

Practice-based commissioning and sexual reproductive health services: opportunities and threats

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Background

The National Health Service (NHS) in England is going through another reorganisation, in the spirit of creating a 'patient-led NHS'. Practice-based commissioning (PBC) refers to devolution of commissioning responsibilities from primary care trusts (PCTs) to individual or groups of primary care professionals; this may be a group of general practitioners (GPs), general practices, private consortia or other health care professionals. Commissioning is a term that has a loose meaning within the NHS but can encompass the process of securing services from providers by contract, as well as the planning and design of integrated care pathways.

Policy context

Primary care-led commissioning was discussed in the mid-1980s; the NHS reforms of the 1990s introduced an internal market system resulting in purchaser-provider split and GP fund-holding. The Labour government abolished GP fund-holding and the 'competitive' internal market in 1997, but the health care market structure remained with a change in semantics from 'purchasers' to 'commissioners'.¹ The NHS Plan explicitly stated health professionals in the front line should have the freedom to shape local health services according to their patients' needs.² After the White Paper,³ the first set of guidance on PBC was published in December 2004.⁴ An analysis of PBC by the King's Fund discussed the lessons learnt from previous schemes such as GP fund-holding and suggested ways of implementing PBC, including risk sharing, incentives and coherent service development with national and local priorities.⁵

What are the benefits?

PBC is driven by the following:

- Patient choice: as an incentive for quality and empowerment. Commissioning groups can secure a wide range of services responsive to their patients' needs.
- Payment by results: where commissioning groups are able to provide or commission services locally, the funds will follow the patients as they choose to use these services. Standard tariffs for each health care resource group may be used.
- Supporting people with long-term conditions: commissioning groups will be able to direct funding into packages of care that best support patients with long-term conditions in the community.

PBC enables primary care professionals to increase the sense of engagement and influence with the strategic work of their primary care organisation. The involvement of frontline professionals and, in some cases, lay members might enhance face validity and accountability with the

public. PBC is not meant to be a return to the inequities and costly bureaucracy of GP fund-holding. Any savings from efficient commissioning should be invested in health services.

How will it be implemented?

Guidance published in February 2005 lacks clarity and is open to interpretation; this contrasts with the prescriptive advice given to GP fund-holders.⁶ Although this arrangement could pave the way for budget-setting and methodology frameworks to be negotiated locally, there is potential for disputes with guidance interpretation. Some organisations have developed advice on areas such as scope of services to be commissioned, budget plans and information systems.⁷⁻⁹ Ultimately, PCTs retain the final say over the actions of commissioners in order to ensure that the needs of the local health community are met.

There is no prescribed scope and timescale of services to be commissioned other than the requirement for the process to be implemented in full by December 2006.

Implications for sexual and reproductive health services

PBC is not about reconfiguring current commissioning arrangements, but rather redesigning service pathways that improve the patient's experience and reduce system costs. Referrals to secondary care should only be for procedures that cannot be provided safely and effectively in the community. In reality, there are many secondary providers in large urban areas like London where service redesign may be difficult; but in rural areas with large geographical spread there may be incentives in creating more local services and development of alternative providers such as practitioners with specialist interests.

Effective collaboration among service providers in traditionally different settings could offer real benefit to patients. Under current arrangements, a young woman with an unwanted pregnancy might have to attend up to four different services: consultation and referral to termination in general practice; sexual transmitted infection (STI) check in a genitourinary medicine (GUM) clinic; termination counselling and procedure at abortion provider; and future contraception advice and provision in a family planning clinic. Under PBC, a more streamlined pathway with one provider might help the user's experience and reduce cost of this process.

The fact that other services already offer contraception (including intrauterine device and implant fittings) might create contestability in the sexual and reproductive health (SRH) market. Hence, current SRH providers might need to consider the added value of their services compared with competitors. Health care pathways should be devised in partnership with other providers such as GUM, abortion providers, gynaecology and primary care so that risks could be shared amongst them.

Conclusions

SRH services will always have a role in implementing public health policies (e.g. reducing the burden of STIs and unplanned pregnancies, screening for cervical cancer and chlamydia). As PBC is driven by patient choice, quality and access, this might be a good opportunity for SRH services to reinforce or consider expanding its role in areas

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such as medical gynaecology, diagnostics, STI screening, sexual dysfunction and abortion. The key challenge now for SRH services is to negotiate collaborative working relationships with current providers, and this may involve changing the attitudes of some key players in order to provide truly integrative care pathways that benefit users.

Here is my advice: do it now or do it soon, before private competitors take over your market!

Statements on funding and competing interests

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