

# The abolition of the GP fundholding scheme: a lesson in evidence-based policy making

Adrian Kay

## SUMMARY

*The general practitioner (GP) fundholding scheme was introduced as part of the Conservative government's 1991 National Health Service reforms and abolished by the Labour government in 1998. This paper contends that the scheme was introduced and abolished without policy-makers having any valid evidence of its effects. In particular, it focuses on the salient features of the decision to abolish. These were: (a) that it was not based on evidence; (b) that it came relatively soon after the introduction of the scheme; and (c) the GP fundholding scheme was voluntary and increasing numbers of GPs were being recruited. The overtly political nature of the introduction of GP fundholding is already well documented and is important in understanding the lack of evidence involved in the development of the fundholding scheme. Keywords: policy makers; fundholding; evidence-based decision making.*

## Introduction

THE pace of health care policy reform in the National Health Service (NHS) is increasing.<sup>1</sup> While the first reforms came 17 years after the inception of the NHS; the GP fundholding scheme was introduced and abolished within seven years. The scheme was abolished despite 57% of GPs having opted to be fundholders by 1997/1998. This figure had increased in every year of the scheme and can be considered a proxy for the increasing acceptance of the scheme among GPs. However, whether this involved choice is a moot point; instead, it may have been a grudging acceptance of an unavoidable fate; the central motivation of many GPs in electing to become fundholders seems to have been the fear of the consequences of not being a fundholder.<sup>2</sup>

The Conservative government decided against any appraisal, early evaluation or piloting of the scheme, partly owing to fears that the medical profession would sabotage such an enterprise.<sup>3</sup> It may be argued that many of the critics of fundholding were willing to attribute negative traits, characteristics or dispositions to the scheme without having the evidence required to substantiate their beliefs or assertions. For example, throughout the period 1991–1997, the Labour Party maintained its commitment to abolish the scheme if elected to power. In a variety of contexts, it consistently made the claim that the scheme had created a 'two-tier' NHS. In particular, while the accusation that fundholders had preferential access to secondary care may have been true, this was never substantiated by robust evidence.

## Development of the fundholding scheme

The fundholding scheme created a different set of 'property rights' for participating practices; that is, they were subject to a different set of rules governing the use of NHS resources than non-fundholders. Unlike the country's non-fundholders, fundholding practices were able to negotiate their own secondary care contracts, decide which providers, services, and patients would benefit from their funds, and keep any surpluses that they generated. Their local health authorities, on the other hand, determined health care priorities for the patients of non-fundholding practices and, before the introduction of various local and national prescribing incentive schemes, non-fundholding practices had no rights to any efficiency savings that they generated.

Initially, applicants for fundholding status had to meet strict screening criteria before securing entry into the scheme. For example, applicants had to demonstrate partner commitment to the scheme, good management skills, and the possession of a business plan.<sup>4</sup> Although it may have reduced the number of practices that secured entry

A Kay, MA, PhD, lecturer in economics, University of Glamorgan Business School, Pontypridd.

### Address for correspondence

Dr Adrian Kay, University of Glamorgan Business School, Pontypridd CF37 1DL. E-mail: akay@glam.ac.uk

Submitted: 6 March 2000; Editor's response: 12 April 2000; final acceptance: 26 June 2001.

©British Journal of General Practice, 2002, 52, 141-144.

into the scheme, the screening process reduced the potential for 'adverse selection' (that is, the recruitment of practices that wished to join the fundholding scheme for the benefits that it offered but were unable to manage a budget). As a result of this selection procedure, GPs who gained entry into the scheme tended to be housed in large, well-organised practices with good management skills, committed partners, and up-to-date computer systems.<sup>5</sup> The selection rules were clearly biased towards producing a fundholding cohort that would allow political success to be claimed.

The fundholding scheme was changed several times during its lifetime in an attempt to make the fundholding option more attractive to non-fundholding practices. For example, the minimum list size was reduced to 7000 patients (from 9000) and the budget was extended to include district nursing, health visiting, chiropody, dietetics, community and mental health services, and provision for people with learning disabilities. The government also made it possible for smaller practices to group together to form fundholding consortia, as a means of meeting the minimum list size requirement. The opportunity to form such groups led to the development, by practices themselves, of a variety of consortia models of fundholding.<sup>6</sup>

A significant extension of the fundholding logic came in 1995 with the creation of three different fundholding options: standard, community, and total. Standard fundholding would be an extension of the existing scheme, but would also include specialist nursing services and virtually all elective surgery and outpatient care. The community option was intended for small practices (with 3000 or more patients) and would allocate a budget for staffing, drugs, diagnostic tests, and most of the community health services in the standard scheme. Finally, total fundholding would cover all hospital and community services, as well as staffing and prescribing. However, in contrast with the introduction of the original scheme in April 1991, the total fundholding option was piloted. This decision marked a shift in the style of Conservative health care policy away from the confrontational, 'big-bang' approach favoured during the introduction of GP fundholding, and towards an emphasis on piloted, incremental change.

This shift was further evinced by the launch of a consultation exercise about the future of primary care with a wide range of health service professionals, patients, and managers that resulted in the policy document *Primary Care: the Future*, published in June 1996. This formed the basis of two White Papers, *Choice and Opportunity* published in October 1996 and *Primary Care: Delivering the Future* in December 1996. They both detailed plans to give family doctors the ability to opt out of the single, national Contract for GP remuneration. The White Papers guaranteed that the principle of a national contract would not be challenged and that any changes in contractual status would be voluntary.

Although the Conservative government wished to promote its proposals for an extension of the contractual arrangements available to GPs, *Choice and Opportunity* stated that 'there was no enthusiasm for moving directly to any or all of these options without careful exploration first and no enthusiasm for forced change'. In keeping with this pledge, the White Papers announced that legislation would be passed

that would allow practices and trusts (that wished to do so) to pilot the different types of contracts before their wider introduction. In reaction to the White Paper's contents, Dr John Chisholm, deputy chairman of the General Medical Services Committee declared: 'It is good to see a package of proposals which reflect the priorities of family doctors ... we can begin to move forward again in general practice'.

The incoming Labour administration introduced personal medical services (PMS) pilots for three years, based on the Conservative government's two White Papers. The Primary Care Act 1997 allowed those providing PMS to set aside the existing contract for general medical services (also known as the 'Red Book') and enter into a more flexible contract with the health authority. The Labour government's acceptance of its policy inheritance in this area and its decision to pilot and evaluate a change in primary care policy are in marked contrast to its attitude to GP fundholding.

### Official and empirical studies

The Public Accounts Committee of the House of Commons published a report on the first three years of the operation of the fundholding scheme in England.<sup>7</sup> The report suggested that fundholders had achieved a faster rate of delivery of secondary care services, while securing reductions in waiting times, improving access, and widening the range of services available to their patients. However, the report argued that the scheme had not affected the care given to patients of non-fundholding practices, as fundholders had secured many of these improvements by purchasing previously unused hospital capacity.

The Public Accounts Committee had two main concerns about the operation of the scheme. First, that the scheme had relatively high management costs, with cumulative expenditures on management allowances and computer purchases during the first three years of the scheme being £147 million. Secondly, that between fiscal 1991 and 1993 a significant number of patients had been removed from their practice list at the request of their GPs. However, there was no clear evidence that this occurred on cost grounds, or that patients were more likely to be expelled from fundholding practices.

The Audit Commission produced several reports on the initiative.<sup>5,8</sup> Their 1996 report *What the Doctor Ordered: A Study of GP Fundholding in England and Wales* considered the first five years of the scheme. This was one of the most comprehensive reports published on the management, operation, and effects of the fundholding scheme. As part of the study, the Audit Commission examined the demographic and organisational characteristics of participating practices. In relation to the former, the commission found that, initially, fewer practices in inner-city areas had become fundholders. As a result, participating practices tended to have more affluent and less socially deprived patients. Indeed, by 1994/1995 significant regional variations in fundholding coverage were evident, with the scheme achieving proportionately lower coverage in some inner-city and/or deprived areas. In relation to their organisational characteristics, the Audit Commission reported that fundholding practices tended to be relatively large, often housed in purpose-built premises, with more support staff and equipment, including

computers. However, they differed from equally large non-fundholding practices as they had more of the features normally associated with high standards and better quality in general practice (for example, higher rates of childhood immunisation and accreditation to provide minor surgery and/or postgraduate training). Therefore, the Audit Commission's work suggests that the fundholding screening process ensured that only larger, well-organised practices were initially allowed into the scheme.

Following the introduction of the 1991 reforms, a number of independent academics also examined the effects of the fundholding scheme on GP referrals, prescribing, and other activities in NHS general practice. Although they varied in terms of years studied, the number of practices examined, and the areas analysed, these studies helped compensate for the absence of a government-sponsored evaluation (or piloting) of the schemes. In this paper, only those reviews of the studies that were available when the decision was taken to abolish the scheme are reviewed; this will show some of the then existing consensus on the effects of the scheme.

One early review of the available fundholding literature<sup>9</sup> concluded that there were 'extensive gaps in current knowledge about the impact of the scheme' and that the claims that 'GP fundholding has resulted in improvements in efficiency, responsiveness, and quality of care are in general not supported by the evidence'. Another review argued that 'few reliable conclusions about fundholding, either positive or negative, can be drawn from existing research'.<sup>10</sup> A review two years later also concluded that there was a dearth of high quality evidence on many aspects of the fundholding scheme, particularly in relation to referral rates, patient outcomes, and service quality.<sup>11</sup> A review of the scheme's effects on prescribing<sup>12</sup> found that, in the short term, many early-wave fundholders had managed to secure economies in their prescribing by switching to cheaper, generic drugs. However, in the longer term, such savings may not have been sustainable. One of the last reviews available to inform abolition<sup>13</sup> concluded that 'evidence concerning the success or otherwise of general practice fundholding over the last six years is incomplete and mixed' and, unless further research was undertaken, 'the jury will have to remain out on whether fundholding has secured improved efficiency in the delivery of health care'.

The fundholding literature reviews suggest that the evidence on the desirability and effectiveness of the scheme was both limited and equivocal when fundholding was abolished by the Labour government in March 1999.<sup>14-17</sup> Instead, the motivating factor for abolition seems to have been the history of fundholding as a political issue.

### Abolition and the implications for general practice research and policy

The new Labour government suspended entry into the fundholding scheme in May 1997 and instructed hospitals to introduce common waiting lists for fundholding and non-fundholding patients. Six months later it published a White Paper, *The new NHS: Modern, Dependable* with proposals for a replacement — the 1998 National Health Service Act that abolished the GP fundholding scheme and introduced Primary Care Groups (PCGs). This was a return to the 'big

bang' approach to health care policy that marked the introduction of fundholding in 1991. There was no provision for: (a) the piloting of PCGs before their implementation; or (b) a systematic evaluation of the fundholding scheme before its replacement. This type of approach to policy reform impedes the gathering of evidence that would have helped to inform policy change.

Each PCG is allocated a cash-limited budget for hospital and community health services, prescribing, and general practice infrastructure for the patients that they serve. The *New NHS* document stated that the groups would be expected to subdivide their allocations among local practices in the form of indicative budgets that cover all of the aforementioned services. Importantly, the ability of fundholders to transfer funds between budgets has been extended to all GPs. For example, the White Paper announced that 'every practice will have a prescribing budget, as most do now' (page 8). Further, the *New NHS* document announced that the 'Government wants to keep what has worked about fundholding, but discard what has not' (page 33). As a result, PCGs may be expected to determine for themselves what aspects of the fundholding scheme should be employed when devising their local, practice-level budget schemes.

Although Labour's plans have allowed fundholding to be abolished without, in principle, discarding the effective aspects of the scheme, the absence of a systematic evaluation has meant that conclusive evidence on what aspects of the initiative actually worked is not available to the government or to PCGs. There are no data, nor is there any model available that explains the effects that the fundholding budget itself, the extra resources given to fundholding practices or the difference in property rights to non-fundholding practices had on general practice. Moreover, it is not clear whether the types of practices that elected to join the scheme influenced its effects, or whether fundholding would have been equally effective among all practices.

### Discussion

Evidence-based policy making requires a degree of trust to exist between policy-makers and the part of society that is the subject of policy. In the case of the GP fundholding scheme, there was an absence of trust in the relationship between the British Medical Association and the government. Two main reasons account for this. First, the scheme was the subject of strong party political opposition and the Conservative government had a long-held suspicion that the BMA had been working in 'unspoken alliance' with the Labour Party.<sup>18</sup> Secondly, the scheme itself was deliberately divisive of GPs; it produced two groups: the fundholders and the non-fundholders. In a climate without trust, any evidence would inevitably be the subject of political manipulation, or in the current terminology, 'spin'. It is significant for this paper that, as the rate of acceptance of fundholding increased among GPs using the proxy of how many were 'in' compared with how many were 'out', the Conservative administration felt more confident in adopting a more conciliatory and evidence-based approach to the future development of the scheme.

The fundholding scheme illustrates the problems associated

with attempting to formulate health policy in the absence of reliable data on the effects and cost-effectiveness of new initiatives and those already in place. Policy-makers may have no means of identifying the strengths and weaknesses of the policy initiatives that they introduce, or of determining what elements of existing policies should be incorporated into future schemes. What is required for a more evidence-based approach to policy-making is a detailed analysis or model of the significant motors of change in NHS general practice. However, for the research community to produce such work requires a commitment by government to systematic policy evaluation and a period of policy stability.

The implication of the abolition of the fundholding scheme is that political exigencies can easily override any ambition for evidence-based policy-making. The result is that research and policy become disconnected and the period between major reforms of the NHS becomes increasingly short. For example, the Labour government's willingness to pilot and evaluate PMSs, but not PCGs, may be attributed to the extent to which fundholding had become a politically divisive issue in the previous seven years; there was a political urgency to the replacement of fundholding but not the implementation of other primary care reforms.

## Conclusions

The abolition of the GP fundholding scheme has not allowed researchers, policy-makers, and the medical profession to reach any firm conclusions on the question of whether the introduction of financial management into NHS general practice is either desirable or effective. It may have been a political necessity to abolish fundholding, given Labour's stance on the scheme when in opposition. However, that conclusion tells us more about the politics of health policy in Britain rather than the strengths and weaknesses of the GP fundholding scheme.

## References

1. Webster C. *NHS reorganisation: learning from history*. London: Office of Health Economics, 1998.
2. Robinson R, Hayter P. Reluctance of general practitioners to become fundholders. *BMJ* 1995; **311**: 166.
3. Lawson N. *The view from No. 11: memoirs of a Tory radical*. London: Transworld Publishers Ltd, 1992.
4. Trent Health. *GP fundholding — in practice*. Sheffield: Trent RMA, 1994.
5. Audit Commission. *Fundholding facts: a digest of information about practices within the scheme during the first five years*. London: HMSO, 1996.
6. Smith J, Bamford M, Ham C, et al. *Beyond fundholding: a mosaic of primary care-led commissioning and provision in the West Midlands*. Birmingham: Health Services Management Centre, 1997.
7. Committee of Public Accounts. *General practitioner fundholding in England*. London: HMSO, 1995.
8. Audit Commission. *Briefing on GP fundholding*. London: HMSO, 1995.
9. Coulter A. Shifting the balance from secondary to primary care. *BMJ* 1995; **311**: 1447-1448.
10. Petchey R. GP fundholding: weighing the evidence. *Lancet* 1995; **346**: 1139-1142.
11. Gosden T, Torgenson D. The effect of fundholding on prescribing and referral costs: a review of the evidence. *Health Policy* 1997; **40**: 103-114.
12. Baines D, Tolley K, Whyne D. *Prescribing, budgets and fundholding in general practice*. London: Office of Health Economics, 1997.
13. Smith R, Wilton P. General practice fundholding: progress to date. *Br J Gen Pract* 1998; **48**: 1253-1257.
14. Stewart-Brown S, Surender R, Bradlow J, et al. The effects of fundholding in general practice on prescribing habits three years after the introduction of the scheme. *BMJ* 1995; **311**: 1543-1547.
15. Surender R, Bradlow J, Coulter H, et al. Prospective study of trends in referral patterns in fundholding and non-fundholding practices in the Oxford region. *BMJ* 1995; **311**: 1205-1208.
16. Bain J. Budget holding in Calverton: one year on. *BMJ* 1992; **304**: 971-973.
17. Duckworth J, Day P, Klein R. *The first wave: A study of fundholding in general practice in the West Midlands*. Bath: Centre for the Analysis of Social Policy, University of Bath, 1992.
18. Klein R. *The New Politics of the NHS*, London: Longman, 1995.