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Schools' relationship with local authorities: lessons from the
decentralisation of healthcare commissioning

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Schools' relationship with local authorities: lessons from the decentralisation of healthcare commissioning

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Institute for Fiscal Studies

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Executive Summary

- With the rapid expansion of the academies programme and planned reforms to schools funding, local authorities may play a smaller role in the provision and commissioning of school services over the next few years. In contrast, schools themselves seem likely to take on new roles and responsibilities for commissioning specific services. Given the long and rich history of devolving similar commissioning responsibilities in the NHS, this report aims to draw out the valuable lessons from this experience for schools policymakers. We also present complementary empirical analyses of schools data to show the current level of spending on services by local authorities and the use of operational and clerical staff by schools themselves.
- Under proposed reforms to school funding, a number of services currently provided by local authorities would be transferred to schools. Other services would be transferred to schools at the discretion of school forums and some would be retained by local authorities. Spending on services proposed to be delegated to all maintained schools currently represents only about 1% of local authorities' schools budgets, and does not vary significantly across local authorities. In contrast, the level of spending proposed to be left at the discretion of school forums is relatively large and varies significantly across local authorities. Under the proposed reforms, local authorities will still retain a small amount to spend on central services (largely to support school admissions processes, and contributions to combined budgets). They will also retain spending on high-needs pupils, which also varies significantly across local authorities.
- Spending on such services tends to be higher for secondary schools than for primary schools. The variation in spending by local authorities partly

reflects differences in levels of special educational needs and use of special schools. Local authorities that are more deprived also retain greater levels of spending for services provided centrally. However, we also observe that larger local authorities (in terms of total pupil numbers) tend to spend less per pupil on services for high needs pupils. There is little variation according to measures of sparsity.

- We find clear differences in the scope of schools to take advantage of potential commissioning responsibilities, as proxied by their current level of operational and clerical support staff – defined as all staff who are not teachers or teaching assistants. In particular, secondary schools currently make more use of operational and clerical support staff than do primary schools with similar numbers of pupils, which seems highly likely to reflect the fact that secondary schools are responsible for providing more services at present. If primary schools are to make best use of new commissioning responsibilities, they may either need to employ greater numbers of operational and clerical support staff, or form collaborations, chains or partnerships to commission services across schools.
- Further analysis of the relationships between employment of operational and clerical support staff and school characteristics reveals that schools with higher levels of deprivation or SEN tend to employ more of such staff than other schools. Meanwhile, secondary schools in inner London tend to employ fewer such staff than comparable secondary schools in the rest of England.
- There is a wide theoretical literature on whether public services should be provided at the central or local level, and the key characteristics that suggest whether public services are best provided locally or centrally. Local information held at lower tiers of a hierarchy can lead to more efficient and effective provision of public services. However, this has to be traded off by the fact that the incentives at these lower levels may not lead to better outcomes for consumers of these services and that they may not be sufficiently accountable to consumers.
- Commissioning of healthcare at the GP level has, under different guises, been a major component of NHS reform since 1991. The main theoretical rationale has been that decentralising commissioning allows GPs to make better choices of care for their patients than more centralised authorities. Another motivation has been to control the growing costs of healthcare.
- There are some clear and general recommendations for effective implementation from the experience of commissioning in healthcare. ‘Getting commissioners’ incentives right’ is crucial in order to ensure that the decentralisation of commissioning and competition does not result in

lower quality services. This is less likely to occur when commissioners are well informed about the quality of services on offer, when they cannot use budget surpluses to increase salaries and when they are accountable to the ultimate consumers (pupils or patients) for the quality of services they purchase. If they are not well informed about the quality of services on offer, then there may be a need to regulate prices in order to ensure that quality is not reduced, as has occurred with the commissioning of healthcare services.

- It is important for commissioners to have specialist knowledge of their service area and to develop good management and commissioning skills, otherwise they will not make best use of the “local information” which can improve services. This may well take resources, and importantly, time for commissioners to mature. However, developing strong accountability to parents can support such a reform.

1. Introduction

Local authorities seem likely to play a smaller role in the provision of schooling over the next few years. This partly results from the continued, rapid expansion of the Academies programme, as well as proposals for maintained schools to take greater financial responsibilities (for instance, in the July 2011 consultation on school funding). Schools themselves seem likely to take on new roles and responsibilities in terms of commissioning services, either on their own or in collaboration with other schools as part of a chain, consortium or federation. In this context, concern has been expressed about schools’ financial management capabilities, especially during periods of financial constraint (National Audit Office 2011). Furthermore although some evidence already exists on the effects of the Academies programme, e.g. Machin and Vernoit (2011), the experience of decentralised commissioning in schools is relatively short. In contrast, there is a much longer experience of commissioning services within the NHS, which can provide valuable lessons for schools policymakers. In this short report, we thus present complementary empirical analyses of schools data together with a review of evidence relating to the commissioning in the health sector.

Section 2 describes the current pattern of spending on central services, whilst Section 3 analyses the distribution of operational and clerical support staff across schools, a proxy for the capacity of schools to take on new commissioning roles. Section 4 presents a detailed review of evidence from the commissioning of services in the NHS, including their impact on outcomes and lessons for effective implementation. From this, we attempt to draw lessons for the decentralisation of purchasing decisions from local authorities to schools. Section 5 concludes and draws out the main policy implications.

2. Current Pattern of Central Service Spending

Local authorities currently retain a proportion of their schools budget to spend on services that benefit all pupils in the area. However, they vary in the degree to which they do so, with some choosing to delegate more responsibilities for providing services to schools. In this section we describe the current pattern of central service spending across local authorities, and the balance of spending on primary and secondary schools. We also examine how spending on central services varies with local authority characteristics such as deprivation and size.

Under the Government's proposed school funding reforms originally set out in the July 2011 consultation on school funding¹, local authorities would continue to provide some of these central services, but funding for a number of other services would be transferred to schools (possibly at the discretion of school forums and local authorities). Other education and youth services provided centrally (e.g. education psychology or music services) would continue to be funded through the Local Government Settlement.

To further understand the implications of these reforms, we split reported spending on central services in 2010–11 into five categories:² those proposed to be transferred to schools; those left at the discretion of school forums; high-needs; central services; and, some services will be transferred to the early years budget. We then calculate how much each local authority currently spends on these categories of services. Figure 1 shows the average amount spent by local authorities in these categories (a) as a proportion of their schools budget; (b) per pupil. The diamonds indicate the degree of variation across local authorities by showing the 10th and 90th percentiles for each category. The figure shows that:

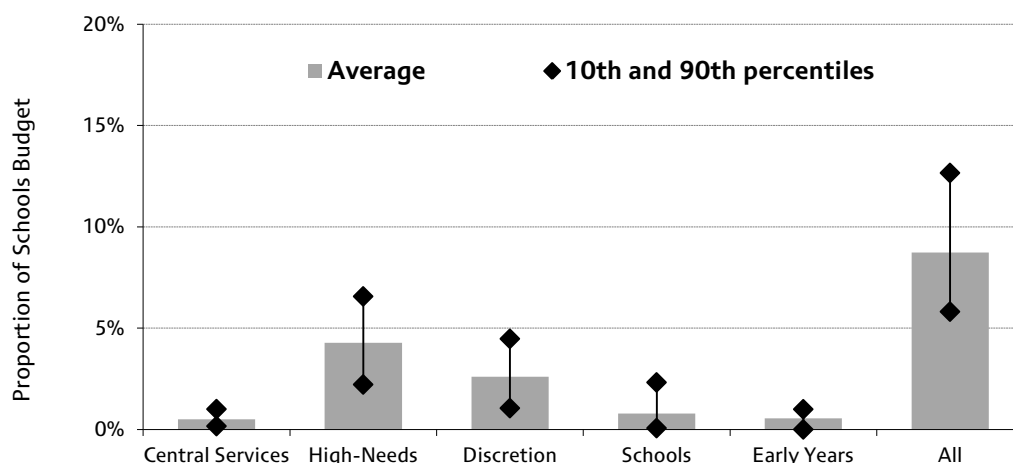
¹ At the time of writing, the July 2011 consultation on school funding reform (“A Consultation on School Funding Reform: Proposals for a Fairer System”) was the most recent set of proposals available. Since then, the Department for Education has conducted a further consultation on school funding reform (“Consultation on School Funding Reform: Next Steps towards a Fairer System”), which closed in May 2012. This consultation confirmed the proposals initially set out in July 2011 with regard to current local authority spending on central services (with the minor exception of SEN transport, see footnote 2). Interested readers should consult the March 2012 consultation for the most recent set of proposals on school funding reform more generally (<http://www.education.gov.uk/consultations/index.cfm?action=conResults&consultationId=1817&external=no&menu=3>).

² Based on “A Consultation on School Funding Reform: Proposals for a Fairer System” Annex F and Section 251 2010-11 figures. Using current data, we are unable to categorise funding for under-performing ethnic groups and CRCs. In this analysis, we include SEN transport within central services (as proposed in the July 2011) rather than the high-needs block (as proposed in the March 2012 consultation). As can be seen in Figure 4, this is a very small component of current local authority expenditure on central services.

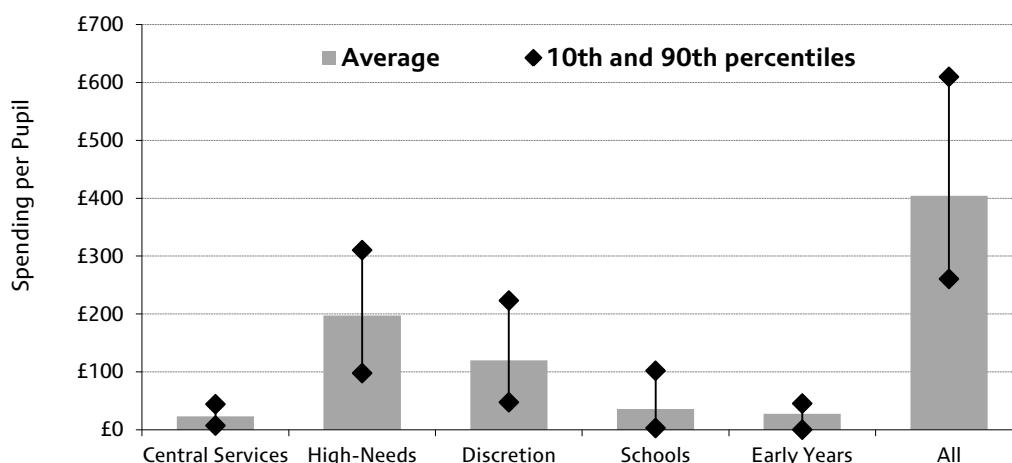
- **All** – Total spending across these categories represented nearly 9% of local authorities' schools budgets or just over £400 per pupil, on average. There is considerable variation across local authorities, with 10% of local authorities spending more than £600 per pupil, while another 10% spent less than £260 per pupil.
- **Central Services** – This currently represents a relatively small proportion of local authorities' schools budgets, at less than 1% or just under £25 per pupil. There is relative little variation across local authorities.
- **High Needs** – This represents the largest single element of local central services spending, accounting for approximately 4% of schools budgets on average. There is also considerable variation in this: 10% of local authorities spend less than £100 per pupil, while at the other end of the scale, 10% of local authorities spend over £310 per pupil.
- **Discretion** – This category represents the second largest element of local authorities current spending on central services (2.6% of schools budgets, on average, or nearly £120 per pupil). There is also considerable variation in the level of this category across local authorities.
- **Schools** – The level of funding being transferred to schools is relatively modest, representing less than 1% of the local authorities' schools budget or £36 per pupil, on average. However, this varies, and is over £100 per pupil for about 10% of local authorities.
- **Early Years** – The transfer of spending on early years is relatively modest, and there is comparatively little variation across local authorities.

Figure 1. Level and Variation in Local Authority Spending (2010-11)

a) As a proportion of schools budget



b) Spending per pupil



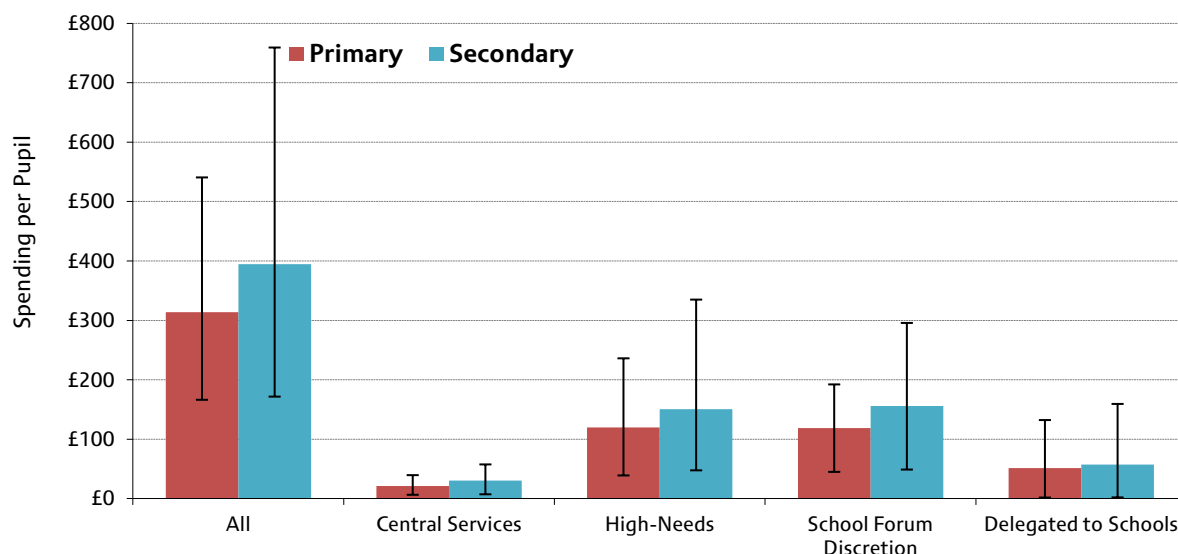
Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

Given this variation, the proposed reforms to central services represent a relatively modest transfer of spending from local authorities to schools, though it may be considerable for a small number of local authorities. A larger proportion of the schools budget will be transferred to schools only at the discretion of schools forums. If all such spending were transferred to schools, then spending by local authorities would be considerably lower, and would mainly consist of spending on high-needs pupils.

What is the balance of such spending on primary and secondary schools? Is a greater amount spent on central services for primary schools than secondary schools? Figure 2 breaks down local authority spending per pupil for primary and secondary schools. Specifically, it shows the total gross spending on each category divided by the total number of primary and secondary pupils in each local authority.

Local authority spending on services for secondary schools is higher, on average, than spending on services for primary schools (about £390 per secondary school pupil compared with £310 per primary school pupil). In fact, this is true across all the broad categories identified above. There appears least difference in the average amounts spent on services that are proposed to be delegated to schools. As before, we see great variation in total spending, largely driven by variation in spending on services for high-needs pupils and the services that could be delegated to schools at the discretion of schools forums and local authorities.

Figure 2. Local authority spending by primary and secondary phase (2010-11)

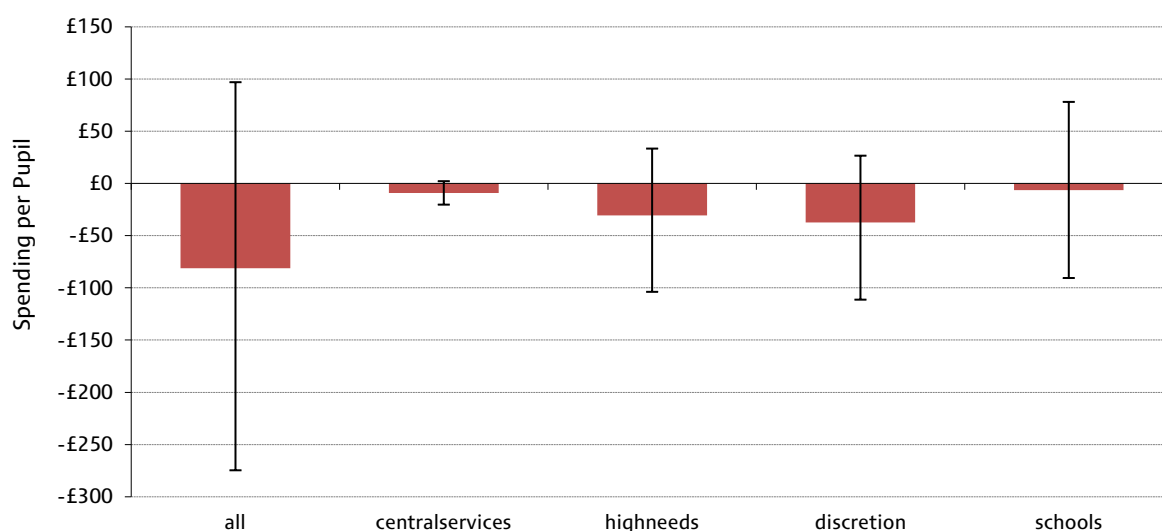


Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

Figure 3 then looks at the difference between spending on services for primary and secondary schools amongst the *same* local authorities. As we saw before, local authorities spend more on services for secondary schools than they do on services for primary schools. These differences are largest for services that could be delegated to schools at the discretion of school forums (nearly £40 per pupil, on average), with the differences nearly as large for high-needs services.

However, the balance between services for primary and secondary schools does vary across local authorities. About 1 in 10 local authorities spend £100 more on services for primary schools than for secondary schools, but 1 in 10 spend £275 more on services for secondary schools. There appears most variation in the services proposed to be delegated to schools in future. On average, the difference is very small, though some local authorities spend more on primary schools and some more on secondary schools.

Figure 3. Difference between primary and secondary spending by local authorities



Note: Difference refers to primary spending per pupil minus secondary spending per pupil

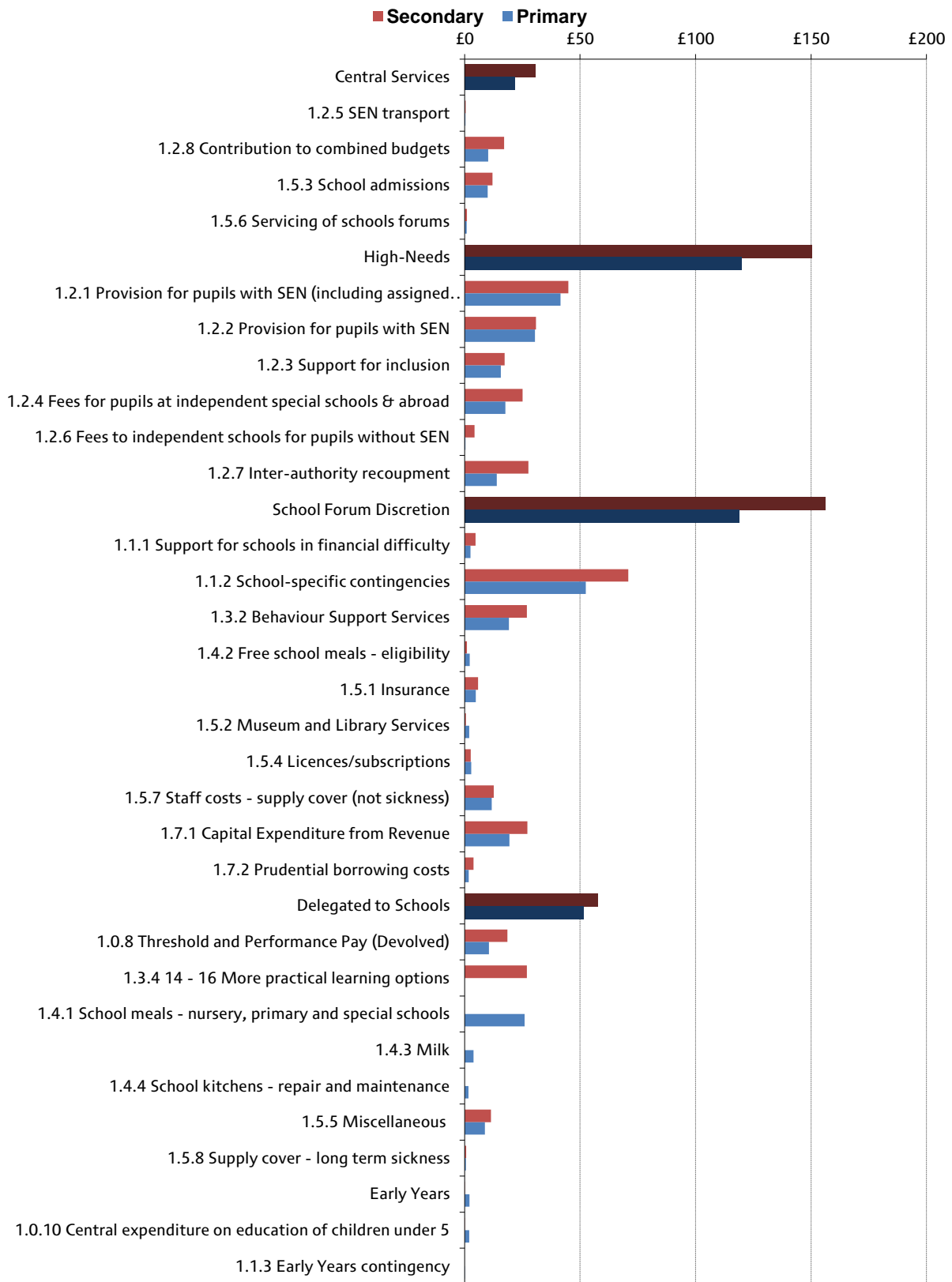
Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

To further understand the pattern of spending on central services, we now consider in detail which areas of spending might be driving the overall differences. Figure 4 shows the detailed levels of average spending per pupil within each category for primary and secondary schools. As we have already shown, spending on central services to be retained by local authorities is relatively small, largely consisting of spending on school admissions and contributions to combined budgets; both of which are slightly higher at secondary schools. In terms of the High-Needs budget, this is split across a range of different areas, including provision of services, support for inclusion and fees for pupils at independent schools or other local authorities.

It is very clear from this chart that the number of services left at the discretion of school forums is relatively large. However, the single largest element is school-specific contingencies, with significant spending on behaviour support services, supply cover and capital expenditure (from revenue account). The services that will be delegated to schools are largely made up of the devolved element of threshold and performance pay, 14–16 practical learning options and school meals/milk.

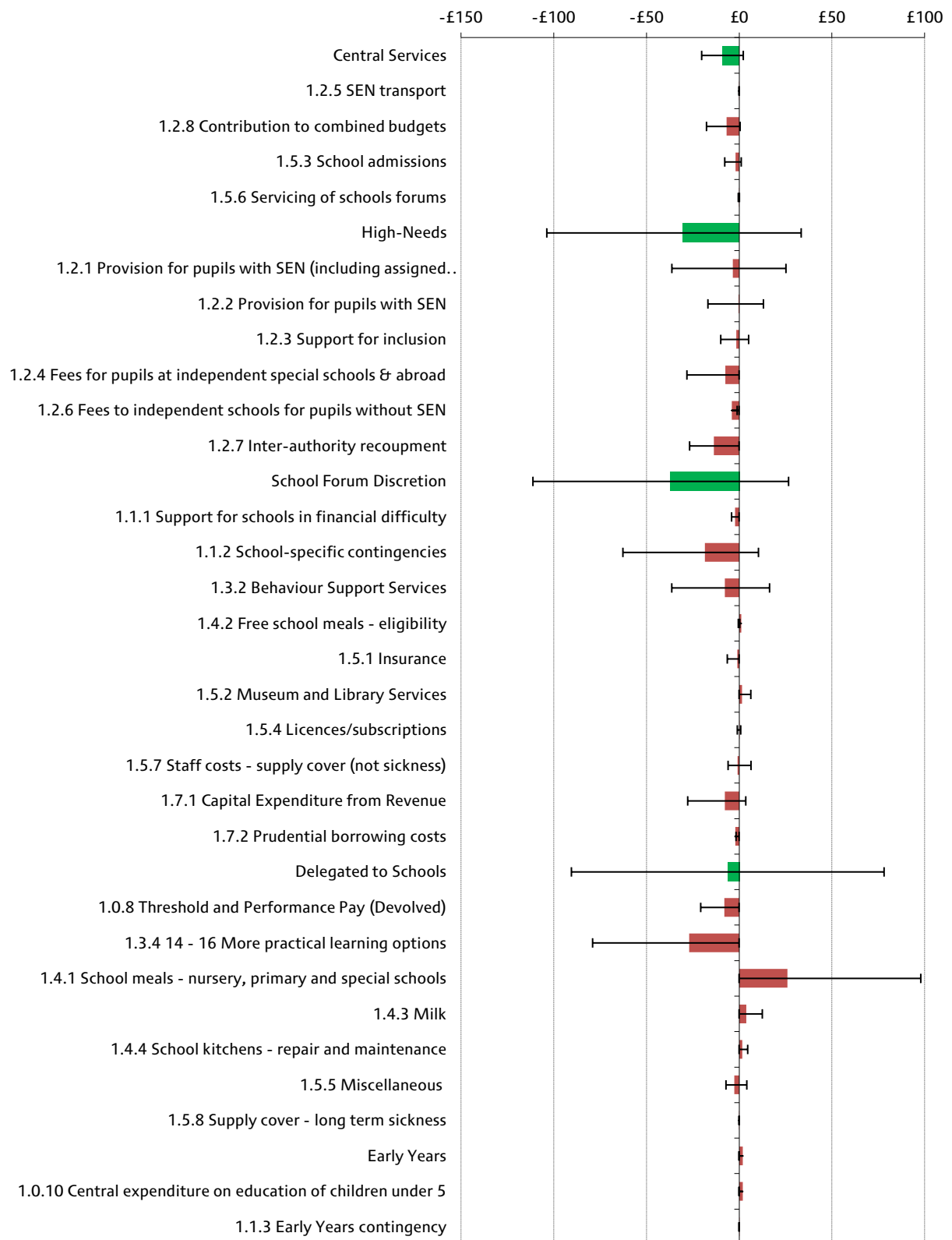
Almost all of these services are focused more heavily on secondary schools than they are on primary schools. Figure 5 focuses on these differences in more detail, showing the average size of the difference between primary and secondary school spending on these categories, and the range of differences amongst different local authorities. The difference between primary and secondary schools appears to be relatively small for high-needs provision and support for inclusion, with some local authorities spending more on primary schools and some more on secondary schools. There is also a sizeable range for behaviour support services and school-specific contingencies.

Figure 4. Detailed spending per pupil by local authorities on services for primary and secondary schools (2010-11)



Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

Figure 5. Detailed difference between primary and secondary spending by local authorities



Note: Difference refers to primary spending per pupil minus secondary spending per pupil
 Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

To what extent do differences in spending on central services reflect the different characteristics of local authorities, e.g. do more deprived local authorities spend more on particular services? In the analysis below we consider five key characteristics that seem likely to affect spending undertaken by local authorities:

- **Deprivation** - proportion of children eligible for FSM
- **Special Educational Needs** - proportion of children with a statement of special educational needs
- **Relative Use of Special Schools** - total number of children at special schools as a proportion of the total number of children with a statement of special educational needs
- **Size** – total number of pupils attending state-funded schools
- **Sparsity** – based on the Local Authority Urban/Rural Classification produced by the Department for Environment, Food and Rural Affairs in 2005 (updated in 2009³).

For the first four characteristics, we group local authorities according to high, medium or low levels of each characteristic⁴. For the sparsity measure, we create the following three groups (Major Urban, Large/Outer Urban and Rural⁵). To ensure consistency, we use the same groups for both primary and secondary school spending. We then examine how the average levels of spending by local authorities on services for primary and secondary schools vary across these different groups. Table 1 shows the results for primary school spending and Table 2 shows the same for secondary school spending. In each case, the columns indicate the broad categories of spending described earlier (central services, high needs, discretion of LAs, delegated to schools and total spending) along with the number of local authorities in each group. The rows indicate the different types of local authority (e.g. low levels of sparsity or low use of special schools).

There are a number of key conclusions that we can draw from this analysis. Firstly, more deprived local authorities tend to spend more per pupil than less deprived local authorities. Indeed, the differences according to deprivation are larger than those seen for any other characteristic. This is true across both primary and secondary schools. These differences seem to reflect higher levels of spending by more deprived local authorities on high needs services and services

³ (<http://www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/rural-urban-definition-and-la/rural-urban-local-authority--la--classification--england-/index.html>)

⁴ The three groups (high, medium and low) for each characteristic have been chosen to ensure approximately equal size groups and groupings based on round levels of each characteristic.

⁵ There are six groups in the original classification. In our analysis we reduce this to three larger groupings: Major Urban; Large and Outer Urban; and Rural (Significantly Rural, Rural-50 and Rural-80).

that will remain at the discretion of local authorities and school forums (e.g. school-specific contingencies and behaviour support services).

Secondly, local authorities with higher levels of special educational needs tend to spend more per pupil on services for primary and secondary schools. As one would expect, this results from higher levels of spending on high needs services.

Third, we see slightly lower levels of spending per pupil amongst local authorities who make greater use of special schools, particularly in terms of high needs services. In such cases, it seems likely that resources are being allocated directly to special schools rather than retained centrally for provision in mainstream schools.

The final set of findings relate to the overall size of local authorities (in terms of the number of pupils) and sparsity. Across both primary and secondary schools, we see that larger local authorities (in terms of number of pupils) tend to spend *less* on services in per pupil terms. This almost entirely reflects lower levels of spending per pupil on services for high needs pupils. Such an observation could reflect the fixed costs of some types of high-needs provision, which needs to be maintained no matter the number of pupils in the local authority.

One might expect more sparsely populated local authorities to have higher levels of spending. However, this is not what we observe. There are actually surprisingly few differences in spending on services for primary schools according to this measure of sparsity, and spending on services for secondary schools actually tends to be lower in rural local authorities.

Table 1. Variation in Local Authority spending per pupil according to different characteristics, primary schools

Local Authority Characteristics	Central Services	High Needs	Discretion of LAs	Delegated to Schools	Total	<i>Number of LAs</i>
<i>Deprivation</i>						
Low (<12% FSM)	£20	£96	£117	£48	£281	39
Medium (12-22% FSM)	£20	£113	£105	£55	£295	65
High (>22% FSM)	£25	£151	£140	£49	£371	46
<i>Special Educational Needs (with statements)</i>						
Low (<2.5% SEN)	£21	£97	£129	£33	£280	29
Medium (2.5-3.5% SEN)	£22	£121	£110	£59	£313	92
High (>3.5% SEN)	£21	£138	£137	£46	£349	29
<i>Relative Use of Special Schools</i>						
Low (<30% of pupils with SEN)	£21	£145	£108	£57	£331	46
Medium (30-40% of pupils with SEN)	£22	£111	£124	£48	£311	50
High (>40% of pupils with SEN)	£21	£108	£123	£50	£302	54
<i>Size of Local Authority</i>						
Low (<30k pupils)	£23	£160	£113	£45	£345	54
Medium (30-50k pupils)	£21	£102	£116	£54	£296	60
High (>50k pupils)	£19	£88	£133	£56	£296	36

Sparsity						
Major Urban	£21	£128	£113	£42	£307	60
Large/Outer Urban	£25	£122	£119	£58	£327	45
Rural	£18	£108	£127	£56	£310	45

Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

Table 2. Variation in Local Authority spending per pupil according to different characteristics, secondary schools

Local Authority Characteristics	Central Services	High Needs	Discretion of LAs	Delegated to Schools	Total	<i>Number of LAs</i>
Deprivation						
Low (<12% FSM)	£26	£121	£133	£45	£324	39
Medium (12-22% FSM)	£32	£122	£130	£50	£334	65
High (>22% FSM)	£32	£217	£213	£79	£547	46
Special Educational Needs (with statements)						
Low (<2.5% SEN)	£29	£111	£199	£32	£371	29
Medium (2.5-3.5% SEN)	£33	£150	£142	£61	£387	92
High (>3.5% SEN)	£24	£191	£157	£72	£443	29
Relative Use of Special Schools						
Low (<30% of pupils with SEN)	£26	£183	£136	£78	£423	46
Medium (30-40% of pupils with SEN)	£28	£155	£165	£48	£396	50
High (>40% of pupils with SEN)	£36	£119	£165	£49	£369	54
Size of Local Authority						
Low (<30k pupils)	£35	£200	£144	£57	£436	54
Medium (30-50k pupils)	£28	£136	£161	£54	£380	60
High (>50k pupils)	£28	£99	£166	£63	£356	36
Sparsity						
Major Urban	£29	£179	£170	£61	£440	60
Large/Outer Urban	£39	£132	£152	£60	£383	45
Rural	£24	£132	£142	£51	£349	45

Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

In summary, under planned reforms to school funding, the responsibility for some services will transfer to schools. This is largely made up of practical learning options for 14–16, school meals/milk and threshold and performance pay. The level of this spending is higher in secondary schools than primary schools and there is only a small degree of variation across local authorities. In contrast, the level of spending left at the discretion of school forums is relatively large and varies significantly across local authorities. This spending is largely made up of school-specific contingencies, behaviour support services and capital expenditure; all of which are more focused on secondary than primary schools. Under the proposed reforms to schools funding, local authorities will still retain a small amount to spend on central services (largely admissions and contributions to combined budgets). They will also retain spending on high-needs pupils, which currently varies significantly across local authorities.

Variation in spending retained by local authorities partly reflects differences in levels of special educational needs and use of special schools. More deprived

local authorities also retain greater levels of spending. However, we also observe that larger local authorities (in terms of total pupil numbers) tend to spend less on services for high needs pupils, as do rural local authorities compared with urban local authorities.

The extent to which a transfer of responsibilities and spending is sensible depends on a number of factors. Some considerations may point in favour of transferring responsibilities to schools, such as the fact that they are better-placed to observe pupils' needs, and that different schools might have quite different ideas about how best to spend this money. Arguments in favour of the local authority retaining funding are based largely on economies of scale considerations, such as the bulk purchasing of services or the greater capacity to deliver such services. For example, some schools (particularly smaller primary ones) are likely to have less on-site administrative or clerical support services. However, schools could benefit from some economies of scale if they are able to form collaborations, chains or federations. For instance, chains of Academies may well be able to purchase some services together. We return to these issues when considering the lessons from decentralised commissioning in healthcare, in Section 4.

The fact that some of the transfer of responsibilities will be determined at the discretion of local authorities and Schools Forums means that the arguments for and against transferring specific services can be debated. However, problems could occur if a minority of schools are highly dependent on specific services. In the next section, we thus analyse the distribution of operational and clerical support staff across schools (a proxy for the capacity of schools to take on new responsibilities for commissioning).

3. Analysis of operational and clerical support staff across schools

This section documents the number of operational and clerical support staff that schools employ, and how this varies across different types of school, to give an indication of the potential capacity that exists for schools to take on new commissioning roles. The analysis in this section is based on January 2010 LEASIS data on schools in England. For the purposes of this analysis, operational and clerical support staff are defined as all staff who are not teachers or teaching assistants.⁶

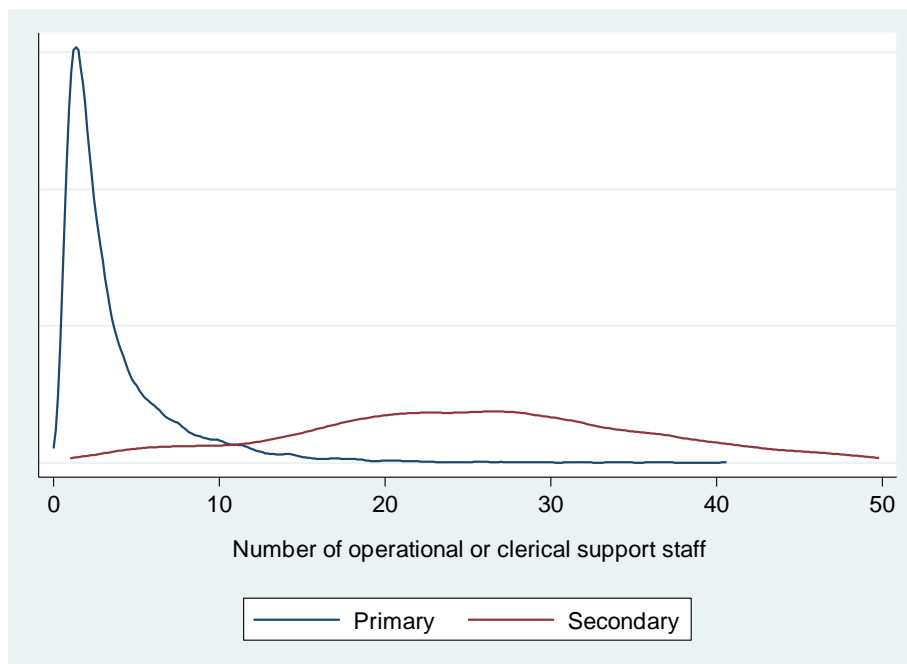
⁶ Specifically, we define operational and clerical staff as any of the following LEASIS categories: administrative officers or secretaries; bursars; other administrative or clerical staff; matrons, nurses and medical staff; librarians; technicians; IT technicians; other education support staff; qualified childcare staff; and, unqualified childcare staff;. Teaching assistants and special education needs and minority ethnic support staff are not included in this definition, but are included in the definition of total staff.

This measure can be thought of as a useful way of summarising the current capacity of schools to take on commissioning roles. It includes the types of staff who might be responsible for delivering services that are currently provided by local authorities (e.g. medical staff and librarians), as well as administrative and clerical staff who could take on extra responsibility for purchasing and arranging services. This is clearly not a perfect measure of capacity as they may well require other forms of staff. It could also be argued that it just represents the extent to which schools provide extra services at present, and it may be that schools are equally capable of employing new staff to deliver and arrange services. Furthermore, teaching staff could, in principle, take on extra responsibilities. However, it does measure the number of existing staff who could be asked to help deliver extra services. The inclusion of administrative staff is also important, as these members of staff seem highly likely to take on extra responsibilities if schools must purchase more services themselves.

The National Audit Office (2011) has highlighted the particular importance of school business managers in terms of effective financial management and procurement. They show that almost all secondary schools have a schools business manager, whilst there is only one school business manager for every three primary schools. Furthermore, in their survey of local authorities, “22% of local authorities [stated] that most of their primary schools bought school business management services from them [and] 27% of local authorities said that most of their primary schools have no access to a school business manager.” On its own, this is already clear evidence that primary schools may have less capacity to take on new commissioning roles unless they are able to employ a school business manager, or share one across a chain, federation or partnership.

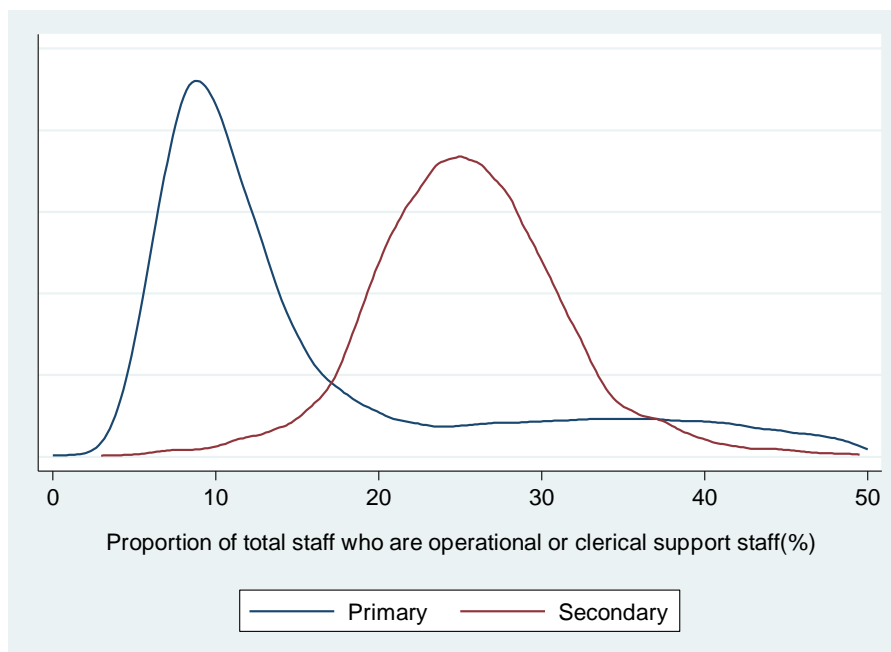
We now consider the overall level of operational and clerical support staff schools. Figure 6 plots the distribution of operational and clerical support staff separately for primary and secondary schools, while Figure 7 plots the distribution of the proportion of total staff that is accounted for by such staff. It is clear from these two graphs that primary schools typically employ considerably fewer operational and clerical support staff – both in number and as a proportion of total staff. While there is a small tail of primary schools that employ a very substantial number of such staff, the majority of them appear to have less scope at present to purchase and deliver extra services than secondary schools would. To develop effective commissioning procedures, such primary schools may need to employ more operational and clerical support staff or form collaborations, chains or partnerships with other primary schools.

Figure 6. Number of operational and clerical support staff, 2009–10



Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

Figure 7. Operational and clerical support staff as proportion of all staff, 2009–10

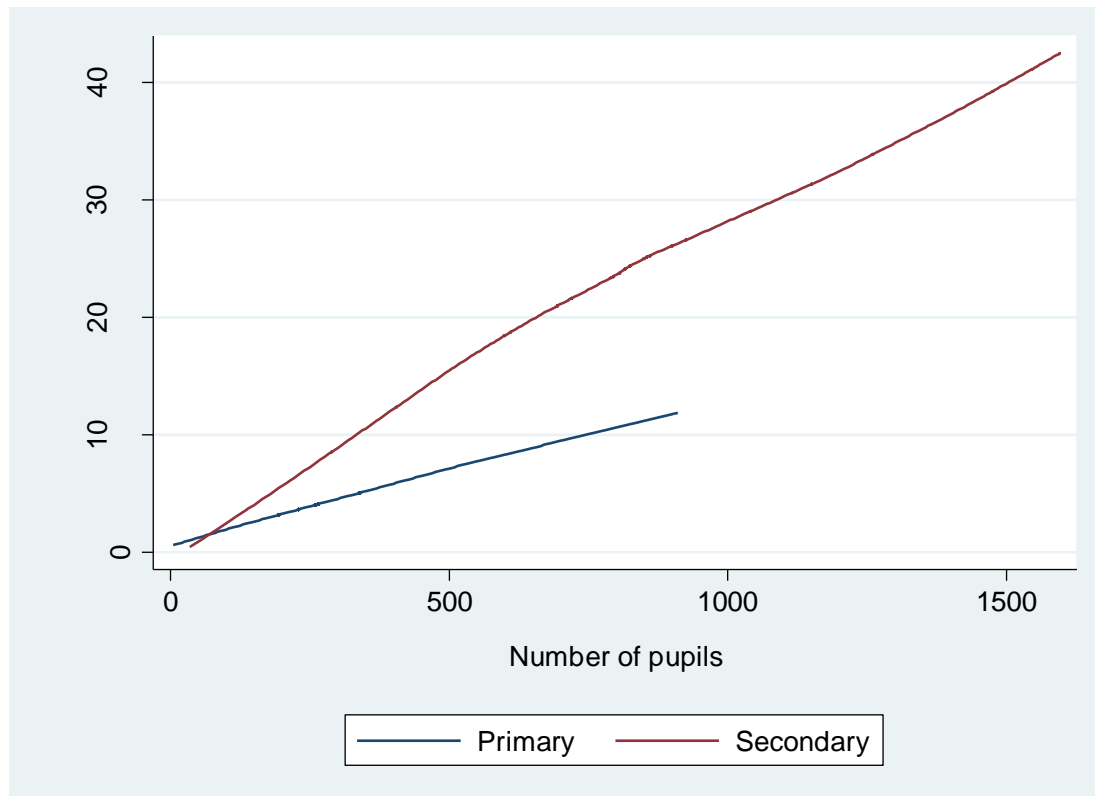


Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

It may not be surprising to find that primary schools typically employ fewer operational and clerical support staff, since they are generally smaller than secondary schools. However, Figure 8 confirms the greater reliance that secondary schools place on such staff, even after taking into account the school size. It plots the number of operational and clerical support staff employed against the number of pupils at the school: the steeper slope for secondary schools indicates that they employ more such staff than primary schools with the *same* number of pupils do. While a primary school with 500 pupils employs

approximately 8 operational and clerical support staff on average, a secondary school with 500 pupils employs roughly twice as many. Such a finding can be explained by the fact that secondary schools are currently responsible for providing more services than are primary schools, e.g. careers advices, school nurses and other services.

Figure 8. Number of operational and clerical support staff by number of pupils, 2009–10



Source: Authors' calculations using LEASIS data for January 2010 linked to section 251 returns.

So far, this analysis has shown how the total number of operational and clerical support staff varies by a particular characteristic (school size) considered in isolation. Clear differences have also emerged in this analysis between schools that cover different phases of education. We now examine how the patterns in operational and clerical support staff usage vary according to a variety of other school characteristics. This enables one to see how the total number of operational and clerical support staff varies with one particular characteristic of a school (for example, region or deprivation), while holding fixed all other characteristics (school size, type, composition, etc.) that can be controlled for in the data. This attempts to remove any coincidental variation that is driven by other characteristics.

Table 3, below, presents estimates of this statistical relationship. The figures in the table show how the object of interest – the total number of operational and

clerical support staff at a school – varies with each characteristic in the table. This relationship is examined separately for primary and secondary schools.⁷

For example, the first row of the table shows that, on average, the total number of operational and clerical support staff at a primary (secondary) school increases by 0.012 (0.026) for each additional pupil – holding other school characteristics fixed. In other words, all else equal, a primary (secondary) school with 100 additional pupils will have, on average, one (three) additional operational and clerical support staff member(s). These estimates are both highly statistically significant, as indicated by the asterisks on each number (denoting the 1% statistical significance level).⁸

The second row of the table shows that the number of operational and clerical support staff also increases with the proportion of pupils eligible for Free School Meals (FSM). The third and fourth rows show that it also increases with the proportion of pupils with Special Educational Needs (SEN), particularly the proportion with a statement of SEN. All else being equal, more deprived schools and schools with more children with a statement of SEN tend to have higher number of operational and clerical support staff. By contrast, there is no statistically significant relationship between the number of such staff and the proportion of pupils with English as an Additional Language (EAL), once other school characteristics are taken into account.

The differences in operational and clerical support staff levels between different school types are very small. In voluntary aided and voluntary controlled schools, the number of operational and clerical support staff is statistically no different to the number of such staff in similar community schools (the reference category). This is true for both primary and secondary schools.

There are clear regional differences in the usage of operational and clerical support staff, particularly for secondary schools. The reference category here is Inner London, so in all other regions of England the number of secondary school support staff is higher than in a comparable inner London school. The region where secondary schools with a given type of characteristics employ the most operational and clerical support staff is the East Midlands: such schools employ, on average, 8.7 more such staff members than comparable secondary schools in inner London. There are also large regional differences for the South East, Yorkshire and the Humber, and the South West. The other regional differences are smaller but are all statistically significant. For primary schools, the regional

⁷ The full table can be found in the Appendix.

⁸ Although not presented here, we have also explored (i) whether the total number of operational and clerical support staff increases in a non-linear manner with respect to the total number of pupils; (ii) whether small schools have a total number of such staff that is different from what a linear relationship might predict. However, no statistically significant evidence was found in either case.

differences are weak and mostly statistically insignificant. The only clear regional differences that emerge for primary schools are for the South East, which employ on average 1.4 more operational and clerical support staff members than comparable primary schools in inner London, and the North West, where primary schools employ slightly fewer such staff than comparable primary schools in inner London.

Table 3. Average relationship between total number of operational and clerical support staff and school characteristics

	Primary	Secondary
Total number of pupils	0.012***	0.026***
% of pupils with FSM	0.033***	0.272***
% of pupils with SEN statement	0.056**	0.409***
% of pupils with SEN without statement	0.015***	0.058**
% of pupils with EAL	0.009	0.013
Voluntary aided school	-0.047	-0.369
Voluntary controlled school	-0.010	0.285
East Midlands	0.242	8.740***
East of England	0.299	5.787***
North East	-0.693	4.017**
North West	-0.877*	3.221**
Outer London	-0.119	2.733**
South East	1.398**	7.367***
South West	0.742	6.428***
West Midlands	-0.417	4.503***
Yorkshire & Humber	0.448	6.859***

Source: Authors' calculations using LEASIS data for January 2010.

Notes: Relationship is estimated using an OLS Regression. *** = statistically significant at 1% level; ** = statistically significant at 5% level; * = statistically significant at 10% level. Community school is the reference category for school type; Community Special schools have been excluded from this analysis as there is no phase associated with them in the data. Inner London is the reference category for region.

Overall, Table 3 shows that, all else equal, the number of operational and clerical support staff is on average higher for schools:

- with a larger pupil body;
- with a more deprived intake (as measured by the proportion eligible for FSM);
- with a higher proportion of pupils with SEN (both with and without statements);
- in the South East (compared with Inner London).

Secondary schools the East Midlands, Yorkshire and the Humber, and the South West also have higher usage of operational and clerical support staff given their characteristics.

Overall, this section has found that there are clear areas where some schools may have more scope than others to take advantage of potential commissioning responsibilities. In particular, secondary schools are heavily reliant on operational and clerical support staff, and make greater use of them than primary schools of the same size. If primary schools are to make best use of new

commissioning responsibilities, they may thus either need to employ greater numbers of operational and clerical support staff or form collaborations, chains and partnerships to commission services.

Further analysis of the relationships between employment of operational and clerical support staff and school characteristics reveals that larger schools and those with higher levels of deprivation or SEN are more reliant on such staff than other schools. Meanwhile, secondary schools in inner London tend to employ fewer operational and clerical support staff than comparable secondary schools in the rest of England.

4. Lessons and insights from commissioning in healthcare

The decentralisation of purchasing decisions in public services has been a feature of public service reform since the early 1990s. In particular, multiple reforms have decentralised the commissioning of health services to lower levels, in the most part to General Practitioners (GPs). The aim of this section is to examine the theoretical basis of decentralisation, and examine empirical evidence on the impact of past reforms to commissioning in the NHS. From this we may be able to draw lessons relevant to the decentralisation of purchasing decisions from local authorities to schools.

There is clearly a difference between the nature of services that schools will be expected to commission compared with those in the NHS, e.g. support for high-needs pupils, behaviour support services and school meals/milk, and the nature of services commissioned in a healthcare context, e.g. treatment for cancer patients or major surgery. However, there will also be some similarities, such as speech and language therapy or support for high-needs pupils more generally. Furthermore, there are likely to be some quite general lessons for the effective decentralisation of commissioning decisions.

Before we discuss the theory and empirical evidence, we must clarify what we mean by commissioning. The commissioning of health services is the process of assessing the need for health services in the relevant population and purchasing these services on behalf of the patient. Since 1991, when the then government introduced the internal market, there has been a split between the providers of health services and the purchasers. Prior to 1991, hospitals were funded on annual budgets directly from the government, rather than through payments for from healthcare purchasers, on the behalf of patients.

The first major decentralisation of commissioning came in the early 1990s when the then Conservative government gave individual GP practices the right to become “GP fundholders”, who would commission most elective care on behalf of patients. This was extended in 1994 to give the possibility for GPs to purchase all health services (known as “total purchasing”). Having dismantled GP fundholding in 1997, in 2004 the Labour government decentralised commissioning from

Primary Care Trusts (PCTs), giving GPs the option to commission services with an indicative budget. This was known as practice-based commissioning and was a voluntary scheme for GPs. In what follows we examine the empirical evidence relating to the impact of these past reforms.

Theoretical rationale for decentralising commissioning

Commissioning of healthcare at the GP level has, under different guises, been a major component of NHS reform since 1991. The belief has been that decentralising commissioning allows GPs to make better choices of care for their patients than more centralised authorities. Another motivation has been to control the growing costs of healthcare. There is a growing academic literature examining decentralisation and other theoretical reasons for decentralising the commissioning process.

Before examining this literature, it is important to understand the fundamental problem in commissioning. In a well functioning market, a well informed consumer will weigh up the costs and benefit of a service before making a purchase. When purchasing decisions are made by commissioners, they are being made on behalf of consumers (i.e. patients or pupils). In such a case, a commissioner does not receive the direct benefit of the service. Depending on the institutional structure, they may or may not face the true cost of purchasing the service either. Instead they will respond to their own incentives and objectives, which will not always perfectly correspond to those of the consumer, e.g. a head teacher clearly wants to improve individual's pupil attainment, but may also place emphasis on a school's league table position. However, such a problem must be balanced against the potential benefits of commissioning. The main one is the commissioners could have a greater specialist understanding of the service that allows them to make an informed decision, as opposed to a consumer's who may well be less well informed about the quality of different services on offer.

Some research in theoretical economics is useful in understanding the trade-offs inherent in decentralising public services. Mookherjee (2006) shows that in the absence of communication costs, the most efficient system will be a centralised authority responsible for all commissioning. This is because information can be costlessly acquired by any level of government, ruling out information only available to local providers. In reality, costless transfer of information does not exist and GPs could have a much better knowledge of their patients' needs than a centralised authority.

In Mookherjee's (2006) framework, the trade off is between the local information held by central and local authorities, which could allow resources to be better directed, and the incentives for that level of government to actually direct those resources in the public interest. This reflects a change in the focus of the academic literature. Previously, Oates (1997) argued the main problem with central provision was that a centralised authority would provide a uniform

amount of the public good to all neighbourhoods, which was inefficient or undesirable. The problem with decentralisation was that the public goods may be provided on an uneconomic scale. However, Bardhan and Mookherjee (2006) argue that the assumption of uniform provision is unrealistic, so this argument for decentralisation is unconvincing.

Understanding the incentives of local providers of services is therefore the key issue. Besley and Ghatak (2005) study the effect of organisations that have a mission as an organisational goal, not profit. They show that if individuals' "missions" correspond closely to the goals of the organisation, it can reduce the need for monetary incentives. However, it is unclear how strong this force is compared with monetary incentives. Moreover, Holmstrom and Milgrom (1991) show that if the output, such as healthcare, has many dimensions, incentivising a single outcome can distort the activity of the providers. This would lead to an inefficient allocation of effort across the different dimensions of their work. Similarly, large monetary incentives for schools based on simple measures of GCSE scores could lead schools to focus on passing the exams rather than encourage pupils' wider understanding of the subject material.

It is also important to take account of the structure and regulation of the relevant market when considering the likely impact of decentralised commissioning. There is a large theoretical literature that shows that when hospitals compete on price and quality, the quality of healthcare may either rise or fall (Gaynor 2006). When purchasers have imperfect information about quality, healthcare providers will produce inefficiently low quality healthcare (Dravnové and Satterthwaite 1992). However, with fixed (regulated) prices for treatments, quality of treatment supplied by hospitals should unambiguously rise under competition and decentralised commissioning (Gaynor 2006). Commissioners make their purchasing decisions in the context of the market structure. If there is competition but regulated prices, commissioners have the incentive to purchase high quality care at a fixed price, whereas if prices are not fixed, they may choose a lower quality care for a lower price for their patient if they are poorly informed about the quality of services.

Translating these conclusions to the commissioning of services by schools, one can conclude that if head teachers are poorly informed about the quality of different services then the quality of such services would seem likely to decline if prices are not fixed. If they are well informed, then competition could increase or decrease quality.

Much of the literature focuses on the decentralisation of public services to lower tiers of government and under what conditions it is successful. The World Development Report 2004 examines "deconcentration", which is the shift of responsibility of provision of public services to the providers themselves. It finds that deconcentration can lead to accountability problems. It makes clear that

difficulty of monitoring local services and weak accountability of the service providers to consumers can make decentralisation problematic.

As the World Development Report (2004) finds, “decentralisation is not magic.” There are clear arguments for why we think that a government should decentralise the purchasing decisions of some services in healthcare and education to GPs and schools: they hold local information a centralised authority cannot. This benefit has to be balanced against the difficulties of getting the incentives right for commissioners of these services to act in the interest of the consumer (patients, parents and children in these cases). Any reform that makes schools and GPs more directly accountable to the consumers of their services should strengthen any decentralisation.

The theoretical literature currently draws broad conclusions: the local information held at lower tiers of a hierarchy can lead to more efficient and effective provision of public services. However, this has to be traded off by the fact that the incentives at these lower levels may not lead to better outcomes for consumers of these services and that they may not be sufficiently accountable to consumers.

The literature helps indicate when GPs’ incentives are to cut costs and quality, and when their incentives are more aligned with patients. In an ideal system, the commissioner would face the true costs and benefits of purchasing a treatment, and would use their specialist knowledge of information to achieve the best quality of care for their patients at a cost-effective price. Key issues to focus upon when examining incentives are: if and how budget surpluses can be spent; whether prices of commissioned services are regulated; and how accountable commissioners are to the ultimate consumers. Finally, how well informed commissioners are does not affect commissioners’ incentives, but can affect their ability to make good decisions on behalf of the consumers.

Empirical Evidence

As well as the theoretical literature, there have been a number of empirical studies on the effect of past reforms to GP commissioning in the UK. Here we focus on studies that seek to robustly analyse the effect of these reforms on various outcomes.

In a review of the evidence, Dixon et al (2011) assess New Labour’s reforms against four criteria: equity (of healthcare outcomes), effectiveness (at moving secondary care out of hospitals), efficiency (not referring patients unnecessarily) and responsiveness to the needs of patients. They conclude that there is no strong evidence on the effect of practice-based commissioning on equity. On the other hand, Propper et al (2002) find that there are lower waiting times for patients from GP fundholders; results which they say are “consistent with fundholding generating an inequitable ‘two-tier system’.” However, there is no evidence that fundholding led to inequities within practices. There is little

evidence of increases in effectiveness or efficiency due to practice-based commissioning. Dixon et al (2011) argue that there was little change of spending by practice-based commissioners and that it did not generate large savings. In terms of responsiveness, 86% of GPs felt that it had allowed them better access to services, although there is little other evidence.

A number of studies examine the GP fundholding experience in the 1990s, but show variable results. Propper et al (2002) find that waiting times fell by about 8% relative to non-fundholders, a result consistent with Dowling (1997). However, Croxson et al (2001) found that there was a small fall in referrals to hospitals by fundholders.

The theoretical literature argued that competition between hospitals can also have an effect on quality. Supporting the theory, Propper et al (2002) find that during the 1990s, greater competition led to lower quality healthcare when prices could be set by hospitals, while Cooper et al (2009) find that when prices are regulated, competition increased quality. This is supported by evidence from America (Kessler and McClellan, 2000), who find that under Medicare (which has regulated prices), competition reduced patient mortality. This supports the idea that one way to maintain high quality healthcare is to have regulated prices.

In summary, the current literature is ambiguous about the effects of GP commissioning on health care outcomes. If there has been a response, it has been to shift some secondary care out of the hospitals and into the community and slightly shorter waiting times. Wyke et al (2003) find that this comes through lowering the number of days in hospital beds and preventing admissions. They conclude that commissioning at the GP level may be able to alter where secondary care takes place, but does not seem to have altered the use of resources or improved healthcare quality. On the other hand, there do not seem to have been large negative impacts of GP commissioning, although there is some evidence that it may have made provision of services less equitable.

In terms of the lessons for schools and local authorities, these findings from healthcare suggest that outcomes might not change significantly as a result of changing who commissions the service. However, if there are differences in terms of the capacity of schools to commission services, then decentralised commissioning could lead to a wider range of outcomes across schools than occurs at present.

As we have seen the evidence for the effect of GP commissioning on outcomes is equivocal. This may be partially due to the difficulties in estimating a causal impact in quantitative studies. There are multiple problems that any researcher faces, which can be broadly categorised into problems of internal and external validity, as explained below.

Internal validity refers to the process of estimating reliably causal effects of the intervention (in this case, introducing GP commissioning) and there are various reasons why this is difficult.

Firstly, these commissioning reforms have not been implemented in a vacuum; since the 1990s, health service reform has included introducing “trust” status for hospitals, introducing Payment by Results, Foundation Hospitals, and initiatives to expand patient choice. Reforms can sometimes be seen as complementary, in which case the impact of one reform can depend on other reforms. Therefore simply looking at changes in outcomes may or may not reflect the impact of introducing GP commissioning. Moreover, the structure of commissioning has changed frequently over the last 20 years, which may make impacts difficult to measure if they only materialise over the longer term.

Most quantitative studies use some form of “difference-in-difference” strategy; that is comparing the change in outcomes for fundholders during the reform period, and comparing this to the change in outcomes among a comparison group who did not become fundholders. However, using non-fundholding practices as a comparison group is potentially problematic. As Croxson et al (2001) show, fundholders’ budgets are based on the referrals to elective care in the year before they become fundholders. This incentivises GPs to refer more patients to elective care in the year before they become fundholders – therefore any fall seen upon becoming a fundholder may not be due to increasing efficiency by removing some secondary care from hospitals, but instead a “return to normal”. Since more practices became fundholders over time, studies such as Coulter and Bradlow (1993), which use non-fundholding GPs as the comparison group, may produce biased results if those “controls” planned to become fundholders. This is mainly a concern for robustly identifying the effect of the reform.

Finally, there is the problem that there may be spillover effects from fundholding GPs onto non-fundholding GPs (see Propper et al 2002). These may be positive (hospitals providing better services to fundholders may also provide them to non-fundholders) or negative (fundholders find the best health services for their patients, leaving other patients with longer waits for poorer care). Either way, the possibility of spillovers means that there is a worry about using non-fundholding GP practices as the comparison group.

Although some studies (notably Propper et al 2002) try to address internal validity issues, there is also the difficulty of understanding the “external validity”: the effect of GP commissioning if it was expanded to cover all practices. It is conceivable that those practices who thought they would benefit most under GP commissioning would select into the schemes. If those who had the best financial management or potential commissioning skill were those that selected into GP commissioning, then extending GP commissioning to all practices may have a less beneficial impact upon healthcare outcomes.

A good example in the case of schools and local authorities is the experience of existing Academies and whether their experiences are transferable to all maintained schools. One might reasonably hypothesise that schools that have recently converted to become Academies might be those with a greater capacity to purchase services more efficiently and tailored to their pupils needs. Indeed, the ability to make use of such freedoms could be one motivation for converting to an Academy. Those who have not converted might have less scope to purchase services more efficiently and could be one reason why some schools have chosen not to convert to an Academy. However, no evidence currently exists on any such differences in capacity to commission service effectively. Moreover, the capacity to purchase services efficiently is clearly not fixed over time and schools might choose or not choose to seek Academy status for many other reasons.

Implementation of GP commissioning

There has also been a substantial literature, primarily based on qualitative studies, looking at the factors that affect the successful implementation of GP commissioning. There are a number of broad themes arising from these studies that may teach us some things about the decentralisation of purchasing of public services more widely. These themes in the qualitative health literature fit in well with the theoretical literature on decentralisation explored earlier and are highly relevant to effective commissioning of services by schools.

a) Management and Administration costs

One of the criticisms of the decentralisation of commissioning is that it has often been accompanied by a large rise in the administrative costs in the NHS. According to the House of Commons Health Select Committee (2011), since the introduction of the internal market, management and administration costs have risen, to as high as 14% of the NHS budget. When GPs are used to commission health services, they will have to take on time involved in commissioning services. Qualitative research has underlined this, with Smith et al (2009) recommending that the optimal size of GP consortia take account of management costs. Higher administration costs are a clear downside of GP commissioning, as the economies of scale from a centralised system are offset or even lost. When it comes to schools, as we saw earlier, many secondary schools may have the capacity to take on new commissioning responsibilities, but many primary schools may need to employ more administrative staff. One potential solution to this problem would be for primary schools to form consortia, chains or federations to purchase services as has occurred with GPs.

The quality of management and leadership is also important. A report on the experience of commissioning by family doctors in the USA (Casalino 2011) highlights how current doctors do not have sufficient training in financial and business skills; there needs to be increase in both non-physician manager-commissioners and a greater understanding of business by physicians. In schooling, as the National Audit Office (2011) finds, whilst most secondary schools have access to school business managers, many primary schools do not.

Furthermore, only 11% of schools have headteachers with expertise in leading a school during periods of financial constraint. This might also limit the capacity of schools to take on new commissioning responsibilities, unless there is a significant improvement in the financial and business skills of headteachers.

The implications of this for the delegation of some more responsibilities to schools are thus as follows. There could be higher administrative costs in the system, as economies of scale are lost, though this can be partly overcome by encouraging schools to collaborate as has happened with GP consortia. It also seems that in order to commission services well, commissioners must have both financial knowledge as well as a good understanding of educational needs.

b) Getting incentives right

Reflecting the theoretical economics literature, there is concern in the health literature that strong incentives for doctors to reduce costs may lead to a fall in the quality of healthcare if they are not well informed about the quality of services on offer. For example, Casalino (2010) argues that incentives to lower costs should neither be “excessively strong nor excessively weak”.

Translating this concern directly over to schools, one might be concerned that giving schools new commissioning powers to schools could reduce the quality of services on offer. It is therefore crucial to understand the conditions under which health commissioners incentives could reduce the quality of services, and whether these conditions are likely to hold or not for schools.

There appear to four key issues identified by the health literature that determine when commissioners’ incentives are likely to produce more desirable outcomes: how well informed commissioners are about the quality of services; what happens to budget surpluses; whether prices are regulated; and, how accountable commissioners are to the ultimate consumers (patients, parents or pupils in these cases).

The importance of the information possessed by commissioners with regard to the quality of services on offer is clear. If doctors or schools are well informed about the quality of services on offer, then they could clearly use any new commissioning powers to purchase the desired quality of services in a cost-effective manner. However, if they are not well informed then giving doctors or schools new commissioning powers could reduce the quality of services. In healthcare settings, even if doctors wanted to raise or maintain the quality services, they may be less informed about their quality than providers, who tend to know significantly more about the service and its quality than the purchaser (Dixon et al 2011). In a school setting, low levels of information on the quality of services could lead schools to choose lower quality, lower cost services, even if they wanted to raise the quality of such services. A good example might be specific forms of provision for high-needs pupils. If a school does not have the experience of some forms of provision, then they might be poorly informed as to

the quality of services on offer. Excessively strong monetary incentives in such a case could lead schools to reduce quality of such services.

The second key issue is what the commissioners can do with any budget surplus. In American healthcare, budget surpluses can be used to increase salaries (Casalino 2011). This may represent quite a strong incentive to cut service quality and increase salaries. One potential response is the creation of “virtual” or indicative budgets. However, it is unclear whether the incentives to make savings are strong enough in such cases. The lack of a real budget in the implementation of the practice-based commissioning system has been criticised as one of the reasons for its perceived failure to increase standards (Dixon et al 2011). A middle way would allow commissioners to use saved funds on other services, but not directly increase commissioners pay, as was the case during GP fundholding. While commissioners may value this, the incentive may not be so strong as to cut quality of services. When considering the schools setting, budget surpluses are likely to be real and could be used on other services. The incentives are thus likely to be stronger than virtual budgets. However, there is much less potential to use any savings to increase the salaries of commissioners, which might limit the potential for the quality of services to be reduced.

The third key issue is the pricing of commissioned services. Both empirical and theoretical evidence (Gaynor 2006) highlights that regulated prices in healthcare lead to higher quality under competition. Moreover, with regulated prices, the commissioner has no financial incentive to cut quality in order to lower costs, because the price of services is fixed by the government. With flexible prices, there is clearly an ability to purchase lower quality services.

The fourth issue is how accountable the commissioners are to consumers for the quality of services they purchase. Greater accountability should lead commissioners to act in the interests of consumers, be they patients, parents or pupils. If other reforms increase the accountability of the individual provider of service to consumers, this should make decentralisation more effective. For example, in a schooling context, allowing parents to hold schools accountable for their spending decisions would be a complementary reform. This could result from simple parental choices of schools, but may need to be accompanied by greater transparency on school spending decisions and their relative efficiency. This is more important when one considers the fact that many services are focused on individual pupils, such as high-need services. Ideally, schools should be held accountable for the quality of provision they commission for high-needs pupils.

Therefore, getting the incentives right is crucial in order to ensure that the decentralisation of commissioning and competition do not result in lower quality services. This is less likely to occur when commissioners are well informed about the quality of services on offer, when they cannot use budget surpluses to increase salaries and when they are accountable to the ultimate consumers

(pupils or patients) for the quality of services they purchase. If they are not well informed, then there may be a need to regulate prices in order to ensure that quality is not reduced, as has occurred with the commissioning of healthcare services. In all cases, greater accountability is likely to increase the quality of services.

c) Learning how to commission effectively

Casalino (2011) argues that it is important to give commissioners time in order to become effective purchasers of health services. This is underlined in Dixon et al (2011), who argue that the effects of recent reforms are only seen at the end of the period of Labour government, highlighting that it is a slow process to adapt to a new commissioning framework. They conclude that “repeated reorganisation seriously undermined the ability of commissioners to mature and operate as commissioners.” This evidence therefore suggests that if reform is undertaken, it should be given time before changing the commissioning structure again, for otherwise one will not see the results of an effective commissioning process.

d) Risk for commissioners

The introduction of real budgets and commissioning by GPs can affect the risks to which GP practices are exposed. GPs could be exposed to the risk of very high costs of healthcare for some patients: indeed, in a US healthcare setting. Some medical groups in California went bankrupt (Thorlby et al 2011). One possible way to deal with this is to introduce a “stop loss” ceiling, which limits the maximum payment for one patient that is borne by the GP practice. Here the main relevance to schools will be with respect to services for high-needs pupils and is an important reason why many local authorities allocate funding for high-needs pupils on an individual basis. If all funding was delegated to schools, then small schools could experience significant variations in costs as a result of a small number of pupils with very high needs.

e) Impact of providers

One crucial effect is the impact of decentralising commissioning on the providers of healthcare, or in the case of schools the providers of central services or high-needs services. This is partly dependent on the structure of the decentralisation: if decentralisation is mandatory, there may well be a different impact to a partial decentralisation. One argument for GP commissioning is that GPs may seek out higher quality services for their patients. Whether or not this leads to better quality provision depends on the suppliers’ response. If there is no change in overall provision quality, then seeking out shorter waiting times is a zero-sum game: any one patient who gets a shorter waiting time will be matched by another who has a longer one.

We can learn from broad principles: providers of these services will only increase quality if they have the incentive to do so. We also know that the market structure will affect how providers compete on price or quality. A lower ability to

monitor the quality of commissioned services may well lead to lower quality services. However, if schools are commissioning services from the private sector (and they have the ability to recognise quality and the willingness to demand it), we may imagine that it will be profitable to increase quality if that is what schools demand, as it should lead to higher profits for these providers.

Clearly the scale of differences in information possessed by purchasers and provider affects the quality of service provided. As Gaynor (2006) shows, with imperfect information, competition in the provision of these services may lead providers to compete on price and reduce quality. The greater the understanding of the commissioned services that schools/ GPs possess, the greater their ability to recognise and purchase high quality services.

5. Overall Conclusions and Policy Implications

With the continued expansion of the Academies programme and planned reforms to school funding, the responsibility for commissioning services seems likely to increasingly rest with schools themselves rather than local authorities. Currently, the level of local authority spending on services that will be delegated to schools is higher in secondary schools than it is in primary schools and there is only a small degree of variation across local authorities. In contrast, the level of spending proposed to be left at the discretion of school forums is relatively large and varies significantly across local authorities. This spending is largely made up of school-specific contingencies, behaviour support services and capital expenditure; all of which are more focused on secondary than primary schools. Under the proposed reforms, local authorities will still retain a small amount to spend on central services (largely the school admissions process and contributions to combined budgets). They will also retain spending on high-needs pupils, which is more evenly distributed between primary and secondary schools, but varies significantly across local authorities.

Spending on such services tends to be higher for secondary schools than for primary schools. The variation in spending retained by local authorities partly reflects differences in levels of special educational needs and use of special schools. Local authorities that are more deprived also retain greater levels of spending for services provided centrally. However, we also observe that larger local authorities (in terms of total pupil numbers) tend to spend less per pupil on services for high needs pupils, as do rural local authorities compared with urban ones.

The extent to which services can effectively be decentralised to schools will clearly depend on schools' capacity to take on these responsibilities. We find that there are clear differences in the current scope of schools to take advantage of potential commissioning responsibilities, as proxied by their current level of operational and clerical support staff. In particular, secondary schools are heavily

reliant on operational and clerical support staff, and make greater use of them than primary schools of the same size. To take full advantage of any new commissioning opportunities, some primary schools may thus either need to employ greater numbers of such support staff or form collaborations with other schools. Further analysis of the relationships between the employment of operational and clerical support staff and school characteristics reveals that larger schools and those with higher levels of deprivation or SEN are more reliant on such support staff than other schools. Meanwhile, secondary schools in inner London tend to employ fewer operational and clerical support staff than comparable secondary schools in the rest of England.

There is only a relatively short experience of shifting the responsibility of commissioning services from local authorities to schools. In contrast, there is a longer and richer experience in the NHS. We have thus examined the theoretical rationales and empirical evidence relating to past reforms that have the decentralised commissioning in healthcare, in order to see what lessons can be learned for schools policymakers.

Reviewing the theoretical literature leads to a number of broad conclusions. Firstly, the local information held at lower tiers of a hierarchy can, in principle, lead to more efficient and effective provision of public services. However, this has to be traded off against the fact that the incentives faced by both commissioners at these lower levels may not lead to better outcomes for consumers of these services and that both the commissioners and providers may not be sufficiently accountable to consumers. Other reforms are clearly complementary and perhaps even necessary. For example, if other reforms also increase the accountability of the individual provider of a service to consumers, this should make decentralisation more effective. In a schooling context, allowing parents to hold schools accountable for their spending decisions would be a complementary reform. This could result from simple parental choice of schools, but may need to be accompanied by greater transparency on school spending decisions and their relative efficiency.

It is difficult to gain a strong consensus on the effect of past reforms to GP commissioning. More rigorous work is required to measure reliably the true impact of this policy on health outcomes. From the evidence that does exist, one general conclusion is that the effect of past reforms on outcomes and quality has probably been marginal, especially after administration costs are accounted for.

Finally, there are some clear and general recommendations for effective implementation. 'Getting commissioners' incentives right' is crucial in order to ensure that the decentralisation of commissioning and competition do not result in lower quality services. This is less likely to occur when commissioners are well informed about the quality of services on offer, when they cannot use budget surpluses to increase salaries and when they are accountable to the ultimate consumers (pupils or patients) for the quality of services they purchase. If they

are not well informed, then there may be a need to regulate prices in order to ensure that quality is not reduced, as has occurred with the commissioning of healthcare services.

Developing good management and commissioning skills is also important, although commissioners should also have some specialist knowledge of the service area, otherwise they will not hold the “local information” needed to improve services. This may well take resources, and importantly, time for commissioners to mature. However, developing strong accountability to parents can support such a reform.

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Appendix

Table A.1. Average relationship between total number of operational and clerical support staff and school characteristics

	Primary	Secondary
Total number of pupils	0.012*** (0.001)	0.026*** (0.001)
% of pupils with FSM	0.033*** (0.004)	0.272*** (0.028)
% of pupils with SEN statement	0.056** (0.028)	0.409*** (0.134)
% of pupils with SEN without statement	0.015*** (0.005)	0.058** (0.026)
% of pupils with EAL	0.009 (0.006)	0.013 (0.015)
Voluntary aided school	-0.047 (0.074)	-0.369 (0.405)
Voluntary controlled school	-0.010 (0.082)	0.285 (1.034)
East Midlands	0.242 (0.639)	8.740*** (1.715)
East of England	0.299 (0.533)	5.787*** (1.559)
North East	-0.693 (0.505)	4.017** (1.640)
North West	-0.877* (0.501)	3.221** (1.306)
Outer London	-0.119 (0.530)	2.733** (1.304)
South East	1.398** (0.594)	7.367*** (1.419)
South West	0.742 (0.681)	6.428*** (1.572)
West Midlands	-0.417 (0.648)	4.503*** (1.334)
Yorkshire & Humber	0.448 (0.712)	6.859*** (1.453)
Constant	-0.350 (0.568)	-9.507*** (1.808)
Observations	16,532	2,348
R-squared	0.259	0.633

Source: Authors' calculations using January 2010 LEASIS data.

Notes: Figures are the estimates of an ordinary least squares regression of the total number of support staff on school characteristics. *** = statistically significant at 1% level; ** = statistically significant at 5% level; * = statistically significant at 10% level. Numbers in brackets are robust standard errors, clustered at the local authority level. The R-squared is the proportion of the variance in the total number of operational and clerical support staff that can be explained by the model. Community school is the reference category for school type; Community Special schools have been excluded from this analysis. Inner London is the reference category for region.