Budget holding: here to stay?

John Bain

In 1991 we visited four parts of England to see how health authorities, hospitals, and general practitioners were implementing the NHS reforms and have since followed them up to see what changes have resulted. Over the next few weeks we will be describing how each of these places find themselves at the start of the third year. In this first article John Bain describes what he found on his third visit to a first wave fundholding practice near Nottingham.

Department of General Practice, Westgate Health Centre, Dundee DD2 4AD
John Bain, *head*

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Nottinghamshire family health services authority serves a population of around a million people and so far eight of the 52 eligible practices have become budget holders. A further eight practices have joined the scheme this April, bringing the percentage of people in budget holding practices to 17% of the Nottinghamshire population.

The Calverton practice was one of the first budget holding practices and has now had two years' experience of developing a new approach to the delivery of care. On previous visits I met only members of the practice team,[1 2] but this time I also met consultants and health service managers. What lessons have they learnt and what impact is budget holding having on patient care and the providers of care?

Improving services for patients

The Calverton practice has a stable population of 9157 patients and a budget of £1 047 084 in 1991-2 and £1 144 948 in 1992-3 (table I). The main focus of the practice's activities has been on reducing waiting times for specialist care. Within the past two years eight practice based clinics have been created, with additional services being provided at the independent Park Hospital (table II); altogether 519 patients have been referred to these clinics. In orthopaedics and ophthalmology these arrangements have led to significant reductions in waiting times for operations such as cataract and hip replacements.

For Norman Stoddart, the senior partner in the practice, "the frustrations of trying to reduce waiting times for hospital care have now gone" and his partner Don Simpson, who previously had doubts about budget holding, is now enthusiastic about "providing services I wasn't able to offer before." Another partner, Tom Venables, views the initiatives as a lever to bring about "a sea change in hospital organisation and bringing the service to the patient."

TABLE I—*Calverton's budget allocations and savings in 1991-2 and 1992-3*

	1991-2 (£)	1992-3 (£)
Hospital services	548 882	590 931
Drugs and appliances	404 920	430 726
Practice staff	93 282	123 291
Total budget	1 047 084	1 144 948
Budget per patient	113·91	125·00
Estimated savings	50 000	25 000

TABLE II—*New clinics created since inception of budget holding either in the health centre or at Park Hospital*

Specialty	Months of operation	Frequency	New patients referred
	Health centre		
Geriatrics	16	Monthly	36
Neurology	16	Monthly	51
Ophthalmology	14	Fortnightly	106
Diabetes	12	Monthly	29
Gynaecology	8	Monthly	82
Orthopaedics	4	Monthly	23
Rheumatology	3	Monthly	10
Counselling	8	Weekly	38
	Park Hospital		
Ear, nose, and throat	4	As required	41
Physiotherapy	17	As required	103

Referrals to hospital outpatients in 1992-3: medical 392, surgical 833.

Organisational changes in the practice

Bringing about changes in services has not been achieved without a major input from Norman Stoddart, who now spends one day a week negotiating with health authority managers, the family health services authority, and consultants. He also coordinates the work of the six practice staff (out of 15) directly involved in administering the budget (see box). A development manager had been in post from 1990 to 1992, but the development of specialist services within the health centre required a doctor to be in charge of bringing about these changes, and it did not prove possible to delegate such responsibilities to the manager. Although Stoddart wonders whether he would have chosen to use his time in this way had he known at the outset how demanding budget holding would be, he is enthusiastic about how things are progressing and is supported by staff who enjoy "the reflected glory of patients liking the services they are now getting."

> ***"If we are being accused of offering a better service what is wrong with that?"***
>
> FUNDHOLDING GP

Any shift in organisation does not occur easily, and niggling problems continue. Despite investment in computer assisted medical records, obtaining accurate information about referrals seems beset with unresolved problems. The coding system in the practice does not match with health authority records, and invoices have still to be checked by hand. With a cost per case approach to budget holding, this is a major administrative task and, according to the trainee in the practice, Dr Kesten Challen, "It is the most paper using practice I've ever seen."

Budget allocation and savings

At the start of budget holding there had been many anxieties about how costs were calculated, and the partners feared that they might not be able to work within their budget. A year ago the financial situation had been unclear, and negotiating the costs of services had been complex. The first completed year of budget holding had shown that the practice was capable of working within the budget and had achieved an underspend of around £50 000, which was within the original estimates. This allowed the practice to alter its premises, and future plans include the provision of counselling and physiotherapy services.

The partners had been displeased about a six month delay in the release of savings for 1991-2 because of auditing procedures within the health authority. "This

Administrative support staff

Practice manager
(2 full time; 5 part time)

Practice secretary

Fundholding administrator*

Clinic administrator (part time)*

Audit and computer coordinator*

Computer clerk*

Finance manager (part time)*

Business consultant (part time)*

*Team that administers the budget

disrupted our planning as we knew what our savings were but could not get access to the actual money." In 1992-3 the projected underspend is around £25 000, and, according to Norman Stoddart, "anything below that will make us look very closely at how we are using our budget."

Consultant clinics in the health centre

The creation of practice based clinics has led to closer relationships with several consultants. A typical example is the arrangement whereby George Milligan, a consultant orthopaedic surgeon, offers a monthly outpatient clinic in Calverton. This has given him a new lease of life at a time when he was becoming disillusioned with the hospital system. He enjoys the more personal service that he can provide; patients can be seen in a less hurried fashion; and if operations are required plans can be made which fit in with everyone's requirements. Orthopaedic procedures requiring admission are carried out in a local private hospital.

George Milligan's views were echoed by Mr Rubasingham, who has been conducting fortnightly ophthalmology clinics at the health centre for over a year. The health centre clinics in orthopaedics, ophthalmology, geriatric medicine, neurology, rheumatology, and gynaecology have all resulted from personal contact between general practitioners and specialists who have been prepared to offer services outwith the traditional outpatient system. Nevertheless, all the consultants I spoke to admitted that the Calverton model would be difficult to apply if there was a major expansion in fundholding. They thought there were too few consultants to visit each practice.

Fears and doubts among other consultants

Consultants in other specialties have openly rejected the concept of fundholding. A dermatology clinic in the health centre had to be abandoned when the dermatology unit in Queen's Medical Centre in Nottingham decided to discontinue separate services for fundholding practices. Consultant dermatologist Les Millard is an outspoken critic of the type of system in Calverton and last year was supported by the British Association of Dermatologists, who do not approve of their members working in fundholding practices.

Dr Millard belongs to a group of doctors who are sceptical of a health service where "the drive is business oriented and depersonalised with the emphasis being on cutting costs and generating income." For him, budget holding "is a direct assault on the delivery of equal services to the population as a whole, and I am deeply concerned about quality of care issues if the main aim is to get patients seen quickly." He could foresee problems for consultants opting to work in community based clinics and being overwhelmed by requests. When I pressed him on the features of the status quo which should be retained it became clear that all was not well within the hospital. Consultants felt that demands on them by management to attract fundholders' money reduced the control they had to maintain a central core of services and to deliver a total service to all general practitioners, fundholding or not.

Professor Malcolm Symonds, the dean elect of Nottingham Medical School, shared the view that there could not be a major shift towards community based outpatient clinics given the present number of specialists. He also wondered how acute services could be safeguarded within district general hospitals if outpatient activity was to disappear from them. He was concerned that it was difficult to plan effectively if "a whole bunch of entrepreneurial general practitioners are negotiating a variety of different services." Professor Symonds also worried about providing suitable general practitioner attachments for medical students. "The economics of student teaching are not attractive and the general practitioners will be so tied up with running a business that they will have little time to spend with students." It was interesting that he did not think that similar problems might arise in hospitals, where consultants may be equally tied up with managing a reorganised health service.

Non-fundholding general practitioners

Among the non-fundholding general practitioners I met were Dr Peter Barrett, chairman of the local medical committee, and Dr Alan Birchall, a partner in a training practice in central Nottingham. Both were convinced that budget holding had led to a two tier system, though Peter Barrett did admit that budget holding "had galvanised the district health authority into action, and we must be grateful for that." He was not, however, convinced that short term gains would alleviate underfunding in the specialties of orthopaedics, ophthalmology, and ear, nose, and throat. He also doubted whether budget holding would lead to more efficient use of resources. The challenge for the local medical committee was to negotiate with the district health authority to achieve optimum services for all patients.

> ***"A shake up in how hospital outpatient services were organised was long overdue."***
>
> CONSULTANT OPHTHALMOLOGIST

Dr Alan Birchall was fiercely critical of fundholding and was opposed to the idea of putting doctors in competition when only some patients were likely to gain, and then only in the short term. With other general practitioners of a similar view he had set up a locality purchasing group. Its aims were to ensure that the patients of all general practitioners get equal access to secondary care and to increase the provision of good quality secondary care to patients.

Dr Birchall had observed relationships between fundholding and non-fundholding general practitioners deteriorating and thought that inquiries from consultants about whether practices were intending to become fundholding eroded professional trust. He was also concerned about colleagues who were contemplating fundholding "through fear of losing out as opposed to a true belief in this approach." As a general practitioner trainer he thought that the reforms were a potential threat to the future development of teaching and that the next generation of general practitioners were being exposed to a profession in conflict about priorities.

The managers' viewpoint

Robert Carter is the family health services authority manager responsible for budget holding in Nottinghamshire and thinks that budget holding can influence the speed of services to patients and reduce wastage in the system. Much of his time was spent negotiating estimates for budgets, and he had to juggle the figures provided from a wide variety of sources. The cost per case approach in Calverton did not appeal to him and he favoured cost and volume contracts. "In a cost per case system, hospital units don't know where they stand and this presents difficulties in planning."

Nottinghamshire family health services authority does not have a policy of actively promoting budget

holding and he considered his role "as one of a facilitator who could help practices achieve their aims." His main problems were insufficient time to visit practices and getting practices to adopt a more rigorous method of determining priority needs for their registered population. The latter required good information systems, and, although computer assisted records had to be in place before a practice was accepted as a budget holder, the available software had many limitations.

He understood general practitioners' frustrations with the delays in releasing savings, but this had been essential to scrutinise financial statements during the uncertain early days. His own support systems for managing fundholding were limited and the lack of good software meant that the volume of paperwork was still immense. His hopes for the future included the creation of a method of encouraging practices to provide planning proposals based on expected clinical activity.

Gillian Whitworth, contracts director of the independent Park Hospital, had found that budget holding was marginal in terms of her hospital's overall service, but "I would be surprised if it is not here to stay." Most of the Park Hospital services for budget holders were concerned with orthopaedics, ophthalmology, and ear, nose, and throat surgery—the specialties which general practitioners claimed were underfunded. The teething problems facing Gillian Whitworth were often related to variations in the ability of practice personnel to handle accounts. Like Robert Carter, she found a cost per case approach cumbersome, and the gap between procedures being carried out and payment was lengthened by practices having to check invoices and then seek approval from the family health services authority. She had some fears about a price war when hospital trusts came on stream: "We will just have to wait and see how NHS provider units and the private sector compete with each other."

Conclusions

The original intention of the Calverton practice had been to develop policies on drug prescribing side by side with changes in the provision of secondary care, but the latter had taken up most of their time and energy. This probably reflects the frustrations which general practitioners have faced over many years when dealing with specialist services, and negotiating changes in these services has been the priority.

The 519 patients who have been referred to specialist clinics in the health centre represent only 5·6% of the practice population—but they suffer from distressing and chronic conditions which can now be dealt with more quickly. Also the health centre clinics were not the only outpatient services which patients were being referred to, and over the past year a further 1225 patients received specialist services. Evidence from a study of fundholding practices has shown that these practices can be agents for substantial changes in how care is provided for large numbers of patients.[3]

As pioneers in a risk taking exercise the partners in the Calverton practice are naturally committed to what they see as a major shift in how secondary care is provided. To have created health centre based clinics for patients with chronic problems and unmet needs has given them a great deal of personal satisfaction, and their original aim of "being in control of our own destiny" is coming about. They now work very closely with eight consultants, who could ultimately become members of an extended partnership. This has also provided a new lease of life to some of the consultants, who felt shackled by hospital bureaucracy.

"Patients think I am now responsible for rationing care and this is upsetting the doctor-patient relationship."

NON-FUNDHOLDING GP

What price has the practice had to pay? It may have lost some friends as it has gone out on a limb, but the partnership is sufficiently robust to continue to explore new frontiers in health care delivery. Negotiating and managing a cost per case system is time consuming but this may be a short term problem. The administrative staff must be costly, and I did wonder if they would all be essential in years to come. The practice support staff budget for 1992-3 was £123 291, and to transfer this level of staffing to all similar sized practices would require a larger injection of resources into primary care. The financial management of the Calverton budget has, however, been efficient.

For those who remain sceptical and even hostile to fundholding, Calverton represents a two tier system. Yet a two tier system was probably inevitable during the first wave of budget holding, when the political aims were to shake up the hospital system. Some general practitioners have undoubtedly used budget holding to settle old scores with hospital departments. From my observations in Calverton and Nottingham, the themes of power and control have been central to the whole process of reorganising patient care. Even the chairman of the local medical committee admitted that budget holding has been the lever to shift the power base from hospital providers to general practitioners, who can now negotiate services for patients.

The fears expressed about the impact of budget holding on educational programmes do not seem to be based on evidence. A vision of the future could include community based integration of primary and secondary care which would provide opportunities for a broader based education for medical students and postgraduates. The notion that tertiary care centres have to remain the corporate base for all medical education may have to be challenged. Likewise, if there are not enough consultants to service budget holding practices there may be a need either to create

RICHARD MAILE

Budget holding: a major administrative task

more consultant posts or to allow specialists in training to work with budget holding practices.

Purely financially the Calverton model is unlikely to be cost effective on a wider scale, but models of budget holding will vary from town to town and from district to district. No one whom I spoke to could foresee a day when all practices could become budget holders; similarly no one could predict what the ceiling for the number of fundholding practices would be. Bosanquet has argued that with increased overheads it will be easier to spread risks across a larger number of practices and share administrative costs.[4] There are no signs yet of fundholding practices joining together as a consortium in Nottinghamshire, though this seems to be a logical next step. A combination of budget holding practices could pool their savings to pay for much needed local services as opposed to each individual practice retaining relatively small sums of money to prop up their own internal needs. There will certainly be a need to subject budget holding to the same critical appraisal that would take place in true market.[5] A recent report suggests that fundholding may be more expensive and less effective than joint commissioning by general practitioners and district health authorities.[6]

> ***"If I make separate arrangements with fundholding practices it will conflict with my service to all patients in the district."***
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> CONSULTANT PHYSICIAN

So far most of the attention in budget holding has been focused on the health care professionals involved, and there is a dearth of information about patients' views. The Calverton doctors believe strongly that patients appreciate locally based consultant services and are now reaching the stage of demanding an extension of these services. But there are anomalies in the range of procedures available within budget holding, and there may be losers within certain groups of patients.

I have no doubt that the Calverton practice will continue to flourish and can handle both the internal and external pressures which their innovations have led to. I was, however, left feeling sympathetic for those non-fundholding general practitioners who are no less committed to providing good quality services for their patients. The challenge for the district health authority will be to try to satisfy the demands of these practices and reduce the obvious inequalities in care. The creation of the locality purchasing group accords with the view that non-fundholders may be best placed to inform district health authorities of the quality of services received from hospitals and how service agreements with providers should be developed.[7] Professionally the consultants seem to be facing the greatest difficulties. Squeezed between purchasing general practitioners and purchasing managers, their power base has been eroded and their discomfort is only too apparent.

Despite claims and counterclaims about the advantages and disadvantages of budget holding, the principle of placing responsibility for negotiating specialist services in the hands of general practitioners seems here to stay. So far, the attention has been on hospital services, but there are now opportunities to negotiate community care services. The lessons to be learnt from negotiating contracts for community care seem to improve general practitioners' understanding of the social services and how best to use them.[8]

At the end of the day views about budget holding still seem to depend on which side of the ideological fence people stand. If there is any lingering disquiet in my mind about how budget holding has developed in Nottingham, it is the hint that trust between professional groups is being undermined. To quote Tom O'Dowd, one of the Calverton partners: "It is the extent to which the apparent gap between winners and losers in the market place can be closed which will determine whether optimising care for all patients can be achieved."

I am particularly grateful to everyone at the Calverton practice and to doctors and health service managers in Nottingham who gave up so much of their valuable time to discuss their experiences with budget holding in the area.

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A MEMORABLE PATIENT

Look at the urine

Many doctors, especially those working in a hospital, seem to have given up direct inspection of the urine. The following case reminded me of the importance of this simple practice.

A 21 year old woman was admitted with acute abdominal pain and vomiting. Two weeks before an intrauterine contraceptive device was fitted and had recently been removed; menstruation had started. Her abdomen was remarkably soft and the pelvic findings normal. She became abusive and uncooperative and diagnosis was difficult. She discharged herself but returned 24 hours later with continued pain and vomiting. Laparoscopy and curettage under general anaesthesia were negative. A specimen of urine taken at that time was sent to the laboratory, but the overnight urine was allowed to stand and by the next morning it was the colour of thin red wine. The laboratory confirmed the diagnosis of acute intermittent porphyria by finding excess porphyrins and porphobilinogen in the urine. She had received thiopentone when anaesthetised.

Management consisted of intravenous dextrose solutions and small doses of pethidine. The patient slowly improved except that she had an epileptic fit, attributed to the inappropriate secretion of antidiuretic hormone. Detailed investigation confirmed the diagnosis and showed that she had inherited the dominant gene from her father and had passed it to her son. Although avoiding oral contraceptives, she has not become pregnant again. Earlier inspection of the urine and use of the old fashioned chamber pot might have led to an earlier diagnosis.—ALAN M SMITH *is a consultant gynaecologist and obstetrician in Wolverhampton*