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Supplementary Material

A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy

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Appendix 1. Inclusion and Exclusion Criteria

No	Date of Study	Include	Exclude
1	Date of study	Papers since 2005	Papers published prior to 2005
2	Language of publication	The study is in English.	Studies not published in full text in English.
3	Country of study	Australia, UK, USA, Canada, Germany, Netherlands, New Zealand	
4	Participants	The study addresses commissioning for 1. Population groups such as Priority populations (Inc. Aboriginal and Torres Strait Islander people, people of CALD background, veterans, people who are homeless, people in prison) 2. Conditions such as chronic disease, disability, mental health 3. Service types such as primary health care, social care, home care, transition care, medication management, maternity services	The study is not focused on commissioning with respect to the intersection of primary care with acute care sector or chronic disease management
5	Type of Study	Qualitative and quantitative studies: 1. Evaluation 2. Research reviews 3. Systematic reviews 4. Descriptive reviews 5. Case studies 6. Comparative studies Opinion pieces/ commentaries that focus solely on describing interventions, approaches or strategies without any evaluation or analysis of the results will be retained for back ground material	
6	Subject of Study	The study describes the elements/activities of commissioning 1. Identification of needs 2. Services planning 3. Purchasing and evaluates the approach in terms of 1. cost containment 2. sustainability	Research purely reporting incidence, prevalence or demographics associated with chronic disease or population screening Research that focuses on a single activity such as service

		3. effectiveness, 4. outcomes, 5. processes 6. access, equity 7. acceptability to users or practitioners and describes the context in which it operates 1. Federated system 2. Payment arrangement 3. Patient enrolment 4. Provider groups explores the needs, potential avenues, challenges, perceptions and barriers to successful commissioning approaches or strategies	purchasing and does not include all aspects of commissioning
7	Who commissions/ commissioning body	The approach or strategy is located in 1. Country of interest Commissioners include a general practice, family practice, health clinic, community health centre, an Aboriginal community controlled health centre (ACCHS), 2. regional health 3. primary care organization, 4. other primary health care service; 5. insurance company 6. Kaiser Permanente 7. NGOs 8. National, state, local governments	

Appendix 2 Summary of Included Studies

Appendix: Papers included in review.

Author/publication details	Country	Model or aspect of commissioning	Study design	Relevant results	Implications drawn from results by authors
Ashman, I., & Willcocks, S. (2014). Engaging with clinical commissioning: the attitudes of general practitioners in East Lancashire. Quality in Primary Care, 22(2), 91-99.	England (East Lancashire)	No specific model of commissioning investigated Commissioning is broadly defined as prioritising, securing, funding and monitoring health improvement and healthcare services provided in a defined locality, or for a specific group of individuals.	*Design* Cross sectional *Data collection methods* Survey: Clinical Commissioning Engagement Scale - CCES (designed for study) *Sample* GPs within one CCG. 35.3% response rate (N=85) *Research questions:* 1. What is the level of GP engagement with clinical commissioning? 2. What are the incentives and/or impediments to engagement with clinical commissioning?	*Processes:* Involvement with clinical commissioning was restricted (two thirds of GPs never or rarely involved). Total mean score across all localities *M*=3.17 (on a 6 point Likert scale). Relatively little difference in mean scores across the 5 localities. Only one district in which every respondent had a least some experience with commissioning. Total means cores for capacity (*M*=2.42) and capability (*M*=2.87) were slightly lower than for attitude (*M*=3.81) and opportunity (*M*=3.58).	Findings highlight potential challenges for CCGs in engaging GPs & responding to problems of capacity & capability.
Ashton, T, Tenbensel,T, Cumming, J,Barnett, P.(2008) Decentralizing resource allocation: early experiences with District Health Boards in New Zealand. Journal of Health Services Research and Policy, 13(2)	NZ	District health boards (DHB) – decentralised commissioning	*Design* Qualitative *Date collection methods* Semi-structured interviews Case studies Document review *Sample* *N*=44 interviews key national stakeholders including ministers, Ministry of Health officials and representatives from national provider organizations; *N*=52 interviews DHB chief executive officers, DHB funding and planning managers, and chairs; case studies in 5 districts, incl.	*Effective (containing system costs)* Cost effectiveness is yet to be determined. Many DHBs inherited large deficits from prior commissioning practices in the 1990s, which emphasised market-oriented purchasing, with focus on price rather than quality of services. These deficits currently constrain innovation, induce short-term thinking, and divert attention from higher order health goals. The elimination of systematic deficits has released some constraints on DHB spending decisions, however, the need to work within budgets still appears to dominate purchasing decisions. *Improving patient outcomes* As above, innovation in services and a public health mind set are constrained by the need to balance budgets. On a positive note, DHBs are required to seek community input into their decision-making to improve delivery of services that are needed in the	The re-structuring of the health sector in New Zealand has enhanced and inhibited the achievement of government objectives. There is a need for further consideration of the key mechanisms and processes that enhance or constrain progress towards these objectives.

Author/publication details	Country	Model or aspect of commissioning	Study design	Relevant results	Implications drawn from results by authors
			N=227 DHB board Members, senior managers, representatives from Primary Health Organisations, nongovernment providers, and local organizations and community-based interest groups, plus observational studies of board and committee meetings; document analysis of cabinet and policy papers, DHB strategic and annual plans, and minutes of meetings *Research questions* What have been the processes associated with the allocation of health resources in the decentralized system? To what extent are four of the government's stated objectives likely to be achieved?	local community. However, research revealed that the needs assessment processes were sometimes not rigorous, dur to DHB lack of skills and the capacity to undertake this work. Also some ambivalence among board members and senior managers about the effectiveness of community consultation. *Satisfaction* No information on public satisfaction with DHB system of service planning & purchasing. However, DHB stakeholders noted difficulties balancing new agenda for commissioning and inherited deficits, which act against this agenda. *Processes* Local decision-making has encouraged greater local responsiveness and new funding arrangements have allayed concerns about inter-regional equity. The system and its processes are less commercially oriented and collaboration between DHBs is improving. However, the combination of increased integration of purchasing and provision within DHBs and the focus on financial deficits in the early years appears to have inhibited the development of partnership relationships between DHBs and non-government providers, and of longer-term funding arrangements for high quality providers. Non-government providers perceive that DHBs have a tendency to favour their own providers when allocating contracts.	
Barnes, K., Longfield, P., Jones, K., Littlemore, G., McDonough, C., McIntyre, A., McLaughlin, M. (2013). Evidence based commissioning: calculating shift potentials for paediatric services. Clinical Governance: An International Journal, 18(1), 39-48.	England	Commissioning (here, funding) in secondary care settings for a specific client group (paediatric) and specific conditions (ambulatory-sensitive). The articles focuses specifically on cost-effectiveness.	*Design* Mixed methods *Data collection methods* Utilised cost data from commissioning PCTs for six common paediatric ambulatory-sensitive conditions (PASC). Also uses case studies to recommend alternative funding avenues for paediatric care.	*Effective (containing system costs)* Current expenditure is not cost-effective. Large amounts of money are being spent on children attending A&E departments with minor illnesses. Of these, many end up admitted for precautionary observation. This provision is expensive and therefore an attractive target for commissioners seeking alternative provision. *Improving patient outcomes* Article recommends two alternative approaches to improve patient outcome and ensure more cost	The study finds that large sums are currently being spent on inappropriate treatment of routine childhood conditions, especially in large urban conurbations. It demonstrates that in the case studies, the alternative provision can provide a viable and effective alternative.

Author/publication details	Country	Model or aspect of commissioning	Study design	Relevant results	Implications drawn from results by authors
			Data analysis Compared the costs of recent paediatric short-stay admissions in secondary care settings for every English PCT for which data was available. *Sample* Cost data for the following paediatric conditions: (1) asthma and wheezing without complications; (2) upper respiratory tract disorders without complications; (3) lower respiratory tract disorders without complications; (4) minor infections without complications; (5) acute infectious and non-infectious gastroenteritis; and (6) acute bronchiolitis without complications.	effective delivery of services. One alternative is to channel funds into a walk-in centre in hospitals to lower emergency admissions. The other is to channel funds and expertise into specialist-paediatric units located in the community in GP surgeries. *Ensuring sustainability of model* The current funding model for paediactric services in secondary care settings is not sustainable in the long-term and needs review. A&E visits and subsequent admissions for minor illnesses are too high and divert funds from more serious childhood conditions. These funds would be better channelled into local and community services. *Service use* . nearly three million children (equivalent to 28 per cent of all children in England) attend A&E departments in hospitals in England each year, accounting for more than 25 per cent of patients seen in A&E nationally; . the number of children presenting to urgent care is increasing (7 per cent from 2004 to 2007); . there is significant variation in average length of stay between organisations, ranging from 1.06 to 5.08 days.	
Baxter, K., Weiss, M., & Le Grand, J. (2007). Collaborative commissioning of secondary care services by primary care Trusts. Public Money and Management, 27(3), 207-214	England	Collaborative commissioning of secondary care services by groups of PCTs	*Design* Case study *Sample* Two sites each involving a lead PCT and other collaborating PCTs and a NHS trust from which secondary services were commissioned. *Research questions/Aim* *To* investigate collaborative commissioning and ways of enhancing partnership working between PCTs.	Delayed service level agreement in the case which involved poor agreement on priorities. Shared information although this varied in quality.	In one case there was agreed priorities and objectives and things worked well. In the other case there were different priorities and this led to delays and inefficiencies.
Bradley, F., Elvey R., Ashcroft D., & Noyce P. (2006). Commissioning services and the new community pharmacy	England	Commissioning: new Pharmacy contracts	*Design* Cross sectional *Data collection methods* Survey (2006)	Most common commissioning approach of PCTs was to engage with local pharmaceutical committees &/or local pharmacists.	The impact of the new contract on enhanced service commissioning levels has been modest. Commissioning of

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contract: (2) Drivers, barriers and approaches to commissioning. Pharmaceutical Journal, 277(7413), 189-192 (Needs to be read with related paper: Elvey			*Sample* All PCTs (n=290) Response rate 74% *Research questions* To identify barriers & drivers to the commissioning of community pharmacy services.	Reported barriers to commissioning: • Access to funding (84%) • Lack of PCT capacity (59%) • Impending PCT restructuring (53%) Main commissioning driver was new pharmacy contract (76%).	services for substance misuse and smoking cessation are high, mapping onto national priorities.
Checkland, K., Coleman, A., Harrison, S., & Hiroeh, U. (2009). 'We can't get anything done because…': making sense of 'barriers' to Practice-based Commissioning. Journal of Health Services Research & Policy. 14(1), 20-26.	England	Practice-based commissioning (PBC). Specifically the challenges that are perceived by PBC stakeholders to achieving their goals.	*Design* Qualitative case studies (part of a larger study into PBC). *Data collection methods* Observation of meetings (n=68), interviews (n=46) and document analysis. *Sample* GPs, PCT employees, Local Authority employees, and patient representatives. Participants came from 3 sites identified as 'early adopters'. These 3 PCTs (within which 5 PBC consortia were selected for study) were chosen purposively to cover a range of consortia types. *Research questions* What are the challenges faced by emerging PBC consortia as they go about developing their commissioning role?	*Effective (containing system costs)* This article focuses mainly on the challenges faced by PBC consortia, rather than providing a balanced overview of effectiveness. Two main areas of difficulty arose during interview: (1) lack of time, personnel and expertise to undertake effective commissioning. GPs do not have time to do the work involved; PCTs are providing insufficient management support and expertise; and the skills available are inadequate; (2) relationship with PCT. Local PCTs seen as obstructing progress. *Improving patient outcomes* Nil *Ensuring sustainability of model* PBC stakeholders evidenced a negative attitude to the sustainability of PCTs. In fact, one respondent explicitly reported many PBC stakeholders actively hoped PCTs would fail due to the negative relationship btw PCTs and PBCs. *Service use* Nil *Satisfaction* PBC stakeholders were not satisfied with PCT management support or involvement with PBC consortia. E.g. PCT management 'keeping an eye' on PBC initiatives and acting outside of PBC engagement. *Processes* Not explicitly reviewed. However, PBC consortia often expressed feeling undermined and under-supported by PCTs or without sufficient autonomy to achieve their goals.	Problems arose from quite different 'sense-making' in the developing PBCs, and as a result, carried different meanings in different organisational contexts. This suggests that centralised or 'top-down' solutions will not work unless local context can be taken into account.
Checkland, K., Snow, S., McDermott, I., Harrison, S. & Coleman, A. (2012). 'Animateurs' and animation:	England	Managerial behaviours in PCTs	*Design* Qualitative *Data collection methods*	*Processes* Typical managerial behaviours included: (1) Management and distribution of information, both upwards towards senior management and down and	Managers of the new commissioning organizations (CCGs) will require a deep and contextualized understanding of

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what makes a good commissioning manager? Journal of Health Services Research and Policy, 17(1), 11-17.			In-depth interviews Formal & informal observation *Sample* *N*=41 interviews with PCT managers and GPs involved in commissioning services for hospitals *N*=150 hours of observation *Research questions* Which of the managerial behaviours elucidated by Hales are visible in the context of commissioning? Are there any other specific or novel modes of behaviour that are important in facilitating commissioning?	sideways to colleagues and subordinates. Complexities around number of levels to be negotiated & confusion around where ultimate decision-making power lay. (2) Internal networking with colleagues and external networking with outside bodies such as hospitals and collaborative groups of managers. Complexities around areas of responsibility & ensuring no duplication of work between colleagues. Commisioning-specific behaviours included: (1) manager as *animateur*: an active, yet non-hierarchical management of disparate groups, working to align objectives and to ensure that the right people behave in the right ways at the right time, and contribute to a particular overall objective. Managers appeared to be working creatively to ensure that the emic concerns of one group were taken account of while aligning activity as a whole with the needs of the wider organization. Found specifically among managers responsible for managing across the boundary between the PCT and groups of GPs with commissioning responsibilities.	the NHS and that it is important that organizational processes do not inhibit managerial behaviour. Legitimacy may be an issue in contexts were managers are automatically transferred from their existing appointments.
Checkland, K., Coleman, A., McDermott, I., Segar, J., Miller, R., Petsoulas, C., Wallace, A., Harrison, S. & Peckham, S. (2013). Primary care-led commissioning: applying lessons from the past to the early development of clinical commissioning groups in England. British Journal of General Practice, 63(614), e611-e619.	England	Clinical Commissioning Groups (CCGs)	*Design* Qualitative Maximum variation case studies (*N*=8). *Data collection methods* Interviews with key stakeholders (*n*=91). Observation at meetings across various levels of governance (2011-2012). On-line surveys at two points in time. *Sample* 8 diverse district CCGs (*n*=91). (Included a mix of those defined as deprived, affluent and mixed population) *Research questions* 1. What governance structures are forming under the CCG	*Processes* 1. Autonomy & governance: CCGs have great degree of autonomy in establishing governance structures. Significant complexity & variety in CCGs structure & governance arrangements. Internal structures & external accountabilities of CCGs constrain their freedom to act. Large internal governance structures & growing awareness of external accountability to NHS England, but lack of clarity around specific reporting requirements created constraints in decision making and autonomy. 2. Engaging members: CCGs are membership organisations and engaging members is crucial to their success. Different CCGs take differing approaches based on size of membership body. Issues for CCGs re member engagement: who feels ownership, communication, role & remit of locality groups.	Past evidence indicates GPs engage & maintain their enthusiasm most were they can see direct relationship between efforts and tangible outcomes. This direct relationship generates a 'virtuous cycle' vs feelings of constraint & inability to make change happen generating 'vicious cycle' of disengagement. In context of complex & multi-layered structures, there is a need for robust CCG governance & accountability frameworks, in absence of CCG parent body

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			model of commissioning? How are these serving the population they represent? 2. How are CCGs engaging members? 3. What areas of commissioning activity are CCGs focused on? 4. What monitoring activities do CCGs envisage for their own and related subgroup commissioning responsibilities?	3. Commissioning activities: Tendency for commissioning activity to focus on small scale & familiar practice level interventions to improve long term care. 4. Monitoring: Emphasised importance of monitoring to improve quality of primary care. CCGs keen to improve quality through performance management, but difficult as limited number of staff to do the work. Tensions between CCGs as bottom up organisation led by members vs perceived need to performance manage members.	
Coleman A., Checkland K., McDermott I., & Harrison S. (2013). The limits of market-based reforms in the NHS: the case of alternative providers in primary care. BMC Health Services Research, 13 Suppl 1, S3.	England	The Alternative Provider Medical Services (APMS) were introduced in 2004 to allow new providers to bid for contracts to provide primary care services. APMS contracts differed from the centrally-negotiated GMS contracts in that PCTs were able to negotiate the terms of the contract. Contract monitoring included payment linked to achievement of centrally set KPIs (access; quality; service delivery; value for money; and patient experience). Achievement of KPIs was worth 25% of the total contract value.	Design Qualitative case studies Data collection methods Interviews, observation of meetings and document analysis (2009-10). Sample 2 case studies Research questions To investigate the commissioning and operation of APPCs.	Processes The procurement and contracting process was perceived as costly and time consuming; negotiation proved more difficult than expected; processes could be contentious in terms of confidentiality and transparency. As a result the process became highly legalistic. There were some early difficulties in the relationships between alternative providers of primary are (APPC) and other local GP practices, especially where they were based in the same building. These difficulties seem to stem from competition over patients. S Local competition had led to some GP-practices to change behaviour. Few systematic differences between APPC & traditional GP-practices re ways of working. The APMS contracts were generally perceived as a relatively expensive way of providing primary care, primarily in the view of difficulties felt in building up adequate list sizes. Some KPIs were unclear or unworkable, and formal contract amendments were required. Monitoring processes were intensive and time consuming. Perceived success factors Meeting KPIs & QOF targets, plus broader measures of providing better patient care or improving health.	The contractual processes were transactional contracting as opposed to relational contracting. They were time consuming and expensive, & perhaps unsustainable. While may have stirred up local practices to change their behaviour, limited wider impact.
Dusheiko, M., Gravelle, H., Jacobs, R. & Smith. P. (2006). The effect of financial	Eng	Fundholding – Impact of GP financial incentives on monitoring quality of care and	*Design* Quantitative	The policy of GP fundholding exerted downward pressure on secondary care admissions for elective surgery. The effect of removing financial incentives	These results strongly suggest that gatekeeping physicians' admission thresholds do

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incentives on gatekeeping doctors: evidence from a natural experiment. Journal of Health Economics, 25(3), 449-478.		cost containment	*Data collection methods* Data drawn from Hospital Episodes Statistics for admissions, General Medical Statistics for practice characteristics and the database assembled for the AREA project (Sutton et al., 2002) for socio-economic characteristics and provider characteristics. *Sample* English General Practices *Research questions* How has the abolition of fundholding financial incentives impacted hospital admission rates?	of holding a budget was to increase chargeable elective admissions amongst the pre-fundholding practices by 3.5–5.1%. This effect was greater on the early wave fund holders (around 8%) than on later wave fund holders. Differences in differences (DID) estimation for two types of admissions (non-chargeable electives, emergencies) not covered by fundholding were calculated as additional controls for unobserved temporal factors. Using DID estimates, data suggested that the abolition of fundholding increased ex-fund holders' chargeable elective admissions by 4.9% (using the non-chargeable DID) and by 3.5% (using the emergencies DID).	respond to financial incentives. Given the importance of gatekeeping in many countries and, in particular, the similarity of the physician incentives under fundholding with those for physicians under capitation contracts with managed care organisations, our findings are also relevant for other health care systems.
Elvey R., Bradley, F., AshcroftD. & Noyce P. (2006).: Commissioning services and the new community pharmacy contract: (1) Pharmaceutical needs assessments and uptake of new contracts. *Pharmaceutical J* 2007; 277: 161-163)	England	Commissioning: new pharmacy contracts	*Methods* As per Bradley et al (2006) above *Research questions* To identify and describe pharmaceutical needs assessment (PNA) activity & the awarding of new pharmacy contracts in PCTs	*Processes* 90% of PCTs had completed PNA & 85% of these had used one or more resources to assist with the PNA process Local community pharmacists were engaged in the process in most PCTs (92%) Most PCTs (90%) had analysed the PNA results & those who had undertaken the PNA earlier were more likely to have used the results when commissioning services.	Local needs assessment important to PCTs when planning & commission pharmacy services Needs assessments take time to do and translate into action and plans
Freeman and Peck. Evaluating partnerships: a case study of integrated specialist mental health services. *Health and Social Care in the Community*. 2006; 14(4): 408-417	England	Joint commissioning mental health services by 8 Hertfordshire PCTs and the County Council.	*Design* Impact of partnership working integrated specialist mental health provision. *Sample* Semi structured interviews, self-complete questionnaires and focus groups of users, carers, service managers, and front line staff. *Research questions* What is the impact of partnership working in integrated specialist	*Effective (containing system costs)* Little effect on *Improving patient outcomes* *Ensuring sustainability of model* *Service use* *Satisfaction* Improved support from team and work satisfaction. However may be lack of continuity. *Processes*	Attributing improved outcomes to partnerships is difficult.

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			mental health provision on role clarity, job satisfaction, fragmentation and integration, teamwork	Improved role clarity	
Goldman. Joint Financing across health and social care: money matters but outcomes matter more. Journal of Integrated Care 2010; 18(1): 3-10	England	Joint Commissioning between NHS bodies and councils	*Design* Survey of Audit Commissions for PCTs; eight workshops in local areas involving participants from executive and director levels; semi structured interviews with two councils, one PCT and one mental health trust; review of documents, expenditure and activity data; seminar with 16 organisations. *Sample* PCTs, councils and mental health services in England. *Research questions:* What is their experience and what is the impact of joint commissioning on value for money and service user experience	*Effective (containing system costs)* Unable to quantify how it has contributed better value for money or improved outcomes for users. *Improving patient outcomes* *Ensuring sustainability of model* *Service use* No change in length of stay, hospital admission, delays in transfers of care *Satisfaction* *Processes* Joint financing represented only 3.4% of total health and social spend but often "pooling" is really aligned budgets.	Need more evidence of outcomes.
Gridley, K; Spiers, G; Aspinal, F; Bernard, S; et al (2012) Can general practitioner commissioning deliver equity and excellence? Evidence from two studies of service improvement in the English NHS. J Health Serv Res Policy 17 (2) 87-93	Eng	PCTs CCGs	*Design* Qualitative (2008-09) *Data collection methods* Interviews *Sample* *10 PCTs: 187 professionals; 99 people affected by services* *Research questions* Explore key assumptions underpinning the development of GP-led commissioning. Part of broader study on evaluation of NSF for long-term	*Processes* PCTs not sufficiently powerful to guide or change patterns of service provision (as per NSFs) without support of performance managed targets. Where there were objectives underpinned by targets & financial incentives (payment by results), changes were seen. GPs do not always have a pivotal role for all patients (e.g. services for people with long term conditions), where care coordination was the job of a specialist team/nurse (not affiliated with a general practice. With children with long term &chronic conditions, GPs took a back seat ongoing care coordination role	Concern that CCGs will not be subject to top-down performance management, with implications for how agreed quality standards will be met. GP-commissioning could lead to greater not reduced disparity in service quality

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			neurological conditions; and a study of health care closer to home for children with a range of conditions.		
Hussey P, Ridgely S, and Rosenthal M. The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems In Implementing New Payment Models Health Affairs, 30, no.11 (2011):2116-2124	USA	'Bundled payment' model – In particular, evaluation of the "Prometheus Payment' Initiative in the US (Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle Reduction, Excellence, Understandability, and Sustainability)	*Design* Qualitative *Data collection methods* Telephone interviews Two site visits in which interviews (*N*=36) were conducted *Sample* Representatives of an employer coalition, health plan administrators, hospital administrators, medical staff management, frontline physicians, and health informatics and quality improvement staff. All participants were involved in the 'road test' of Prometheus across three pilot sites. *Research questions* Can the Prometheus Model be implemented under real-world conditions? What factors might contribute to its success or failure?	The PROMETHEUS road test encountered major challenges, and none of the pilot sites had made bundled payments as of May 2011. Challenges PROMETHEUS builds on fee-for-service claims infrastructure and thus adds to the complexity of existing payment systems. Modifying complex insurance claims processing procedures to identify services that are part of a bundle. Difficulty in changing member benefits only for patients identified as clinically eligible for bundled services and attributed to a participating provider organization. Communication issues - language used in Prometheus is largely oriented toward broad conceptual categories, whereas physicians are accustomed to thinking in terms of specific, concrete cases. Difficulty identifying patients eligible for benefits using Prometheus terminology. Executing contracts is difficult because of the number and complexity of considerations involved, including the market power—or lack thereof—of individual payers and providers in their own health care markets.	Bundled payment is complex and must build on existing complex health care systems. Despite numerous challenges in implementing Prometheus, participants continued to see promise and value in the bundled payment model. However, the desired benefits of this and other payment reforms may take time and considerable effort to materialize.
Kennington E, Shepherd E, Evans D, Duggan C. Benefits of healthy living pharmacies for commissioner and contractor / employer. International Journal of Pharmacy Practice. 2013;21:122.	Eng	Healthy Living Pharmacy (HLP) HLP is a tiered commissioning approach that aims to deliver health services through community pharmacies.	*Design* Mixed methods *Data collection methods* Commissioners' responses taken from Pathfinder area reports free text entries. Short online survey to gather contractor/employer views.	*Effective (containing system costs)* No hard data available on the impact of HLP on income. However, commissioners viewed HLP scheme as an effective model with which to deliver increased volume, quality and reliability of community health services. *Improving patient outcomes* As above, commissioners viewed HLP scheme as an	HLP has acted as a catalyst to help develop and improve working relationships between commissioners and providers. Services have been commissioned or further extended as a result of pharmacies having HLP status, demonstrating that commissioners have confidence

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			Sample Commissioners (*N*=14) Contractor/employer survey (*N*=153) – 38% response rate *Research questions* What are the benefits of the HLP scheme to commissioners, contractors and employers?	effective model with which to deliver increased volume, quality and reliability of community health services. In addition, public health teams perceived HLP as beneficial to improving community health outcomes. *Ensuring sustainability of model* Nil *Service use* Take-up on HLP schemes has risen and increased service activity (61.8%) in participating pharmacies. *Satisfaction* Authors surmise that increases in up-take of HLP is indicative of public satisfaction with the model. In addition, 70.6% of contractors/employers agreed that becoming an HLP had been worthwhile from a business perspective and 91.5% felt it was beneficial from a staff development perspective.	in the outcomes of services.
Ly DP, Glied SA. The impact of managed care contracting on physicians. Journal of General Internal Medicine. 2014;29(1):237-42.	USA	Impact of managed care contracting among physicians	*Design* Quantitative *Data collection methods* Secondary data analyses on the nationally representative Community Tracking Study Physician Survey (1996–2005) *Sample* 36,340 physicians (21,567 PCPs [primary care physicians] and 14,773 specialists *Research questions* How do physician practice outcomes vary with the number of managed care contracts held or the availability of such contracts?	*Effective (containing system costs)* For specialists, increases in the number of contracts are associated with increases in income. Moving from a practice with only one contract to the average practice with 12 contracts is associated with about a 3%, statistically significant, increase in physician income per year. For PCPs increases in the number of contracts is related to insignificant increases in income. *Improving patient outcomes* Not specifically measured. However, greater number of contracts are associated with about 30 more min spent by PCPs in direct patient care and 20 more min spent by specialists in direct patient care. *Ensuring sustainability of model* Nil *Service use* The median practice contracted with eight plans – but 19 % of practices that participated in at least one managed care plan had fewer than five contracts and	Contracting opportunities confer significant benefits on physicians, although they do add modest costs in terms of time spent outside patient care and lower adequacy of time with patients. Simplifications that reduce the administrative burden of contracting may improve care by optimizing allocation of physician effort.

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				12 % of such practices had more than 20. The average number of reported managed care contracts held by a practice was 12. *Satisfaction* Participating in additional contracts did not have a significant effect on physician satisfaction. For PCPs only, each additional contract was associated with of reporting very low adequate time with patients.	
Marks L, Cave S, Hunter D, Mason J, Peckham S, Wallace A. Governance for health and wellbeing in the English NHS. Journal of Health Services & Research Policy. 2011;16 Suppl 1:14-21.	Eng	Commissioning role of PCTs for populations	*Design* Qualitative *Data collection methods* Semi-structured interviews and an online survey	8 PCTs said partnerships are required to fulfil the stewardship role; 7 said public is involved in local health needs assessment and five said public is involved in priority setting. 10 PCTs said leadership/commitment of board and of executive directors to the health of the population and to addressing health inequities would enable prioritizing prevention. Author comment: Public health commissioners are likely to have multiple objectives such as concern for the distribution of health benefits across the population (equity issues), representation of local user views, and balancing long- and shorter term health gains. They therefore need to combine public health intelligence with decision-support methods relevant for public health priority setting. 8 PCTs said that corporate governance/performance management should be aligned to strategic priorities 6 said there should be accountability for achieving return on investment for population health and 2 said awareness of opportunity cost is required 1 said applying the principle of social equity is needed. 10 PCTs said that outliers in cost and outcomes should be identified through benchmarking using national data, 9 said services need to be redesigned to release efficiencies within and across pathways of care, others had disinvestment strategies in place or planned, scenario modelling, while a few used PBMA/decision conferencing to assess opportunity costs (PBMA: Program Budgeting and Marginal Analysis)	There is complexity in the governance structures currently in operation and contradictions in relation to commissioning preventive health services arise. The stewardship role is changing and is sometimes narrowly defined; an emphasis on governance as meeting targets and performance management impacts PCT capacity to work jointly with stakeholders on health and wellbeing commissioning; incentive schemes for preventive health care are still only optional extras; contextually relevant prioritization tools still needed to make decisions about strategic preventive health services. Shifts towards local priorities and increased public accountability co-exist within hierarchical forms of governance. It will be important to ensure that future changes to British health care are critically assessed and realigned to promote preventive services which are key for the longer term sustainability of the

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					NHS. Leadership will be needed to negotiate the complexities of the governance structures currently in place, and re-emphasise the strategic importance of preventive health.
McCafferty S, Williams I, Hunter D, Robinson S, Donaldson C, Bate A. Implementing world class commissioning competencies. Journal of health services research & policy. 2012;17(suppl 1):40-8.			*Design* Qual *Data collection methods* *Sample* PCT commissioners, PBC representatives, PCT non-executive directors and Strategic Health Authority Staff, acute trust staff and patient groups. *Research questions* Explore development &implementation of world class commissioning	*Satisfaction* Partnership working with providers, was perceived as being impossible by respondents due to a) a perceived imbalance of power between the PCT and acute providers, b) differing objectives, c) providers in competition with one another. There was a perceived skills gap between GPs and the PCT with regard to commissioning, with the PCT skills, experience and capability in commissioning not available or resourced within PBC groups. The organization of health care was highly politicized and thus beyond the control of the PCT. Challenges included: perverse political incentives; constant change; and policy misalignment. Continual change was seen to impact negatively on PCTs' ability to maintain and sustain focus and momentum in commissioning; a lack of leadership and the loss of tacit knowledge in building and maintaining 'organizational memory' around commissioning.	
McLeod, H., Blissett, D., Wyatt, S., & Mohammed, M. A. (2015). Effect of Pay-For-Outcomes and Encouraging New Providers on National Health Service Smoking Cessation Services in England: A Cluster Controlled Study. PLOS ON 10(4):1-15	England	Commissioners adopted novel 'any qualified provider' regulations, which allowed any provider to deliver services that met specified criteria, including adhering to NHS service quality requirements and accepting new payment, contractual and reporting obligations. Providers were paid for quits achieved (4 and 12 weeks) whilst encouraging new market entrants.	*Design* Cluster controlled RCT *Data collection methods* Published PCT data on stop smoking services for 2009/10-2012/13 (provider level data) *Sample* 8 intervention PCTs, 64 matched control PCTs. *Outcome measures* Changes in quit at 4 weeks. Number of new market entrants within the group of 2 largest providers at PCT level.	*Improving patient outcomes* There was a statistically significant increase in the number of four-week quits per 1,000 adult population in the intervention PCTs compared to the control PCTs (9.6% increase in the intervention PCTs compared to 1.1% decrease in the control PCTs per year). *Processes* The largest 10 providers in the intervention accounted for 84% of the four-week quits, and three of these providers were new market entrants.	Although provision was dominated by existing NHS community services providers, the finding that a new entrant generated most quits in two of the eight intervention PCTs suggests that provider diversity has been promoted.

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			Research questions Examine impact of pay-for-outcomes on new market entrant providers.		
Naylor C, Goodwin N. The use of external consultants by NHS commissioners in England: what lessons can be drawn for GP commissioning? Journal of Health Services & Research Policy. 2011;16(3):153-60.	Eng	Assesses how commissioners in the NHS use external support, the impact of external support, and factors that influence effectiveness of external support in commissioning of health services by PCTs. External support is defined as short-term consultancy projects of an essential advisory capacity, longer-term partnership arrangements in which internal and external teams share commissioning responsibilities (and in some cases related financial risk), and outsourcing	*Design* Qualitative field work supported by quantitative analysis. *Data collection methods* Baseline survey of PCTs (*N*=96) In-depth interviews (*N*=10) and focus groups (*N*=11) at 3 case sites Follow up survey of PCTs (*N*=76) *Sample* Baseline and follow up survey sent to PCT Managers Interviews and focus groups with members of the senior management team and commissioners, as well as support staff. Also included 10 of the organizations approved to supply services through the FESC framework, and two other companies. *Research questions* How do commissioners in the NHS use external support? What impact is this perceived to have on commissioning activities? What factors influence the effectiveness of support?	*Effective (containing system costs)* A number of factors impacted the effectiveness 7 cost effectiveness of support services: (1) clarity of purpose, (2) procurement processes, (3) working relations btw PCT & service provider, (4) client characteristics (i.e., work culture, managerial capacity), (5) consultant characteristics, (6) using support appropriately (i.e., tapping into skills & expertise of support organisation fully). *Improving patient outcomes* Nil *Ensuring sustainability of model* Nil *Service use* In 2009 (Baseline) 77% of PCTs had used external support for commissioning (defined as any service purchased in support of the commissioning function). In 2010 (follow up) this had risen to 89%. World class commissioning was a major driver prompting commissioners to seek external support, with 54% percent using external consultants to help prepare for the world class commissioning assurance process. There were several areas in which external support was perceived to have been particularly useful: data analysis; managing contracts & provider relationships; engaging clinicians in commissioning; organisational transformation. *Satisfaction* The majority of respondents indicated that external support achieved its goals either completely or partially: 87% in 2009(Baseline); 79% in 2010 (Follow up). On most occasions the service received was rated as 'excellent' or 'good' overall. Interviews revealed more mixed experiences with external	External support can play a role in improving the quality of commissioning in a publicly-funded health system However, it is clear that while external support is now widely used in the NHS it is not always used effectively. The nature of external support, sources from which it is drawn and type of support offered are likely to change significantly in the move to GP-led commissioning. GP commissioners will need considerable guidance in using external support successfully.

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				support. *Processes* The processes related to seeking external support were not specifically detailed. However, limitations to effective support highlighted the fact that commissioners sometimes struggled to identify their needs and access appropriate support to address them during the procurement process. They also experienced difficulties associated with poor working relationships once support has been procured during the roll-out process. Processes related to securing support and utilising this effectively need to be closely considered.	
Newton JT, Alexandrou B, Bate BD, Best H. A qualitative analysis of the planning, implementation and management of a PDS scheme: Lessons for local commissioning of dental services. British Dental J. 2006; 200: 625-630	Eng	Capitation-based funding of personal dental services. Scheme included rewards for quality rather than quantity of care Increase uptake of children, improve quality, integration and control escalating costs Prevention and treatment of dental problems Activity and population reach	*Design* Qualitative *Data collection methods*: Interviews *Sample* 3 PCTs; 29 participants (PCTs, dental teams & other key informants) *Research questions* To identify the experiences of the planning, implementation & management of a personal dental services scheme (PDSS)	*Service use* Not known whether PDS was meeting local needs. Practitioners' perception that they delivered more & higher quality preventive care (related to additional time they could spend with patients re health education) *Satisfaction* Positive provider experiences re increase in the quality of care, more professional management approach. *Processes* Significant differences in perceptions of PCTs and dental practitioners. Little quality benchmarking which would have allowed for robust measure of success.	For local commissioning: needs to identify mechanisms for ensuring effective planning, management and evaluation of the impact of schemes. The disparate views of practitioners and PCTs highlights the challenge for local commissioners in drawing together these differing views.
Perkins, N., Coleman, A., Wright, M., Gadsby, E., McDermott, I., Petsoulas, C., & Checkland, K. (2014). The 'added value' GPs bring to commissioning: a qualitative study in primary care. The British journal of general practice: the journal of the Royal College of General Practitioners, 64(628), e728-	Eng	CCGs	*Design* Qualitative (Sept 2013) *Data collection methods* Interviews *Sample* 7 CCGs. 40 clinicians & managers. *Research questions* 1. Explore key assumptions underpinning CCGs 2. Examine the claim that GPs	*Processes* Claims of 'added value' centred on GPs detailed & concrete knowledge of their patients which improves service design. Close working relationship between GPs and managers strengthens manger's ability to negotiate. Concerns expressed about the large workload both groups faced & difficulty in engaging the wider body of GPs	Will CCGs be any better at supporting & enabling effective use of GP knowledge than previous initiatives. Concerns about representativeness & extent to which other perspectives are considered Including systematic public health intelligence.

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e734.			bring 'added value' to commissioning		
Petsoulas C, Allen P, Checkland K, Coleman A, Segar J, Peckham S, et al. Views of NHS commissioners on commissioning support provision. Evidence from a qualitative study examining the early development of clinical commissioning groups in England. BMJ Open. 2014;4(10):e005970.	Eng	Clinical Commissioning Groups	*Methods:* As per Checkland et al (2013) above *Research questions* Exploration of attitudes of CCGs towards outsourcing commissioning support functions during the initial state of reform	*Processes* Many CCGs reluctant to outsource core commissioning support functions (e.g. contracting): risk of fragmentation of services & loss of trusted relationships & local knowledge. Others were disappointed by the absence of choice and saw CSUs as monopolies. Many participants were at ease with outsourcing transactional commissioning functions, (e.g. business intelligence and data management. Doubts expressed that outsourcing of commissioning support functions will result in lower administrative costs. Some keen to keep vital CS functions in-house, and share support personnel across CCGs thereby reducing their overall management costs.	
Robinson, S., Williams, I., Dickinson, H., Freeman, T., & Rumbold, B. (2012). Priority-setting and rationing in healthcare: Evidence from the English experience. *Social Science & Medicine, 75*, 2386-2393.	Eng	Priority-setting activity in PCTs	*Design* Qualitative (case study) *Data collection methods* Documentary analysis, interviews with priority-setters and overt non-participant observation of priority setting boards. *Sample* Documentary information relating to priority-setting activity; senior management teams & wider stakeholder groups from five PCT sites. *Research questions* What current priority-setting arrangements and processes are in place? What is the impact and effectiveness of these arrangements and processes; What are the implications for	*Effective (containing system costs)* Priority-setting was viewed as fundamental to delivering cost effective, high quality services. Within the context of government financial stringency and pressure on PCTs to reduce costs, priority-setting was viewed as a way to meet budget targets (e.g., a focus on disinvestment). In addition, the World Class Commissioning (WCC) programme provided a strong motivation for PCTs to examine their priority-setting processes (Department of Health, 2007). The WCC assessment criteria aims to increase transparency, efficiency and quality of services. Further, the Quality Innovation Productivity and Prevention (QIPP) agenda (Department of Health, 2010c) also served to draw attention to efficiency and quality. *Improving patient outcomes* Focus in priority-setting was more on budgetary considerations than explicitly on patient outcomes. *Service use* A wide range of stakeholders were involved in priority-setting activities in each of the sites, including: local authority professionals and representatives; local councillors; health organisations such as primary care providers, acute	To be effective as a management tool, priority setting needs to be central to local planning activity, rather than being treated as a bolt-on mechanism for allocating spare funds. It is yet to be seen whether priority-setting can form a central part of health service investment and disinvestment arrangements either in the English NHS or elsewhere. However this study suggests that a well-resourced and designed priority-setting function can help to make contentious decisions more palatable and defensible for those involved.

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			future priority-setting both in England and other healthcare systems.	providers, voluntary sector and mental health providers; practice based commissioning groups, and; GPs. However, the levels of such involvement varied between sites. There was limited engagement of citizens in decision-making. *Satisfaction* All sites noted the difficulties in engaging the acute sector in priority-setting. Even in the two sites where there was engagement and signs of fairly strong partnerships (between the acute and commissioners), the power of the hospital sector and differences in culture, focus and strategy made priority-setting a challenge. *Processes* Decision-making processes which involved the use of priority setting aids (such as MCDA and business proposal templates) tended to be more explicitly supported by evidence for example via either individual or collective scoring of investment proposals. Explicit priority-setting tools helped to provide a structured setting for deliberation and coalition-building, thereby facilitating the decision-making process rather than algorithmically deriving the 'answer'.	
Robinson S, Williams I, Freeman T, Rumbold B, Williams I. (2012) Structures and processes for priority-setting by health-care funders: a national survey of primary care trusts in England. Journal of Health Services Management 2012:5(3)133-20	Eng	Priority setting	A national survey of Directors of Commissioning in English Primary Care Trusts (PCTs). The survey was designed to provide a picture of the types of priority-setting activities and techniques that are in place and offer some assessment of their perceived effectiveness.. A	There is variation in the scale, aims and methods of priority-setting functions across PCTs. A perceived strength of priority-setting processes is in relation to the use of particular tools and/or development of formal processes that are felt to increase transparency. Perceived weaknesses tended to lie in the inability to sufficiently engage with a range of stakeholders	Although a number of formal priority-setting processes have been developed, there are a series of remaining challenges such as ensuring priority-setting goes beyond the margins and is embedded in budget management, and the development of disinvestment as well as investment strategies. Fostering a more inclusive and transparent process will be required.
Rooshenas, L., Owen-Smith, A., Donovan, J., & Hollingworth, W. (2013). Saving money in the NHS: a qualitative investigation of disinvestment practices, and	England	Disinvestment practices of CCGs	*Design* Qualitative ethnographic *Data collection methods* Observations of routine meetings Interviews	*Processes* Few examples of active disinvestment decisions, with agendas dominated by requests for new health-care provision. Challenges in identifying opportunities for disinvestment, with previous approaches being	Need for sustainable methods to guide local disinvestment practices. Disinvestment needs to be a collaborative effort, which includes health-care providers in the decision-making process.

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barriers to change. The Lancet, 382(S3).			*Sample* 2 NHS decision-making groups (PCTs, public health, CCGs,2ary care providers. *Research questions* 1. To investigate how local decision-makers recognise and negotiate opportunities for disinvestment 2. Identify barriers to implementation of disinvestment decisions	unsystematic and unsustainable. A lack of capacity, methods, and training were identified. Differences in how commissioners and providers understood & portrayed disinvestment, contributing to poor collaboration. Lack of provider input into previous disinvestment initiatives which they felt compromised the clinical validity and acceptability of decisions. All groups perceived a lack of central support for developing the disinvestment agenda.	
Salmon et al. A collaborative accountable care model in three practices showed promising results on costs and quality of care. Health Affairs 2012; 31(100): 2379-2387	USA	Accountable Care Organisation	*Design* Case study *Sample* Three practices in different states. *Research questions* What facilitated or impeded care quality and cost saving?	*Effective (containing system costs)* Reduced medical costs ($27 per patient per month) *Improving patient outcomes* Improved quality of care and intermediate outcomes.	*What helped:* Imbedded care coordinator. Clinical resources – e.g. coaching, pharmacy consultation, case management. Capitation model (full risk) for many patients, pay for performance, feedback of performance data in a "patient dashboard" to clinicians. *Barriers* Preferred provider arrangements for referral services that limited patient and primary care provider choice. Lack of integration between primary care and speciality providers and services. Lack of funding for IT and care coordination infrastructure.
Shaw SE, Smith JA, Porter A, et al. The work of commissioning: a multisite case study of healthcare commissioning in England's NHS. BMJ Open 2013;3: e003341.	Eng	Commissioning health services for populations with chronic conditions. Commissioning cycle included assessment of local health needs, coordination of healthcare planning and service specification, reviewing and	*Design* Qualitative - Multisite mixed methods case study. *Data collection methods*: Interviews, documents and observation of meetings.	*Process* Commissioning services was a long term process involving a range of activities and partners. Only some activities were aligned with commissioning cycle. Additional activities included service review & redesign, supporting implementation of new services.	Commissioning for long term condition services challenges distinction between commissioners and providers. Significant redesign work required as a partnership approach. Such work is labour intensive

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		redesigning services and providing support for implementation of new services. These activities largely separate from contracting and financial negotiations. Commissioning activities reviewed as part of primary care trust (PCT) model & prior to CCG model implementation in the UK.	*Sample* 3 "commissioning communities" (covered by a single PCT): managers and clinicians, general practice-based commissioners, NHS trust and foundation trust senior managers and clinicians, voluntary sector and local government representatives. *Research questions* (1)What is involved in commissioning chronic condition services? (2)What factors inhibit or facilitate commissioners in making service change?	Processes involved partnership working, largely divorced from contract/financial negotiations. For long term services the time & effort involved was disproportionate to anticipated/likely service gains. Incremental vs large scale change appeared more successful (i.e. in delivering planned changes).	&potentially unsustainable in times of reduced finances. Need to balance relational and transactional elements
Sheaff R et al. How managed a market? Modes of Commissioning in England and Germany. BMC Health Services Research 2013; 13 (Supp1): S8	England & Germany	Contrasts two basic generic modes of commissioning	Systematic case studies using systematic observation and comparison *Research Question:* How can commissioning be used for exercising governance over health-care providers in a quasi-market?	Surrogate planning (English NHS), in which a negotiated order involving micro-commissioning, provider competition, financial incentives and penalties are the dominant media of commissioner power over providers. Case-mix commissioning (Germany), in which managerial performance, an 'episode based' negotiated order and juridical controls appear the dominant media of commissioner power	Governments do not necessarily maximise commissioners' power over providers by implementing as many media of power as possible because these media interact, some complementing and others inhibiting each other. In particular, patient choice of provider inhibits commissioners' use of provider competition as a means of control.
Slater B, White J. Practice-based commissioning: learning from a development programme. Journal of Integrated Care. 2007;15(2):13-25.	England	Learnings on implementation of PBC	Audit of service redesign initiatives in the first six months at PBC 27 sites.	Some early successes in referral management and service redesign were observed. Implementation barriers related to fear among PCTs of loss of power and loss of income were observed.	Enablers were payment by results and the levels of interest and engagement among practices.
Song. Z. Accountable Care Organizations in the U.S. Health Care System. *J Clin Outcomes Manag.* 2014;21(8):364-71.	USA	Review of evaluations of Accountable Care Organisations	Synthesis of evaluation findings.	Evidence points to the potential of ACOs to slow spending and improve quality, but also the significant obstacles that they face.	One encouraging lesson is that quality of care need not be threatened by a contract that rewards savings, provided that meaningful incentives for quality are in place.
Turner D, Salway S, Mir G,	Eng	Views on CCG commissioning	*Design*	*Processes*	Agreed need to improve on the

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Ellison GT, Skinner J, Carter L, et al. Prospects for progress on health inequalities in England in the post-primary care trust era: professional views on challenges, risks and opportunities. *BMC Public Health*. 2013;13:274.		versus PCT commissioning	Qualitative *Data collection methods* Semi structured interviews *Sample* Purposive sampling and snowballing used to identify 42 individuals involved with health and social commissioning at either national or local level. Interviewees included representatives from the Department of Health, Primary Care Trusts (PCTs), Strategic Health Authorities, Local Authorities, and third sector organisations *Research questions* (1)professional background and experiences; (2)commissioning structures, networks and processes; (3)commissioning impact; (4)role of evidence and knowledge in commissioning; (5)barriers and opportunities for improved commissioning to address inequalities; (6)implications of new commissioning arrangements for such work.	Concern that GP-led commissioning will not achieve measurable improvements in health inequalities any more than the PCT era, particularly in a time of reduced spending. Specific concerns centred on: reduced commitment to a health inequalities agenda; inadequate skills and loss of expertise; and weakened partnership working and engagement. On a positive side, there could be greater accountability of health care commissioners to the public and more influential needs assessments via emergent Health and Wellbeing Boards in the context of the CCG commissioning, leading to more equitable health outcomes. On the other hand, key actors expect the contribution from commissioning to address health inequities to become more piecemeal in the CCG context, as it will be dependent upon the interest and agency of particular individuals within the CCGs to engage and influence a wider range of stakeholders.	PCT-led era of commissioning as far as a health inequalities agenda is concerned. General pessimism about whether the move to CCG-led commissioning would improve health inequalities given the primary care focus of GPs and their relative inexperience with commissioning. A general feeling that GPs would need to shift focus from the immediate concerns of the people they see in practice, to a broader public health view, in order to meet the needs of under-represented groups. The decision to fund CCGs on the basis of age of population, rather than level of deprivation, may constrain CCG capacity to address health inequalities. However, hopes for greater accountability of commissioners to local communities via the Health & Wellbeing Boards (HWBBs), as well as stronger Joint Strategic Needs Assessments (JSNAs) and more coordinated work to address wider social and economic determinants resulting from public health's move to Local Authorities.
Tynkkynen LK, Lehto J, Miettinen S. Framing the decision to contract out elderly care and primary health care services - perspectives of local level	Finland	Mainly concerned with municipal government contracting of health and elderly care services. Other aspects of commissioning (aside from purchasing) are not	*Design* Qualitative *Data collection & analysis methods* Group and individual interviews	*Effective (containing system costs)* Contracting services was viewed as a rational, cost effective measure for ensuring quality health and elderly care services in Finland. *Improving patient outcomes*	Decisions about contracting are often wrapped up in 'rational' argument and seem free from and free from political, ideological or other exogenous influences. However, ideological and political

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politicians and civil servants in Finland. BMC Health Services Research. 2012;12:201.		considered.	*Frame analysis* (Goffman, 1974) used to identify decision-making frameworks *Sample* Civil servants and elected officials from six municipalities *Research questions* What is the underlying argumentation for contracting health ad elderly care services to private and third party providers?	The focus on patient outcomes was not a strong rationale for contracting services. While 'good for the local people' was one rationale put forward, the focus was more on diversity of choice for consumers and provision of services into the future. *Ensuring sustainability of model* Municipalities focused on delivering what they viewed as 'core services'. In general, contracting with private providers was viewed as a 'sustainable' way to deliver additional, non-core health services into the future. The specific contracting models used by municipalities were not directly assessed. *Processes* Contracting with the private sector was viewed mostly as a means to improve the performance of public providers, to improve service quality and efficiency and to boost the local economy. Competition and consumer choice (i.e., purchasing options) was reported as potentially endangering the affordability of the services (out of pocket expenses) Concern that too much diversity in providers could result in fragmentation, inefficiencies and extra costs; and that there was also a risk of local monopolies & and removing small local providers from the market. Measures to monitor the quality of care were viewed as fairly poor.	preferences are also present. Decisions about contracting are mostly grounded in what is 'good for the municipality' (cost effective, job outcomes, tax offsets), rather than what is 'good for the people'. The current rationales for contacting out health and elderly care services may be undermining the integrity of the 'welfare state' in Finland.
Vergel YB, Ferguson B. Difficult commissioning choices: lessons from English primary care trusts. Journal of health services research & policy. 2006;11(3):150-4.	Eng		*Data collection methods* Analysis of relevant PCT rationing policy documents (2003) Survey (interviews) of 25 PCTs from 2 regional SHAs *Sample* 14 documents *Research questions* Describe recent local developments on prioritisation decision-making The study compared priority	*Processes* Rationing by exclusion was the most common approach for setting priorities. Involved identification of 'low-priority' services which are excluded from agreements (all or except for exceptional cases), by most policies failed to make the rationale for decisions accessible , apart from vague references to clinical effectiveness Public participation in production of rationing polices was relatively limited. Some PCTs had engaged in a formal process to support evidence-based commissioning & integration of NICE guidance with local decision-	Adopting AFR as a prioritization framework can serve to improve the fairness and consistency of the decision-making process, reducing the vulnerability of PCTs to legal challenge. Characteristics of rationing policies already in place fulfil some of the AFR conditions but there remains scope for further improvements in their design and dissemination.

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			setting by PCTs with the ethical framework of 'accountability for reasonableness' (AFR).	making. Appeals process varied re aims and panel composition. The level of dissemination both of rationing policies and the patients' right to appeal was relatively modest. PCTs primarily relied on GPs and consultants to provide information about patients' options and rights regarding rationing policies implemented by the PCT.	
Wilson E, Sussex J, Macleod C, Fordham R. Prioritizing health technologies in a Primary Care Trust. *Journal of Health Services Research & Policy.* 2007;12(2):80-5.	England	Use of a Program Budgeting & Marginal Analysis (PBMA) tool in PCTs	Pilot of a Program Budgeting & Marginal Analysis (PBMA)	Using a Program Budgeting & Marginal Analysis (PBMA) tool can help prioritization and understand the opportunity costs of purchasing decisions	The method appears to be a practical approach to prioritization for commissioners of health care, but the pilot also revealed divergences in relative priority between nationally mandated service developments and local health-care priorities.