per cent (Casalino and Robinson, 1997; Robinson, 1996; Robinson and Casalino, 1995). By the early 1990s, it appeared that this capitated/ delegated model of risk contracting would sweep the nation. Hospitals spent hundreds of millions of dollars trying to prepare for it by purchasing PCP practices and creating physician-hospital organisations (PHOs); which may be thought of as IPAs that are partly owned by the hospital (Bazzoli and others, 2000; Burns and others, 2000).

However, the anticipated spread of the model never occurred, and severe problems with the model developed, even in California where it had become prevalent (Hurley and others, 2002; Robinson and Casalino, 2001). There were five reasons for this:

First, most IPAs were loosely structured organisations that lacked strong physician leadership; drastically under-invested in management and infrastructure; and failed to gain physicians’ cooperation (physicians’ loyalty was to their practice, not to the IPA network of practices). They lacked adequate data systems, experienced executives and financial reserves. They never developed the many capabilities needed to succeed in risk contracting. They were unable to: create adequate incentives for their physicians to cooperate with the IPA programmes; track and

“Risk contracting was perceived by patients and by most physicians as being entirely about limiting the cost of care, rather than as a means to improve the quality of care.”

manage utilisation of physician, hospital and ancillary services; calculate accurately the actuarial risk for their population of capitated patients; pay claims (when they assumed that responsibility); negotiate contracts with other providers; or create effective care management programmes (for example the use of nurse care managers to coordinate care for patients with chronic illnesses). Large medical groups were more tightly structured, but most nevertheless failed to invest sufficiently in developing the capabilities needed. Large medical groups were usually dominated by specialists, and IDSs by specialists and hospitals; neither had a real interest in the success of risk contracting.

Second, HMOs failed to perform adequate risk adjustment when setting the budgets for IPAs. Capitation payments for specialist and PCP services, and budgets for hospital and other services, were typically adjusted only for patients’ age and sex, so groups that had sicker patients were enormously disadvantaged, and were not able to accurately predict the likely cost of care for their populations of HMO patients.

Third, there was a strong backlash from both physicians and patients (often encouraged by physicians) against risk contracting and against ‘managed care’ more generally (Blendon and others, 1998; Robinson, 2001). This backlash led the government to create ‘patient protection’ regulations; forcing health insurance plans to create new products that did not involve risk contracting, did not require patients to choose a GP, and involved little or no management of care; and forcing physicians and hospitals to pull back from their plans to become organisations that could succeed at risk contracting. Physicians disliked utilisation management, even when it was being done by their own organisation, rather than by an HMO. Specialists disliked having PCPs as gatekeepers, and many PCPs were uncomfortable with being required to serve as physicians whose perceived role was to say ‘no’ to patients. Patients hated the prior authorisation requirements of utilisation management, did not want to have their access to specialists limited by a gatekeeper and could not understand why they were unable to be treated by providers who were not part of the network of the IPA, medical group or IDS to which their physician belonged. Patients and many physicians (Hadley and others, 1999) believed that there was a conflict of interest if physicians were able to profit from reducing the cost of care for their patients – that this gave them an incentive to engage in skimping and in ‘cream-skimming’; that is, to withhold care and to avoid sicker patients. Risk contracting was perceived by patients and by most physicians as being

entirely about limiting the cost of care, rather than as a means to improve the quality of care.

Fourth, during the 1990s, hospitals responded to managed care and risk contracting by reducing their excess capacity and by merging with each other. This gave them the negotiating leverage to demand higher payment rates from medical groups and health plans. Large, prestigious hospitals had enough leverage simply to refuse to engage in risk contracting or to cooperate with physician groups that were doing so (Devers and others, 2003). Their size and prestige made it impossible for physician groups and health plans to refuse to admit patients to these hospitals. The result of merger activity was that it became much more difficult for physician groups to generate cost savings from lower payment rates to hospitals.

Fifth, even the largest and most competent medical groups and IPAs discovered an unanticipated problem with capitation. During the early years of risk contracting, when days in hospital per thousand patients per year were high, and HMOs provided correspondingly high budgets to the groups for hospital services, it was relatively easy for the groups to generate savings and to profit from doing so. They were able to reduce hospital days per thousand much faster than the rest of the market; yet the capitation rates they received reflected the costs in the market as a whole. As the groups successfully reduced hospital utilisation, and as HMOs also succeeded, although to a lesser extent, in reducing hospital days per thousand for physicians who were not in the large capitated groups, the HMOs reduced the amount of funds in the risk contracting budgets.

Over time, the physician groups found that they had picked the ‘low hanging fruit’, for example by not hospitalising healthy mothers and newborns for several days after delivery, and that further reductions in utilisation were much more difficult to achieve. Once the budgets physician groups received from HMOs were reduced to correspond to reduced utilisation, the groups found that they were holding a great deal of insurance risk, rather than ‘service risk’ for costs that they could affect by managing care effectively. But the groups were not insurance companies – they were much smaller and less actuarially competent. Year-to-year variations due to chance or to influxes of sicker patients could and did cause severe financial difficulties for even the best groups.

Between 1995 and 2000, some very large medical groups and IPAs, especially, went bankrupt, causing large, high-profile disruption to patient care and to the careers of their physicians (Bodenheimer, 2000; Casalino, 2001). Many of these groups were engaged in the third model of risk contracting – taking global risk with the provider organisation paying claims. Their bankruptcies left HMOs, which had in theory already provided all the money anticipated to pay for care for the groups’ patients for that year, to pay millions of dollars of claims to providers that the groups had not paid. State regulators in California and other states created much stricter capital and competency requirements for groups that wanted to assume financial risk, and limited the amount of risk that could be taken (Brewster and others, 2000).

Risk contracting continues to exist in California and, to a lesser extent, in a few other states, but its prevalence has declined greatly, and the amount of risk assumed by groups has decreased (Himmelman and others, 2009). Surprisingly, there was little research on the effectiveness of risk contracting. It appears that it did reduce health care costs, but its effects on quality are uncertain. For the past decade, there has been little talk of the ‘delegated/capitated model’ of risk contracting. Nevertheless, some medical groups and IPAs have created and maintain highly competent organisations (Thorlby and others, 2011) that prefer risk contracting to fee-for-service; the standard model of payment for physicians in the US. The concept of risk contracting is still favoured by some policy-makers, who are attracted to the idea of giving provider groups pools of money, freeing them from micro-oversight (for example health plan-operated prior authorisation programmes), and telling them, “You figure out how to use this money to best care for your patients; and we’ll leave you alone except for measuring patient experience and the quality of care you provide”. The concept may be making something of a comeback, albeit in a modified form, as a result of the recent interest by the US Government in fostering the creation of Accountable Care Organizations: provider organisations that agree to be held accountable for the cost and quality of care for their population of patients (Devers and Berenson, 2009; Fisher and others, 2009; Shortell and Casalino, 2010).

Ten suggestions for GP commissioning

Suggestion 1: GP commissioning consortia and NHS policy-makers should seek to learn from US independent practice associations, not just from US integrated delivery systems

As the NHS prepares to transfer responsibility for commissioning health services to groups of GPs acting together as commissioning consortia, there are important lessons to be learned, particularly from the experience of IPAs in the US. Like IPAs, GP commissioning consortia will be networks of small independent practices. In the short to medium term, GP consortia will not even remotely resemble large US medical groups or IDSs like Kaiser Permanente, Intermountain, Geisinger or Mayo. There is much to be learned about best practices for improving medical care from these well-known organisations, but IPAs can provide much more relevant information on what it takes for a network of small practices to succeed.

Suggestion 2: To succeed, GP consortia will have to invest heavily in leadership, management and infrastructure

Of more than 1,500 US IPAs that have been created, many have disappeared, and perhaps 150, at most, have been successful at risk contracting. Most that remain are simply shell organisations that no longer engage in risk contracting or any meaningful activity. Successful IPAs have skilled leaders and invest in leadership, management and infrastructure (Thorlby and others, 2011). Unsuccessful IPAs did not. The successful IPAs are an anomaly: left to themselves, most physician groups will under-invest in leadership and infrastructure. Physicians in the US tend to grossly under-estimate the amount of investment that is necessary; focus on their current income and dislike reducing their current income to pay for things that they do not value, that is leadership, management and infrastructure. It seems likely that most GP consortia in England, left to their own judgement, will also under-invest. It might be helpful if they were provided information about the extent of the investment in leadership and infrastructure by successful US medical groups and IPAs that engage in risk contracting (see, for example, Thorlby and others, 2011).

In the early years of GP commissioning, the NHS should provide consortia with a generous, ring-fenced budget to invest in leadership, management and infrastructure. Failure to make this investment will make it very likely that many, if not most, consortia, will fail.

“Successful consortia will need an active clinical leadership board, with medical directors whose members devote substantial time to the organisation.”

The coalition Government plans to cut NHS management costs substantially, but this is not the place to do it. A relatively small investment in consortia management (compared to the NHS budget) will greatly increase the probability that the GP commissioning consortia policy will succeed.

After the first three years, the NHS contribution to leadership/management/infrastructure should no longer be ring-fenced, but should be blended into the overall payments to GP consortia, and gradually reduced. By then, GPs should recognise the importance of these functions for the success of their consortium, and be more willing to invest in them. Individual consortia, rather than the NHS, would then decide the proportion of their revenue to spend on leadership, management and infrastructure.

Suggestion 3: Provide training for GP leaders

Creating and operating GP consortia is not a job for amateurs; it is not something to be done by a GP in one or two sessions a week, in his or her spare time. Highly skilled, full-time non-physician managers will be necessary for consortia, but not sufficient – concerted clinical leadership will be required as well. The experience of successful IPAs in the US suggests that a consortium with 100,000 patients will need at least two physicians who spend the great majority of their time leading the consortium. In addition, successful consortia will need an active clinical leadership board, with medical directors whose members devote substantial time to the organisation.

Neither contracts with external organisations nor access to timely data will be magic bullets that will reduce the need for consortia to have leaders. Consortia may choose to contract with external organisations, such as private companies or local authorities, but these organisations will not reduce the need for consortia to have skilled non-physician and physician leaders whose time is devoted to running their consortium. It will not be possible to push a button and have outside organisations provide what a consortium needs. Consortium leaders will have to invest substantial time in deciding what kind of help is necessary; in working closely with outside organisations; and in using the help that outside organisations provide. Unfortunately, if evidence from PCTs is any indication, weaker consortia, which will most need help from external organisations, will also be the least able to contract for and use it effectively (Naylor and Goodwin, 2010).

Access to timely financial and clinical data will be necessary for consortia, but having the data in itself is useless. There must be leaders within the consortium with the time and skills to put the data to use.

Past NHS experiments with PCTs, practice-based commissioning, total purchasing pilots and GP fundholding have undoubtedly resulted in the emergence of some GP leaders (Smith and Goodwin, 2006). But it seems unlikely that England currently has the 1,000 or so GP leaders likely to be the minimum necessary for 500 GP commissioning consortia to succeed. The fact that there currently are a number of charismatic GP leaders does not mean that GP commissioning can quickly be made into a generalisable national policy.

The NHS potentially has an advantage over the US (see Box 1 on page 23) because it can provide funds directly to GP consortia to support leaders, and because the NHS itself could provide training for upcoming GP leaders. Additionally, in the early years of GP commissioning, the NHS can make ring-fenced funds available to GP consortia to ensure that they invest sufficiently in management/leadership. There is no way to do this in the US.

Suggestion 4: Balance quality, patient experience and cost incentives

If GP commissioning is perceived to be focused primarily on cost, it will likely generate a strong physician and patient backlash. The NHS should provide consortia with balanced incentives. In addition to rewards that GP consortia may receive for controlling the overall costs of medical care, they should be eligible to receive incentives for providing high-quality care and excellent patient experience of care. The potential quality/patient experience incentives should be roughly as large as the potential rewards for cost savings. If recognising both would be too expensive, the NHS could distribute quality/patient experience rewards only to consortia that are able to achieve some minimum level of savings, and/or distribute savings rewards only to consortia that have achieved reasonably high quality and patient experience scores.

Patients and physicians in the US perceived risk contracting to be a means to reduce costs, not a means to improve quality and patients' experience of care. Physicians communicated their discontent to patients during innumerable consultations, and the media was quick to amplify their complaints. If physicians are dissatisfied with GP

“GP consortia should be rewarded not only for generating cost savings, but also for improving the quality of care and patient experience.”

commissioning as a policy, patients are very likely to oppose it as well. Risk contracting was in fact structured by health insurance plans so that rewards for physician groups came entirely from reducing costs, although that has been changing in recent years. GP consortia should be rewarded not only for generating cost savings, but also for improving the quality of care and patient experience.

As currently structured through the national GP contract, the NHS Quality and Outcomes Framework (QOF) for GPs may prove to be an obstacle to balancing incentives for GP consortia. If all or most available funds for quality continue to flow directly from the NHS to individual GP practices, consortia will not be able to use the distribution of quality bonuses as an incentive to gain GP cooperation with their efforts to improve quality. Continuing the QOF in its present form will make it impossible to move from the process measures of quality used by the QOF and appropriate for individual GPs and small practices, to more robust outcome measures that could be used with consortia as the units of analysis.

The NHS has a considerable advantage compared to the US system because it can have one consistent policy that applies to all of the funds received by GP consortia (see Box 1 opposite). In contrast, in the US, physician groups must deal with multiple different, and often conflicting, incentives from health insurance plans and from the federal government’s Medicare programme. For example, groups engaged in risk contracting often receive a significant part of their revenue both from risk contracting, which gives an incentive to economise on services provided for patients covered under risk contracts, and from fee-for-service payment, which gives a very strong incentive to provide as many services as possible for patients covered under fee-for-service contracts.

The NHS and the Government should take care that communications about the programme to the public and to physicians make clear that it is not just about reducing costs, but also about improving the quality of care and patient experience.

Box 1: NHS advantages compared to the US in implementing GP consortia

1. The NHS is a single-payer system, so it can provide consortia with a single consistent set of incentives, unlike the conflicting incentives offered in the US multi-payer system.
2. GPs in the NHS already have electronic medical records; this is not the case for most US GPs.
3. GPs represent a higher proportion of all physicians in the UK, and are more highly respected by the public.
4. The NHS can provide consortia with funds dedicated to leadership, management and infrastructure.
5. The NHS already has a cadre of GP leaders with some experience of GP fundholding and commissioning.

Suggestion 5: Incentives for GP consortia to generate cost savings for the NHS should neither be excessively strong, nor excessively weak. GP consortia should have the ability to use meaningful incentives for their member practices

Each GP consortium must be ‘at risk’ in some meaningful way for the cost of care provided to the consortium’s patients; and the individual GPs within the consortium must have something ‘at risk’ as well. However, the risk should be for costs that the consortium can reasonably be expected to control, and should not be so large that it is likely to lead to attempts at skimping and ‘cream-skimming’; that is to provide less and/or lower quality care than appropriate, and to seek to register patients who are likely to be low cost.

It is not yet clear what incentives the NHS will provide to GP consortia, but it appears that they will be quite weak, at least by US standards and compared to the QOF. It is important to note that US physicians have relatively strong incentives to join and to cooperate with IPAs that engage in risk contracting with health insurance plans (Rosenthal and others, 2001). By joining and cooperating with an IPA or medical group, physicians can negotiate much higher payment rates from health plans than they would be able to gain on their own. In addition, physicians can take their share of any savings generated and use them to increase

“To make it possible for consortia to have sufficient influence with their members, it will be necessary to... give more power to consortia in relation to GPs’ performance as primary care providers.”

their personal income. Yet even with these two inducements, most US physicians have not been very interested in IPAs, and, as noted above, most IPAs have not been successful.

In most cases, US physicians have been much more interested in their own practice, and in increasing their take-home income for the next year or two, then they have been in investing time and money in an IPA, and in giving up some of their autonomy to the larger organisation (for example, their autonomy to order an MRI scan for a patient with lower back pain even when clinical guidelines would suggest that this is not appropriate). GPs in England will be required to join a GP consortium, but that will not be enough in itself; consortia will need active cooperation with their programmes from the great majority of their GPs if they are to succeed (Mays and others, 2001).

Successful medical groups and IPAs in the US are selective about which physicians they permit to join. They can distribute the quality and cost-saving rewards they receive to their physicians differentially, based on criteria that the physician group develops, and physicians can use these rewards to increase their personal income. As a last resort, physicians who repeatedly fail to improve their performance and to cooperate with the group’s attempts to improve care for its population of patients, can have their relationship with the group terminated.

It is not clear whether GP consortia in the NHS will have the ability to select their members, or to terminate members’ relationship with their consortium when they refuse to cooperate with its programmes and improve the care they provide. GP consortia should be able to select their members, terminate the membership of persistently poorly performing GPs, and distribute savings and quality bonuses received by the consortium differentially to members based on their performance.

Permitting GPs to use bonuses they receive to directly increase their personal income, as is done in the US, would be controversial in the UK. It may or may not be necessary to do so to provide a sufficiently strong incentive for GP cooperation. In addition to caring about their income, physicians care about three other things:

- they want to improve care for their patients
- they want their workday to be rewarding and not overly chaotic or excessively demanding
- they want the respect of their peers.

To the extent that consortia can make GPs' working lives better in these three respects, it will be less important for GPs to be able to use bonuses to increase their personal income. Simply showing GPs within a consortium each GP's performance, on a quarterly basis, can provide a strong incentive for improvement, as was found within primary care groups in the NHS over the period 1999 to 2002 (Smith and Goodwin, 2006).

The reform plans contain a proposal for consortia to pay out a 'quality premium' against the achievement of commissioning goals (as yet undecided), but at the same time state that GP contracts are to be held and managed centrally (by the NHS Commissioning Board) and not by the consortia (Department of Health, 2010b). To make it possible for consortia to have sufficient influence with their members, it will be necessary to rework the NHS contract with GPs and give more power to consortia in relation to GPs' performance as primary care providers (NHS Confederation and Primary Care Trust Network, 2010; Smith and Thorlby, 2010).

Suggestion 6: The consequences for poorly performing consortia should be made clear in advance and should be consistently enforced

The NHS Commissioning Board will be able to withdraw its contract with poorly performing consortia. Presumably, in this case, a new consortium could form in the area, or another, more successful consortium could take over the contract. This threat will provide a strong incentive for good performance for a consortium's leadership, but not for GPs who do not like their consortium anyway, or who oppose the idea of GP commissioning. There should be financial consequences, at least to some extent, for the GPs in a consortium that persistently fails: the absence of such sanctions was a key failing in the GP fundholding scheme of the 1990s.

Suggestion 7: To the extent possible, minimise the ‘insurance risk’ that consortia bear

GP consortia will not have the size or capabilities of insurance companies. As far as possible, they should not be made to bear risk for costs that they cannot control (Anderson and Weller, 1999). There are four ways to minimise this risk; all should be used within the NHS.

First, the likely cost of care for each patient within a consortium’s population should be used when calculating the consortium’s budget; that is that the budgets should be adequately risk-adjusted. Failure to do this may lead consortia to try to cherry-pick patients, and in any case would lead to the failure of a significant number of consortia.

Second, consortia must be large enough to reduce the risk that, simply by chance, a consortium’s costs in a given year are much higher than predicted. I am not aware of any research that rigorously attempts to estimate how large will be large enough, but 100,000 patients (about 50 GPs) is probably a minimum size (The King’s Fund, 2010; Smith, 1999; Martin and others, 1998). The size needed to take a large amount of financial risk is an empirical question, which the Nuffield Trust is investigating (Dixon, forthcoming). There are other reasons for consortia to be reasonably large in addition to their ability to bear risk. Larger consortia will also have more resources and potential economies of scale to be able to afford high-quality leadership and staff, such as nurse care managers for patients with chronic illnesses like congestive heart failure. However, as consortia grow larger, they run the risk of developing diseconomies of scale, for example, of becoming more bureaucratic and inflexible, and less in touch with their GPs and patients (Smith and others, 2004; Bojke and others, 2001).

Third, consortia should be required to purchase reinsurance (‘stop-loss’ insurance, which is initiated when a claim reaches the threshold) from the NHS (which should be able to provide it inexpensively without having to keep large pools of funds in reserve), or elsewhere. This insurance would pay the costs of an individual patient’s care once they exceed a certain limit.

Fourth, consistent with the White Paper (Department of Health, 2010a), consortia should not be responsible for commissioning high-cost, low-frequency illnesses, such as transplants or severe burns.

“It is essential that consortia receive timely and accurate information on the costs their patients are incurring... Failing to adequately account for ‘incurred but not reported’ costs was a major cause of failure of many physician groups in the US.”

Suggestion 8: Either ‘real’ or ‘virtual’ budgets can work, but details matter

Should consortia pay hospitals and other providers directly, or should another NHS body pay these bills? Put another way, should consortia have real budgets, that is should the NHS transfer to consortia all the annual funds estimated to be necessary to pay for their patients’ care, or should they be virtual budgets? If real, consortia would pay for services themselves; if virtual, the NHS would pay claims, and monitor costs. Real budgets would make it possible for consortia to closely control which claims are paid and to track expenses carefully. However, this control and tracking should also be possible with virtual budgets, if suitable arrangements are made between a consortium and the NHS.

Whether the budget is real or virtual, it is essential that consortia receive timely and accurate information on the costs their patients are incurring, and that consortia make realistic estimates of costs that have been incurred, but for which claims have not yet been received. Failing to adequately account for ‘incurred but not reported’ (IBNR) costs was a major cause of failure of many physician groups in the US. Halfway through a budget year, a group would believe that it was running a surplus, not realising that its patients had already incurred millions of dollars of claims that had not yet been submitted for payment. This led to bankruptcies, and to health insurance plans having to pay for services twice: once in the annual budget given to the group, and again to pay providers outside of the group for services they had provided that the group was unable to pay.

In California and many other US states, physician groups that take substantial risk for the cost of their patients’ care must now provide ongoing proof that they have the capital reserves to cover higher than anticipated costs of care. The NHS may not want to adopt such a requirement, but if it does not, the NHS Commissioning Board must receive timely and accurate information on each consortium’s costs in relation to budget and IBNR costs, and there must be an explicit failure regimen specifying the actions that the NHS Commissioning Board will take if a problem seems to be emerging for a particular consortium.

Suggestion 9: Encourage hospitals and specialist physicians to cooperate with GP consortia and remove barriers to cooperation

Hospital and specialist care are responsible for the majority of health care costs, and are likely to be the areas in which the greatest savings can be made. GP commissioning is a real threat to the income of hospitals and specialists. One organisation's savings is a loss in another organisation's income. In the US, hospitals and specialists cooperated with medical groups and IPAs engaged in risk contracting to the extent that they believed that they had no choice. 'No choice' meant that they believed they had to cooperate, or they would no longer receive referrals from groups and IPAs engaged in risk contracting. However, over time, specialists and hospitals successfully fought back both in the political arena and in the market. They supported public discontent with risk contracting and primary care gatekeeping, and therefore encouraged health insurance companies to retreat from these strategies. Hospitals merged with each other and reduced excess bed capacity to increase their negotiating leverage with health plans and with physician groups. Prestigious hospitals and those that held a monopoly on providing certain services in a geographic area realised that it would not be feasible for even very large medical groups and IPAs to steer their patients elsewhere, and began to demand high payment rates; be uncooperative with groups' programmes to reduce the volume of unnecessary admissions and hospital days; and refused to engage in risk contracting (Devers and others, 2003). To the extent that they were able to do so, specialists used the same strategies (Casalino and others, 2004; Rose, 2001). In addition, hospitals began to employ primary care physicians, thus locking in a referral base.

GP commissioning consortia may have to deal with even larger obstacles to gaining hospital and specialist cooperation (Ham and Smith, 2010). At the onset of risk contracting, many areas of the US had a surplus of hospitals and of specialists; this will not be true in much of England. Medical groups and IPAs in the US usually include a large number of specialists, which greatly increased the opportunities for PCP-specialist cooperation. This is unlikely to happen in England, where specialists are employed by hospitals and where specialists' pensions may be adversely affected if they leave hospital employment. The NHS should adopt policies that facilitate specialist involvement in multi-specialty medical groups.

“It would not be an exaggeration to argue that one important test of the success of GP commissioning will be whether telephone consultations between GPs and specialists become common.”

The Payment by Results programme, which pays hospitals more when they and their specialists generate a larger volume of services, provides a direct disincentive to cooperation with GP consortia. For example, it can be extremely useful for a GP to call a specialist to consult on management of a patient, including consulting on whether it would be advisable to refer that patient to the specialist. This can result in high-quality, cost-effective care that is convenient for the patient and professionally satisfying for the GP and the consultant. However, in the NHS at present, specialists have no incentive to provide telephone consultation to GPs; there is anecdotal evidence that some hospitals have explicitly encouraged their specialists not to engage in such consultations if they are likely to reduce the number of referrals.

GP consortia could try to build incentives for cooperation into their contracts with hospitals, but many, if not most, may lack the leverage to do so. During GP fundholding and total purchasing, GPs did not have a great deal of success in influencing hospital and specialist behaviour (Mays and others, 2001). The NHS should consider building strong incentives for hospitals and specialists to cooperate with GP consortia into the basic contract that it signs with them. For example, if hospitals are paid less for readmitting patients within 30 days, they will have an incentive to cooperate with consortia in trying to reduce readmissions (for example, by providing timely and complete information to GPs when one of their patients is discharged from the hospital). Additionally, hospitals (and their specialists) could receive financial bonuses or penalties based on surveys of GP satisfaction with their performance.

It would not be an exaggeration to argue that one important test of the success of GP commissioning will be whether telephone consultations between GPs and specialists become common. For this to occur, both GPs and specialists must have incentives to take the time to engage in these conversations.

Suggestion 10: Assume that, even if the NHS creates perfect incentives, it is likely to take many years for most consortia to become highly competent

Even if the NHS creates perfect incentives, it is likely to take five to ten years for most consortia to become highly competent. The Government should plan accordingly.

The performance of GP consortia will be a function of the incentives they face and the capabilities they develop. The capabilities required to manage 70 to 80 per cent of the NHS budget, and generate cost savings, while improving patient experience and the quality of care, will be substantial. Successful consortia will have to do much more than simply try to influence the clinical decisions of their individual physician members and decide on the providers from which they will commission services. They will have to develop organised processes to improve care, for example, they will need excellent, timely clinical data, including the ability to maintain an up-to-date registry of their patients with various chronic illnesses, stratify these patients by risk, and develop programmes (for example, the use of nurse care managers to communicate with patients between physician visits) to help them (Casalino and others, 2003; Rundall and others, 2002; VanderLaan and others, 1998). They will need the ability to make sophisticated financial projections and do complex financial accounting. They will have to create an internal incentive programme (even if the programme simply involves performance feedback) and manage it. They will have to negotiate contracts with providers of medical services outside of the consortium, track performance of contractees and, perhaps, pay claims. They will have to account for their performance to the public and to the NHS Commissioning Board.

In short, GP consortia will need to develop leadership, data and personnel infrastructure, organisational routines, and a shared culture. Based on the US experience, all these things are particularly difficult to do in network organisations (IPAs in the US and GP consortia in England) and all will take significant time. Leaders of US IPAs and medical groups repeatedly state that the culture of their organisations is critical to their success – that ‘culture eats strategy for lunch every day’. Development of culture by definition takes time; there will be no short cut. Additionally, the time needed to develop large numbers of high-functioning GP consortia will be slowed by the major changes being made in the NHS as a whole (Roland, 2010).

“Somehow, the NHS must find a way to give consortia time to develop, without providing support year after year for consortia that fail to improve.”

The NHS should take care to avoid the economistic fallacy: ‘if you get the incentives right, hundreds of high-performing organisations will magically appear’. If the incentives are right, they will appear – a few very quickly, but most only when given significant time. Max Weber, in his famous essay ‘Politics as a Vocation’, stated that: “Politics is a strong and slow boring of hard boards” (Weber, 1946). The same will be true of GP commissioning.

The NHS is facing a period of constrained budgets, and would like to see GP commissioning produce lower health care costs immediately. However, it is likely that many consortia will not be able to do so within the first year or so (or even longer), but might be able to produce savings eventually. There will be some consortia that will be unable to ever produce savings. Somehow, the NHS must find a way to give consortia time to develop, without providing support year after year for consortia that fail to improve. Several complementary approaches can be tried:

First, the Government should not over-inflate expectations for rapid change (Roland, 2010).

Second, as discussed in Suggestion 2, in the early years, the NHS should provide consortia with a generous, ring-fenced budget for leadership, management and infrastructure.

Third, there should be a phase-in period, as the Government appears to be planning. Consortia that appear to be competent should be permitted to begin commissioning within the next year or two, but the requirement that all GPs be members of consortia should probably not take effect for three years at a minimum. By that time, there will be some opportunity to learn from successful consortia (including methods that these organisations have developed to obtain help from external bodies), and successful consortia could be permitted to expand, within limits, to take over consortia in geographic areas where it does not appear that a competent GP group is forming. This will create some additional administrative burden on the NHS, but this short-term price will be well worth the benefit of avoiding large numbers of failed consortia during the early years of the programme.

A complementary approach would be to permit consortia to start by taking on relatively small degrees of risk, if that is their desire, and to increase the amount of risk taken over time (Thorlby and others, 2011). This could be done either by starting with a relatively narrow scope of services for which a consortium is fully at risk, or by starting with a broad scope of services, but limiting the amount of downside risk (and, correspondingly, the amount of upside financial gain that the consortium could make). Over time, as a consortium proved its ability, the amount of risk would be increased. Consortia that failed to progress would be replaced by more successful groups.

Fourth, the failure regimen should be explicit. The NHS may want to assist consortia that fail to stay within budget or to improve quality during their first year or two, but contracts with consortia that show little or no promise for improvement should be terminated and given to higher performing organisations.

Conclusion

GP commissioning is a very promising concept. But there are many ways in which implementation of the concept could go wrong, and relatively few ways for it to succeed. The consequences of turning 70 per cent of the NHS budget over to GP consortia that do not yet have the capabilities to manage these funds well would be severe.

There was, and is, no entity in the US that has the authority to mandate broad restructuring of the health care system. In contrast, the British Government, through the NHS, does have that authority. It should be used to anticipate possible problems with GP commissioning and to carefully plan ways to minimise them.

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59 New Cavendish Street
London W1G 7LP

Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk



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