Empowering GPs as purchasers

Virginia Morley

This is the first in a series of articles on the future of family health services authorities

Summary

- FHSAs have defined their role in purchasing primary care
- FHSAs have also found themselves intermediaries between district health authorities and general practitioners
- All of the purchasing authorities recognise the need to educate general practitioners on how to use their influence in the purchasing process
- General practitioners should be involved in the purchasing process as they purchase the bulk of health care; are the first point of contact for the users of the health service; need to have input on what is purchased; and need to be able to manage the changes resulting from the shift in the balance of power towards primary care
- The involvement of general practitioners in the purchasing process at present varies considerably among health authorities. Several district health authorities have developed models of purchasing that enable different levels of involvement

The NHS reforms gave general practitioners and primary health care teams a long awaited chance to exert greater influence over the pattern of services in both hospitals and the community. Practices can now purchase as fundholders[1] or exercise their new found powers through commenting on the purchasing plans of the health authorities. In this way general practitioners have begun to be involved in making decisions about effecting change in the balance of services between primary and secondary care and in establishing priorities for the types of services they wish to see delivered in the future.

Family health services authorities have found themselves acting with and on behalf of district health authorities wanting to get closer to general practitioners and to understand better what they want purchased. However, they have also found themselves caught between what district health authority purchasers with a population based public health focus want and what general practitioners want based on their patients' needs.

Educating GPs

Fundholding has undoubtedly had its successes,[2] reflected in a sea change in the attitude of hospital clinicians and management towards general practice and recognisable improvements in the management and organisation of practices. However, it still remains a scheme that is limited to a relatively small proportion of practices. This is certainly the case in many inner city areas, where there has been philosophical and political opposition to the scheme and where the organisational barriers to becoming a fundholding practice have been considerable.

Meanwhile, purchasing authorities themselves have changed, particularly where previous districts have merged. Family health services authorities have spent considerable effort defining not only a role in purchasing primary care but also working in tandem with district health authorities to begin discussions about extending purchasing across the interface between primary and secondary care.[3] Increasingly during this time almost all purchasing authorities have struggled with how to educate general practitioners and so empower them to use their influence constructively in the purchasing process.

This seems a two stage process. The first stage is eliciting a general practitioner's interest and commitment to being involved in purchasing. It may seem obvious to suggest that the level of understanding about purchasing among general practitioners and primary health care teams is extremely varied, but primary care has a long history of suffering from being physically distanced from other parts of the service and the discussions taking place there. Recognising this as a structural problem and using educational and other networks to offer general practitioners maximum opportunity for discussion is a first step to facilitating their involvement. The level of understanding they need to play an active part in the process and thereby challenge decisions taken is often underacknowledged.

Many general practitioners still need to be convinced that their views will be listened to and where appropriate acted on. Practitioners who initially took a stance against involvement in purchasing because of their concerns over fundholding leading to a two tier system need to be persuaded that they are still needed in influencing purchasing decisions overall. All of this must be achieved against a background of general practitioners in inner cities struggling with an increasingly challenging role as services providers in primary care. They need to be encouraged to put minimum effort to maximum effect by focusing on areas where they and the public will be able to identify changes and value the results.

Secondly, priority needs to be given to establishing structures that will enable all general practitioners to be involved in influencing the views of the purchasing authorities, including those who have hitherto expressed little or no interest and those who already have a clear interest in participating. Confusion has existed about how to achieve this. There is also a lack of clarity over where the emphasis should be for promoting the involvement of general practitioners. To date this has been placed on involving them in acute services where the current bulk of expenditure is for district health authority purchasers. However, this may not be the most appropriate frame of reference for general practitioners for whom purchasing primary and community care may be much more relevant on a day to day basis.

Need for GP involvement

There are several reasons why general practitioners and primary care need to continue to stake their claim on involvement.

Firstly, general practitioners and other members of the primary health care team in effect purchase the bulk of health care, the resource implications of which are considerable. Encouraging active responsibility for this is vital.

Secondly, general practitioners and primary health

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care teams are the first point of contact for users of the health service. They can therefore be considered to be close to the community they serve and have the potential to be advocates for the health needs of patients. Local involvement of general practitioners, the new breed of practice managers, and other members of the primary health care team is needed. Working with district health authorities they may offer some new solutions to longstanding problems, give greater priority to local need, and enable the development of services with the capacity to respond to changing needs over time. This builds on their existing knowledge of local services and the potential for their development.

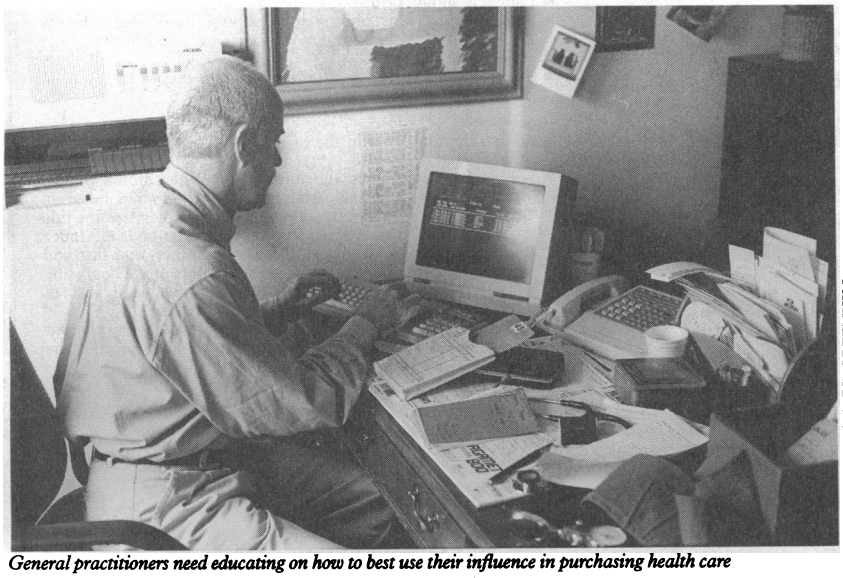
Thirdly, the current pace of change in ideas about what needs to be purchased is increasing. The language that has developed to express these ideas is becoming increasingly more difficult for those outside the immediate discussion to understand. This means primary care needs to continue to develop its own capacity to question the decisions that are being taken.

Finally, the reforms aimed to shift the balance of power in determining use of resources from hospital doctors to general practitioners. This has been described as a golden opportunity for primary care to develop a much enhanced role. What seems important, however, is that the transition is managed through an informed use of general practitioners' influence on decisions. While relishing this opportunity there is a need for considered action. Undoubtedly there is a need to continue to emphasise the importance of change in an area where exhaustion of general practitioners is clear. There is a need to protect primary care from becoming a dumping ground for services which need to be provided but which they are currently not resourced to deal with.

General practice and primary care need to be centre stage to ensure that the rhetoric of a transfer of resources from secondary to primary care does not actually entail an overall loss of resources.

A range of possibilities

While much of this is difficult to achieve in practice, there are examples where changes and developments have been seen. In south east London, for example, the status of general practitioners as effective contributors to the debate about services has grown and led to the recognition of an umbrella group set up to represent their views in purchasing. General practitioners are also active members of focus groups that discuss particular areas of service such as diabetes. Communication has improved and an outreach approach has developed, with practices being courted by both purchasers and providers.



SALLY AND RICHARD GREENHILL

General practitioners need educating on how to best use their influence in purchasing health care

The purchasing authority have made considerable efforts to collect general practitioners' views towards services. A survey identified high levels of consensus around key areas for change in acute services which has made the setting of some priorities for change easier.[4] Perhaps more interestingly, it indicated general practitioners' overall high level of satisfaction with the quality of community health services but identified a wish for a much greater volume of services to be provided. Initiatives such as the "quality alert mechanism," which enables a quick feedback of problem areas from general practitioners to the purchasing agency, also have to be seen as straightforward and practical moves to better enable monitoring of contracts through the year.

Many authorities are widening the scope of discussion with general practitioners to develop appropriate means of local involvement. What seems to exist is a continuum of purchasing involvement.[5] General practice fundholders are at one extreme, with regional health authority top sliced budgets, although only very few practices are participating in the most deprived inner city areas. At the other end of the scale are what can be called "sensitised district health authorities" such as Tower Hamlets or South East London Commissioning Agency, where the district health authority retains all the strength of combined purchasing power but seeks to maximise general practitioners' participation in decisions about what is commissioned. The most likely pattern, which is already being discussed, is a mix of these two extremes. The following three examples are used to highlight possible options.

Example 1

Stockport District Health Authority has developed a locality model of purchasing with extended outposts in localities. A purchasing plan constructed by the authority in close collaboration with the family health services authority is modified through local negotiation with practices. While at the current time the main focus of this work has been to better assess need through localities, work is being undertaken to identify ways in which budgets could be allocated to localities and purchasing carried out at the local level. This model also emphasises not only general practitioners' voices but all local voices, including those of nurses, community leaders, voluntary groups, and others.

Example 2

North Derbyshire District Health Authority has established "locally sensitive purchasing." While locality links are planned to aid general practitioners' involvement a major thrust of this initiative is to allocate the district budget to individual practices on an indicative basis. This is a challenging model, attempting to allocate 75% of all district health authority expenditure on services rather than the 20-25% currently given to practitioners through fundholding.

Example 3

Closer still to delegated purchasing to practices is "practice sensitive purchasing," which is developing in Bath.[6] This seeks to divide the district health authority budget notionally between practices, thereby delegating purchasing authority to each practice. This clearly has strengths both in building contracting from the "bottom up" and emphasising equity in distributing resources. However, the level of sophistication required both in allocating resources and in organisational competence within practices means it is unlikely to find widespread acceptance.

Which model?

There are four main questions which emerge from these discussions which are central to all of these proposed models. These are: How do we continue to aim for a principle of equity in distributing limited resources across populations? How are management costs and the administrative burden of any of these models minimised? How do we develop systems that are sensitive to the needs of users as well as the expressed needs of practitioners? and, How do we maintain the practitioners' interest when the need for change is identified but managing a planned process of change will take time?

Further, there are underlying themes that are relevant to the subsequent discussion of possible models for general practitioners' involvement in purchasing. There is a need for a continuing range of models which enable different levels of involvement both by practitioners and the wider community. There is a need for debate with practitioners and the public to revise the local model. While supporting the practitioners' role as proxy for the patient in purchasing, there is a need to recognise the limitations of this, and wherever possible we should be seeking the opinion of the public. Any models developed need to maximise health gain while retaining the strength of the focus on individual patients.

It is clear that general practitioners have the potential to be able contributors to the discussion of what needs to be purchased and where, although the mechanisms by which this is achieved need a variety of well thought out and appropriate structures. There is also a need to reassure general practitioners that proposed changes in service can be realistically achieved through their influence.

1 Department of Health. *Funding general practice: the programme for the introduction of the GP budgets.* London: DoH, 1989:199.
2 Glennister H, Matsaganis M, Owens P. *A foothold for fundholding.* London: King's Fund Institute, 1992. (Research report 12.)
3 NHS Management Executive. *Integrating primary and secondary health care.* London: NHSME, 1991.
4 Department of Public Health Medicine. *GPs views of local health services.* London: South East London Commissioning Agency, 1992.
5 *Northampton options in purchasing project: interim and final report.* Northampton: Northampton DHA, 1992.
6 Tarnowski J. *Practice sensitive purchasing (PSP) in Bath: DHA report on the feasibility study.* 1992.

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