the social sciences,[22-31] and new philosophies and methodologies are emerging. There is a whole philosophical movement, devoted to structures of human understanding, which has important relevance to the human meanings of scientific evidence.[32] The sociopolitical contexts of research projects, and the intentions, ideologies, traditions and interests of both researchers and interpreters, are all regarded as relevant data for an open process of interpretation that emphasizes plurality, uncertainty and philosophical critique.

This is not to say that outcome studies are not important — the ones that have been done have been immensely important in stimulating theoretical argument — only that they are unlikely to be conclusive. The one thing we do know is that people are increasingly asking for the kind of unhurried, skilled and compassionate attention that qualified counsellors are educated to provide, and it may be that this kind of attention deserves to be sufficient outcome in itself.

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General practice fundholding: time for a cool appraisal

THE subject of general practice fundholding arouses strong passions. Its proponents claim that giving general practitioners control over budgets has resulted in improved efficiency, greater responsiveness to patients' needs and enhanced quality of care. Critics of the scheme argue that it leads to widening inequalities, fragmentation of services and deterioration in relationships with patients. The government has hailed it as a great success, claiming that fundholders have proved to be better purchasers than district health authorities with the result that their patients receive more appropriate services.[1] In October 1994 the secretary of state for health announced a further extension of fundholding so that more patients might benefit. This underlined the government's confidence in the scheme, but how far is this confidence justified?

There is no doubt that fundholding is becoming more popular among general practitioners. Despite strong opposition when it was initially introduced, the voluntary scheme has grown rapidly such that in England it now encompasses 1682 fundholding practices who between them control £2800 million of health service resources. Their combined practice populations make up 36% of the population of England[2] and this is set to rise again in April 1995. In some parts of England population coverage is already over 70%. New and even more radical developments include the 'total fundholding' experiments in which some practices hold budgets for all their patients' health care needs, including accident and emergency services, medical and psychiatric inpatient care, and maternity services, which are excluded from conventional fundholding.[1]

Surveys of general practitioners and anecdotal reports have shown that many fundholders are convinced that they have achieved major benefits through their involvement in the scheme.[3-6] However, reports from non-fundholding practices

engaged in joint purchasing with their local district health authorities make similar claims.[7-9] These impressionistic accounts do not amount to specific proof that one mode of allocating health service resources is superior to the other. There is no doubt that for some general practitioners involvement in fundholding has provided an exciting new challenge to set against the ennui of everyday general practice and the relentless pressure of patient demand. An answer to the mid-life crisis perhaps, but is this a firm enough basis for a major policy change?

When the National Health Service reform package was first announced there were many calls to introduce the changes on a pilot or experimental basis.[10] However, the secretary of state for health remained set against commissioning scientific evaluations on the grounds that to do so would suggest a failure of resolve and would impede progress with implementation.[10] Fortunately a few research funders, notably Oxford Regional Health Authority, the King's Fund and the Scottish Office, took a more enlightened view and some interesting results from evaluative studies have begun to emerge.[6,11-17] Evidence in support of the government's claims that patient care has benefited from the introduction of fundholding is limited.

There is evidence that budgetary control has provided an incentive to implement more cost-effective prescribing policies[11,13,14] and that fundholding practices have been able to use savings on their drugs budgets to invest in new practice-based services.[4,5] Some of these innovations, such as practice-based physiotherapy services, diagnostic technology and consultant outreach clinics, are popular with patients, but may not be the most cost-effective use of scarce health service resources.[18,19] It is also important to remember that none of these innovations is exclusive to fundholding practices. Good practices were reviewing their prescribing protocols and investing in new facilities long before fundholding was invented. There have been suggestions that fundholders have been over-funded in comparison with the amounts available for the care of patients registered with non-fundholding practices.[15] It will be hard to resolve the truth or otherwise of this allegation until a satisfactory system of weighted capitation funding has been devised, but this is proving difficult.[20]

Claims that fundholding leads to more efficient use of resources tend to ignore the fact that the administrative costs incurred in dealing with numerous small-scale purchasers are inevitably greater than when purchasing is carried out by one large district health authority. This increase in transaction costs would be justified if it had resulted in improvements in the quality of care and responsiveness to patients, but to date there is little hard evidence that this is the case. The government hoped that the reforms would foster consumer choice,[21] but there is no evidence that patients are exercising greater freedom of choice,[22] nor that fundholding general practitioners are more likely to take account of patients' preferences.[23]

Howie and colleagues' study, published in this issue of the *Journal*,[17] is the most sophisticated attempt yet to measure change in quality of general practice care since the introduction of the NHS reforms. The lack of a non-fundholding control group means that we must be cautious about attributing the observed changes to any particular model of health care purchasing, but the findings raise the interesting question of whether the incentives have resulted in benefit to certain patients at the expense of others. In view of the increase in social problems experienced by the patients of these Scottish practices, it is questionable whether it makes sense for busy general practitioners to shoulder the additional administrative burden of managing patient care budgets at a time when their patients' needs are becoming increasingly complex.

There are risks inherent in the headlong rush to fundholding. While there are obvious attractions of a scheme which shifts the balance of power in favour of primary care, there are serious concerns that when budgetary pressures begin to bite, fundholders may be tempted to remove patients with expensive health care needs from their lists.[6] There are also worries that the scheme will lead to greater inequalities in access to health care and damaging fragmentation of complex services, for example inhibiting the coordination of services for patients with serious long-term mental illness. These concerns may prove to be unjustified, but it makes no sense to behave like an ostrich and refuse to investigate the issues. It is high time we had a well-funded, coordinated attempt to gather scientific evidence on the risks, benefits and costs of the alternative models of health care purchasing.

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