The fundholding fandango

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SUMMARY. General practitioner fundholding allows flexible use of resources at the coal-face, provides incentives to alter practice such as prescribing within cash limits and forces hospitals to be more responsive to general practitioner demands. However, the additional administrative costs both in time and money, the fragmentation of purchasing power compounded by a lack of expertise and experience in contracting, and the poor information and financial systems which exist in the National Health Service are severe constraints. A suggested way forward is to delegate responsibility for running the scheme, including the contracting and billing, to district health authorities offering more flexible budgets to all practices and extending the scheme as local information systems allow. This will reduce fragmentation of purchasing power and administrative costs and re-establish local accountability. It will also give the general practitioner more time to see and treat patients, who will see the system as being fairer.

Keywords: GP budget holder; health service internal market; health service purchasers; health service organization; quality assurance.

Introduction

THE 1992 United Kingdom general election delayed all but a political discussion on the fundholding scheme at its first anniversary. More general debate can now proceed in the context of the government's overall intentions. The Conservative party manifesto stated 'we will ensure that the benefits of fundholding arrangements are available to any GP who wishes to apply, and we will be ready to extend the scope of the scheme further as it develops.'[1]

It will not be possible to reach any conclusions as to the value of fundholding based on empirical data within the lifetime of the government, and anecdotal evidence is patchy.[2] The evidence that is available for the first year of the scheme suggests no difference between the experiences of patients of fundholding and non-fundholding general practitioners as shown by volume of, or waiting times for, elective surgery or outpatient care (Bradlow J, Coulter A, paper presented at the 36th Annual Scientific Meeting of the Society of Social Medicine, Nottingham, 1992). Before discussing some of the problems of fundholding and how they can be dealt with, it is worth summarizing the advantages which will need to be consolidated.

Advantages

Responsive providers

The direct general practitioner purchaser changes the relationship between general practitioner and provider hospitals and their consultants, shifting the general practitioner into the driving seat and forcing hospitals to be more responsive to general practitioners' and patients' demands.

Flexible use of resources

Within practice management, in prescribing and at the interface between primary and secondary care, the ability to change the balance of services to meet local demand is a real advance. The use of high technology equipment of small size in general practice such as is available for surgery based chemical pathology testing is but one example of how the balance of services will change in the future.

Success of cash limited budgets

Substantial funds have been saved through generic prescribing.[3] Fundholders can channel these savings into other aspects of patient care. Cash limited prescribing budgets are an incentive to rationalize prescribing and so can save money. This is also likely to be true of cash limited referrals, although it is not known whether this process would improve patient care. The effect could be to limit the referral of patients who would benefit from specialist care.

General practitioners have identified different opportunities arising from fundholding. The feeling that they can provide a faster and more appropriate referral is a powerful one, but changes in referral patterns have mostly been small.[4] Objectively, the most direct advantage of fundholding for general practitioners has been the change in services available within practices. The numbers of counsellors, practice nurses and nurse practitioners is increasing as funds are diverted from drugs and secondary care. This change seeks to reduce the pressure on general practitioners themselves while giving them more time to spend with patients. However, are people always happy to see someone other than their family doctor when they attend the surgery? Skill mix in primary care is an issue which needs to be addressed.

Disadvantages

Unsustainable costs

The estimated expenditure for preparatory and management allowances to cover expenses for fundholding in general practice surgeries was £8 million in 1991–92 in England (*Hansard*, 30 January 1991, column 667). Additional costs include the extra hours spent by general practitioners themselves and the many hours spent by provider units dealing with contracting and invoicing for general practitioner fundholders. The greatest burden has probably fallen on hard pressed provider units. Instead of devoting time to improving resource management the hospital accountants have had to deal with the administration of general practitioner funding. While recognizing the necessary expense incurred by introducing fundholding, in the long term simplifying the administration of the funds is necessary if costs are to be controlled.

Limited entrepreneurial endeavour

How true are the stories of imaginative entrepreneurial purchasing by general practitioner fundholders? Alternative provision using non-National Health Service facilities and the switch of services from one provider unit to another are often cited.[5] These possibilities are not just a feature of the general practice scheme but of the changes to the NHS as a whole, through the new purchaser–provider arrangements.[6] Where district health authorities

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are freed of provider issues and have taken on the single role of purchaser, the purchasing power at their command has allowed considerable entrepreneurial endeavour.[7] Their ability to develop the NHS market has been far more successful than the sum of the efforts of general practitioner fundholders. The imaginative ideas generated by general practitioners and stimulated by the scheme need to be magnified and given the opportunity to be put into effect.

Poor information and financial systems

The NHS information system, made up of hospital and community services computer systems providing minimum data sets prescribed centrally and by purchasers, has not been able to cope with fundholding. *Ad hoc* data collection has been time consuming and the results difficult to interpret. Computer systems for fundholders were rushed onto the market in 1991 and many still have considerable problems. The data systems of providers and practices are incompatible, even in the coding systems used. There are considerable information technology problems to overcome, and at ever increasing costs. General practitioner fundholders have had to spend far too long dealing with administrative matters at the expense of clinical care. Where costings have been inaccurate fundholders have been able to take advantage of artificially low prices. Markets only work where real, not spurious efficiency is rewarded.

The financial arrangements of fundholding can be circumvented, for example by using funds not spent to pay staff or to improve premises, and then using money that would have been spent on these to increase partnership income. Rigorous financial audit will need to go hand in hand with any increase in the flexible use of funds.

Discussion

It is not surprising that general practitioners, without training in health care evaluation, management or financing secondary care have neither the expertise nor the experience to contract for services. An apt analogy is a chain store manager in each local shop being given the task of visiting factories, commissioning next year's designs and purchasing a selection. This is not good for business because knowing what the customer is asking for is but a small part of successful purchasing. As important are the skills of the buyer who combines knowing what the customer wants with knowledge of design developments and the comparative capacity of factories to produce good quality articles at competitive prices, and has negotiating skills and forward planning expertise to anticipate the future market. In terms of the NHS these are the skills and expertise held in the district health authority purchasing agencies by general managers, accountants and public health physicians. Their skills and the time to carry out purchasing properly need to be made available to all general practitioners, fundholders as well as non-fundholders, leaving the general practitioner free simply to make choices.

Individual fundholding practices have limited ability to bring about changes in provider units. But bulk purchasing power can and has produced the changes sought by general practitioners.[8] Proper consultation with local general practitioners can produce a broad consensus on priorities for the coming year that gives the purchasing authority a sensible shopping list of quality issues to raise with providers. Imaginative schemes are underway in some districts. For example, in one district health authority substantial bonus payments are being made to provider units if general practitioner related quality targets (such as receipt of discharge summaries within two days, discharge letters within two weeks, outpatient appointments within two weeks and so on) are achieved (Somerset Health Authority, unpublished report). These quality issues are being addressed at the same time as contracts have been negotiated with clinical directors that are targeted to eliminate patient waiting times of more than 12 months for elective surgery.

In theory fundholding provides more flexibility, but in practice the small size of each fundholding budget, and the relative shortage of providers in many places, limits the choice of secondary care. To develop the market, alternative providers need to be encouraged. This requires large purchasing budgets and fundholders will thus tend to form consortia. To avoid more bureaucracy and duplication of financial systems fundholders could enter some form of consortium arrangement with district health authorities to negotiate contracts on their behalf with standards, qualities and prices which would be to the mutual advantage of both, with the balance of the general practitioner fundholder's budget being used to purchase individual hospital treatments from trusts with which the district has no contract.

At the opposite end of the spectrum to fragmented purchasing is the monopoly purchasing authority. The NHS reforms did not include the use of insurance companies to give people choice of purchaser. Rather, they confirmed the use of geographically located purchasing authorities. The expensive experience of the American health care system using insurance companies should encourage us to continue to commission health care for whole communities, while using comparisons of performance rather than competition, together with the ability of general practitioners to opt out to some extent, to keep purchasers on their toes.

At present regional health authorities are responsible for ensuring the appropriate use of the tax payers' money given to general practitioner fundholders. In practice, this leaves general practitioners accountable to no one, and there is a clear conflict between their accountability for providing general medical services and their accountability for purchasing secondary care. The inclusion of the purchase of community services accentuates this conflict. The wish of many general practitioners is to be able to be in control of all staff, including nurses, who are caring for their patients for whom they are responsible in the community. This will be easiest to facilitate if they are able to provide not purchase community services. The purchasing of community services by general practitioner fundholders is tending to confuse the arrangements being agreed between local authority social services departments and local health authorities to implement the community care legislation.

Where purchasing authorities are dynamic and have instituted changes using the new powers conferred on them by the NHS and community care act, patients of non-fundholding general practitioners will be on the top tier of a two tier system. They will receive more services of higher quality, and which represent better value for money. Where the purchaser–provider split has not yet developed, the patients of general practitioner fundholders may receive better care. In a national health service all patients should be getting the best out of the system and should feel they are doing so.

The way forward

The government is looking to develop the NHS market further. How can this be done effectively, taking into account the experience of the first year of fundholding? The following changes are suggested:

- Accountability for the primary care element of the fundholding budget needs to be held by the local family health services authority and the secondary care element by the local district health authority — combined into a common health authority in due course.
- All general practitioners should be offered fundholding budgets for hospital outpatients, elective surgery and diagnostic

services, and they should be given the opportunity of providing (but not purchasing) community health services.

- Flexibility should be increased to allow virement of funds from one part of the budget to another to allow the best use of resources in the general practice surgery.
- Commissioning, contracting, financial arrangements and billing should be carried out by the district health authorities on behalf of the general practitioner fundholders and not by the individual general practitioners themselves. This will eliminate duplicate administration.
- Local extension of the scheme, for example to include all geriatric services, should be permitted as local information and financial systems allow.

Such developments will eliminate the two tier system, allow all general practitioners to participate at a fraction of the projected administrative cost while re-establishing accountability, increasing flexibility, reducing the fragmentation of purchasing power and developing commissioning and contracting skills within health authorities, which will give the general practitioner more time to see and treat patients. This will in turn make fundholding more attractive to more general practitioners and would be fairer to patients. Such developments would give us, not so much a fandango, but more a foxtrot — patient and doctor as partners, dancing in time, to a less frantic rhythm.

References

1. Conservative party. *Conservative manifesto 1992.* London: Conservative Central Office, 1992.
2. Coulter A. Fundholding general practices. *BMJ* 1992; **304:** 397-398.
3. Bradlow J, Coulter A. Effect of fundholding and indicative prescribing schemes on general practitioner's prescribing costs. *BMJ* 1993; **307:** 1186-1189.
4. Coulter A, Bradlow J. Effect of NHS reforms on general practitioners' referral patterns. *BMJ* 1993; **306:** 433-437.
5. Smith R, Crawford M, Roberts H. Purchasing in practices. *Health Services Journal* 1993; **103:** 28-30.
6. Department of Health. *Funding and contracts for hospital services. Working paper 2. Working for patients.* London: HMSO, 1989.
7. National Health Service Management Executive. *Good practice and innovation in contracting.* Leeds: Department of Health, 1993.
8. Mawhinney B. *Purchasing for health. A framework for action.* London: National Health Service Management Executive, 1993.

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