What do we know about fundholding in general practice?

Jennifer Dixon, Howard Glennerster

Abstract

The general practice fundholding scheme was introduced four years ago. So far its impact has not been formally evaluated nationally, but review of published research shows some trends. Fundholding has curbed prescribing costs and given general practitioners greater power to lever improvements in hospital services—for example, reducing waiting times for hospital treatment—but fundholding practices may have received more money than non-fundholding practices. The impact of fundholding on transactions costs, equity, and quality of care (particularly for patients of non-fundholding general practitioners) is unknown. Research into costly reforms such as fundholding needs to be coordinated.

If the general practice fundholding scheme was an afterthought in 1989, it is now at the forefront of the NHS reforms.[1,2] Many practices have joined, covering just over 40% of the population and controlling around 8% of the NHS budget for hospital and community health services. The scheme is evolving from one with large numbers of go it alone fundholding practices towards "multifunds" and the 60 new total purchasing pilot schemes. And at the end of last year the NHS Executive heralded a new closer relationship between health authorities and fundholders, in which health authorities should share information on purchasing and begin to monitor and regulate fundholders.[3]

But as fundholding evolves there is a blip on the horizon—the next general election. While decisions on the future of fundholding will be based on a mix of politics and evidence, the time is overdue to review the evidence on the impact of the scheme to date. We review the main published evidence on efficiency, equity, organisational change, patient choice, and quality of care.

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The scheme

The twin aims of introducing fundholding were to promote better value for money and to improve consumer choice.[4] Individual or groups of practices with a registered population of over 5000 can opt to hold a budget to pay for specific hospital care; drugs; staffing in the practice; and community services—so called standard fundholding.[5] Practices with more than 3000 can hold a budget for community services and outpatient care only (so called community fundholding). Practices can also opt for total purchasing, in which practices can buy any type of NHS care. Any type of fundholding practice can pool management resources with others to form a multifund. Sixteen multifunds are currently operating.

Fundholders are free to choose the type, volume, and location of care to be purchased, although they are obliged to indicate in their purchasing plans how they will address national policies such as the goals in the *Health of the Nation* and the patient's charter.[6,7] Until now fundholders have been monitored by family health services authorities and regional health authorities, although the focus of this has been on the financial management of the fund.

Efficiency

One aim of fundholding was to secure better value for money by encouraging general practitioners to scrutinise their prescribing and referral patterns and to shop among competing providers for the best price and quality. Most research on this subject has focused on the impact of fundholding on expenditure alone and not considered efficiency.

CONTROL OF DRUG COSTS

The effect of holding a budget on prescribing costs has been measured in several studies. In Oxford prescribing costs in fundholding practices decreased while costs in non-fundholding practices increased.[8] In Scotland the volume of prescribing fell in both fundholding and non-fundholding practices, but fundholders held down their unit costs of drugs more successfully.[9,10] It was concluded that the quality of prescribing was maintained. Elsewhere, fundholding has stimulated greater use of generic prescribing and generated sizeable reductions in costs.[11]

REFERRAL RATES TO HOSPITAL

Early work by Coulter and Bradlow investigated referrals from 10 fundholding and six control (non-fundholding) practices in Oxford. They found no evidence that referral behaviour of fundholders was influenced by holding a budget,[12] although Keeley pointed out that some of the controls were preparing to become fundholders at the time and thus may have contaminated the results.[13] In contrast, in Scotland referral rates in fundholding practices fell significantly after entry into the scheme.[10,14] Howie *et al* observed that this drop was matched by an increase in the use of direct access services.[10] The impact of changing referral rates on the quality or appropriateness of care is not known.

SHIFT OF SECONDARY CARE TO PRIMARY CARE

Several surveys have reported that fundholders are offering more services within their practices—for example, specialist outreach clinics, physiotherapy, counselling, dietetics, and chiropody.[10,15,16] Outreach clinics are becoming increasingly popular among fundholders and non-fundholders and provide better access to specialist care for patients.[16,17] But important questions about the appropriateness, efficiency, and quality of care offered in outreach clinics and their impact on general practice and outpatient services remain unanswered.[18] Similarly, whether the other inhouse services are effective or add to or substitute for care in other settings is unclear.[19,20] Therefore whether they are an efficient use of NHS funds is also unclear.

UNDERSPENDING

By the end of the second year of fundholding, fundholders had underspent by £31.7m (3·6% of the budget allocated), of which £2.8m was voluntarily returned to regional health authorities by fundholders.[15] Against this, fundholders had overspent by £9.8m in the same year. By 1995 the total underspend was estimated to be £120m.[21]

This underspend may result from several factors. These include cautiousness to avoid overspending in view of the uncertain demand for care; efficient purchasing and good financial management; underbilling by providers; lower demands for care by the practice population; or an excess of funds allocated to the practice. The influence of each factor relative to another has not been investigated.

Whether fundholders have used their savings efficiently is also unknown. In a recent survey by the National Audit Office fundholders reported using savings to buy equipment for their practice and the local hospital, to improve practice premises and information systems, and to employ extra staff to provide services inhouse.[15] While more exotic uses of savings have been reported elsewhere,[22] it is unclear whether what the general practitioners spend their savings on is better value for money than what health authorities might have done with the money.

TRANSACTION COSTS

The administrative and time costs to the NHS of managing resources and contracting (transaction costs) are likely to be higher with many decentralised practice budgets (held by fundholders) than with larger centralised budgets (held by health authorities).

Despite this, there have been no detailed studies comparing the transaction costs of fundholders with those of health authorities. One recent paper estimated the annual cost to the NHS to be £81 638 per fundholding practice.[23] The Audit Commission is currently studying the transaction costs of fundholding in more detail and is due to report early in 1996.

TECHNICAL AND ALLOCATIVE EFFICIENCY

There has been no published work on how far fundholders are using information on the effectiveness of care (such as the *Effective Health Care Bulletins*) to decide the type of care to purchase. Similarly, how fundholders set priorities for purchasing and how these compare with the priorities of the local health authority are also unknown.

Equity

DISTRIBUTION OF NHS FUNDS FOR HOSPITAL CARE

Comparing the funding of fundholding and non-fundholding practices is a complex task and has been largely uninvestigated. The only published work we know of estimated that the per capita funding of non-fundholding practices varied from 59% to 87% of that for fundholding practices for inpatient hospital care and from 36% to 106% for outpatient care.[24] This work was criticised for relying on the low quality routine data available.[25] Until there is more evidence, it will not be clear how far any of the successes of fundholding are due to generous funding relative to health authorities.

ACCESS TO CARE

That fundholding sets up a two tier NHS has been an accusation levelled since the scheme began. Two tier usually means better access to hospital care for patients registered with fundholding practices than for those registered with non-fundholding practices regardless of need. Many examples of this have been published, having been reported not only by non-fundholding general practitioners and health authorities but also by consultants, hospital managers, and others.[26-31] The amount of complaint suggests a two tier system exists, although evidence from systematic study is so far lacking.

A two tier system may have developed for several reasons. Firstly, the patients of some general practitioners may always have had preferential treatment because of informal professional networks between general practitioners and consultants. The internal market may have simply made these more visible.

Secondly, hospital managers may be more anxious to attract income from fundholders because fundholders can more easily move contracts to other hospitals while health authorities are looked on as captive purchasers. Fundholders may also be more effective at negotiating improvements in services through more direct contact with patients and clinical colleagues in hospitals. Therefore preferential treatment may be offered to fundholders.

Thirdly, fundholders may have more funds than health authorities to buy elective care.[24]

Probably all three are happening to some degree—the extent of each has not been studied. It raises a key but unanswered question: if a two tier system of access is occurring, how far is it because fundholders are forcing quality improvements for all, or how far is it at the expense of patients in non-fundholding practices? Although examples exist to support both suppositions,[27 32 33] research comparing the impact of fundholding on access for patients in fundholding and non-fundholding practices is needed. This comparison has been absent from published studies to date.

"CREAM SKIMMING"

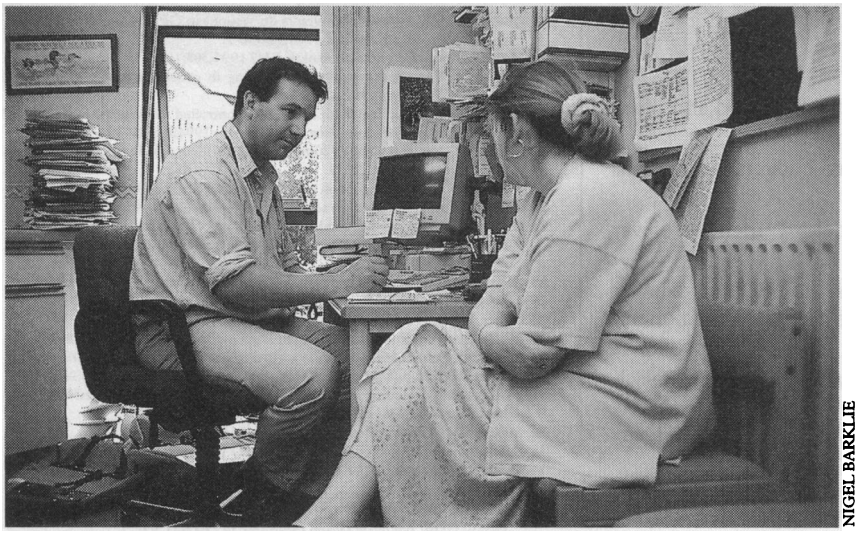
The question of how to set a fair budget for fundholders (meaning a fair distribution of available resources between fundholders and non-fundholders, or a budget which covers the likely need for services) is not resolved.[34] Some patients use a lot of NHS resources, others none. For example, in one practice, 27% of patients used up all of the fund.[35] This provides an incentive for general practitioners to discriminate against patients who are likely to need costly care.[36] We know of no published work assessing whether this is occurring. In theory, adjustments to a capitation formula for funding practices could be made to compensate for expensive patients, but in practice this is likely to be technically difficult.[37]

Organisational change

Another rationale for fundholding was to give an extra incentive to hospitals to be more responsive to general practitioners and through them to their patients. This subject has been studied more than any other.

One of the first studies was by Glennerster *et al*, who found many examples in which fundholders were using their market power effectively to improve the hospital services received by their patients.[36 38] Their conclusion was, at the micro level, that general practitioners were more effective contractors than health authorities because they had better information, were closer to the patient, and were able to make marginal decisions (such as changing contracts with providers) more easily.

Many of these findings have been echoed in other surveys of fundholders and experiences of individual practices. The reported improvements in the process of care have included more informative and prompt discharge letters; a faster response to general practitioners' inquiries; improved access to services such as physiotherapy, inpatient care, and specialist outreach clinics; and a change in the power relationship between general practitioners and hospital consultants.[15 32 39-43]



NIGEL BARKLIE

Fundholders are free to choose the care to be purchased for their patients

Although these surveys provide valuable descriptive information, none has compared the experience of fundholding practices with that of non-fundholding practices (particularly those also active in commissioning[44]) or with other models of purchasing over the same period.

Patient choice and satisfaction

In theory, patients in fundholding practices may have a greater choice where to be treated than patients in non-fundholding practices because fundholders are not locked into the contracts set by health authorities. Again, there has been little work to investigate whether this is so, or whether patients think that it is important.

One survey, of about 1500 patients and 200 general practitioners, found that fundholders were more willing than non-fundholding general practitioners to refer their patients greater distances for elective surgery and they were also less likely to consider only one hospital for referral.[45] However, the patients reported that they were not willing to travel further to be treated more quickly. In Scotland patients' satisfaction with the quality of services provided by fundholding general practitioners was consistently high.[46]

Quality of care

Only two published studies have sought to assess the quality of clinical care provided in fundholding practices. In one of the studies, of joint pain in six fundholding practices, Howie *et al* found that the length of a consultation and the proportion of patients prescribed pain relieving drugs did not change after the practices became fundholding.[14] However, after fundholding was adopted patients reported being less able to understand and cope with their illness. How far these effects reflected changes in the quality of clinical care offered was not clear. In the other study investigating specific conditions Howie *et al* concluded that the clinical care of patients had been maintained.[10]

We know of no work directly investigating whether fundholding has forced improvements in the quality of clinical care in hospitals. In one recent study fundholders ranked confidence in the clinical abilities of a consultant more highly than almost all other aspects of hospital care[47]; in another fundholding general practitioners worked with a local health authority to disinvest in a perceived low quality clinical service.[48]

Summary and discussion

Although fundholding has been studied more than any other aspect of the NHS reforms, empirical evidence on the impact of the scheme is still lacking. What we can conclude from the published research is limited because either the study designs have not included a control group with which to contrast the experience of fundholders or the control groups later decided to join the scheme and were likely to be contaminated. But with these methodological drawbacks in mind, a picture is emerging.

The financial incentives of fundholding seem to be curbing the upward trend in prescribing costs, but the effect on rates of referral to hospital is unclear. Fundholders are challenging the traditional interface of primary and secondary care and offering more services inhouse. Significant improvements in access to and the process of care have been secured by some fundholders. Giving budgets to general practitioners has been associated with a noticeable change in their relationship with hospital consultants.

Set against these important gains, some drawbacks are evident. The costs to the NHS of contracting with many fundholding practices are unknown but estimated to be high. While fundholders report greater access to care, there is a weight of anecdotal (though not yet hard) evidence that a two tier service is operating. Research suggests that fundholders have been funded more generously than non-fundholding practices.

Alongside this scanty balance sheet are a long list of don't knows. These can be grouped into at least five main categories. Firstly, it is not clear how far any gains of fundholding have been because of the greater participation of general practitioners in purchasing, because general practitioner fundholders have had the responsibility and power of a budget, or for other reasons.

Secondly, the impact of fundholding on services for patients in non-fundholding practices, or on services not covered by the scheme, is unknown.

Thirdly, the effects of having many fundholders each with different priorities on the availability and use of services by a district population are also unknown. For a health system with a basic principle of equal access for equal need, this will be an important subject to monitor.

Fourthly, the costs and benefits of fundholding relative to other forms of purchasing such as purchasing in a locality in which general practitioners participate,[44 49] multifunds, or total purchasing projects are largely unknown.[50]

Finally, and perhaps most importantly, the effect of fundholding on the quality of clinical care offered in hospital and in the practice is unknown.

These don't knows are a challenge to those working in the NHS and those in the research community. Given the turbulence in the NHS, teasing out the specific effects of fundholding from those of other policies is difficult and requires careful analysis. The large numbers of people and the resources entailed in managing and operating the scheme raises three questions. Why has not more information about the operation and impact of fundholding been collected or aired? How should research into fundholding and other NHS reforms be coordinated, funded, and initiated? Which methodology is best? These points have recently been discussed by others.[51-53]

Conclusion

A key question for policymakers must be whether or how far to proceed with fundholding. The recent announcement of the extension of fundholding indicates that this question has already been answered by the government. With the general election in sight and little likelihood of major new information about fundholding before then, this balance sheet is almost

Key messages

- Research on the impact of fundholding has been uncoordinated and often methodologically weak
- Evidence suggests that giving general practitioners budgets has helped to curb the costs of prescribing in primary care
- Giving general practitioners budgets has also helped them to lever improvements in hospital services
- The impact of fundholding on transaction costs, equity, and quality of care (particularly for patients of non-fundholding general practitioners) is largely unknown
- Research into reforms of the NHS should be coordinated and study design strengthened

all policymakers have to go on. If decisions are based on a mix of politics and evidence, not surprisingly, politics will win out.

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A MEMORABLE PATIENT

Of sea devils and things

Elizabeth was 12 years old and nearing the end of her inpatient treatment for tuberculosis at the small government hospital in the Western Solomons. One day her grandfather, who had remained with her throughout her stay, drew my attention to a rash which had arisen on the front of her left thigh. The rash appeared vesicular and covered the whole of the thigh in a non-dermatomal distribution.

"Perhaps this is a jellyfish sting," I ventured. No, she had not been in the water. Elizabeth sucked on her lollipop and six pairs of eyes looked at me. I looked at the nurse for inspiration: "This is the mark of Tamalokolo, the sea devil," she said in pidgin English. "Ah, so it is a jellyfish sting then." "No, no, it's the mark of a devil, the sea devil." The six pairs of eyes waited expectantly. I started to sweat. "Mostly," she continued, "they fly through the air in a fiery form and strike people out in canoes, but Elizabeth was on the shore when she was struck. That can happen sometimes. If you see one and you lie down quietly in your canoe sometimes they don't see you and go away again."

Over the next week or two the rash got better of its own accord and Elizabeth remained as unconcerned as ever. Our visiting consultant physician drew a blank and as I recounted the story to all who would listen over the next few weeks I became more and more disenchanted with the sceptical, patronising corner that I was manoeuvring myself into. "How charming. How ingenuous. The mark of a sea devil—who would have thought it?" Gradually, the implicit superiority and arrogance of my stance became increasingly distasteful and, eventually, I stopped telling the story altogether.

I think that Elizabeth has taught me two things. Firstly, just how much lighter and more harmonious it is to respect the beliefs of these gentle people than it is to set about them with the axe of rational cynicism. Secondly, I now know what to do the next time I am out in a canoe and see something fiery coming through the air towards me.—DAVID BERGER *is senior medical officer in Gizo, Solomon Islands*