Can there be fair funding for fundholding practices?

Jennifer Dixon

Most regional health authorities set budgets for fundholding practices according to the amount of care used by the practice population. This article explains why this funding method can only lead to an inequitable allocation of resources between fundholding and non-fundholding practices. Using the experience of North West Thames region, the efforts made to make funding fairer are discussed. The steps that health authorities could take to investigate and reduce the problem are also outlined. In the absence of a capitation formula for funding fundholding practices, the paper suggests that health authorities should do much more to investigate the amount of money they spend on non-fundholding practices. Regions could develop and use other methods to set budgets rather than rely on activity recorded by practices. Regions and the Department of Health should resolve urgently if and how far the budgets for fundholders should be compensated for increases in provider prices.

Treatment in the national health service has always been a bit of a lottery. Treatment depends on where you live, who you are, and the competence of the health professionals who care for you. The NHS inevitably offers a multitiered service to the population despite striving for equity of access for equal need. But now, nearly three years after the 1991 NHS reforms, evidence is mounting that the general practice fundholding scheme has caused a systematic and explicit two tier service to develop, regardless of need.[1-3] While the evidence for two tierism is still largely anecdotal, critics of the fundholding scheme claim that overgenerous funding of fundholding practices lies at the root of such inequity.

This article examines whether the current method of funding general practice fundholders is fair. Using the experience of North West Thames region—a region with one of the highest proportions of residents covered by the scheme—the paper describes how the fundholders have been funded and explains why funding inequity has been inevitable, although difficult to measure, and why progress to reduce it has been slow. It concludes by indicating how the funding process could be made more fair in future.

The GP fundholding scheme

The general practice fundholding scheme was first described in the white paper *Working for Patients*.[4] Under the scheme, practices with a registered list size of 7000 and above can choose to manage a fund which covers four areas of care for their patients: 110 specific hospital treatments (mostly elective surgery) and most outpatient care; community services; drug costs; and practice staff costs. The fund does not cover other hospital care (including emergency care)—fundholding practices rely on the local health agency to purchase care in these areas. The aims of the scheme were to deliver better care for patients, shorter waiting times, and better value for money.

Working for Patients gave regional health authorities the responsibility to set the budgets for each fundholding practice. Funds to cover staffing and drug costs come out of the budget of the local family health services authority. Funds to cover specific inpatient hospital care, outpatient care, and community services are "topsliced" from the budget of the local district health authority.

Here lies the rub. Overgenerous funding of fundholders means fewer resources available for the patients of non-fundholders, the consequences of which are likely to be most acute in areas with high numbers of fundholders, such as in North West Thames region. By April 1993 an estimated 26% of residents were registered with a fundholding practice in the region. In Hertfordshire this proportion reached almost 50% and is likely to top 70% by April 1994. Here, any differential in funding can add up to a disproportionately large impact on the district health authority budget for hospital care. This can lead to a two tier service where fundholders have money to buy care when the district has run out; elective surgery is the area where inequities are most apparent. How funds for the fundholders are calculated and negotiated is therefore crucial.

Calculating the GP fund

Setting the budget for drugs, practice staff, and community services has been least problematic because funds are calculated for all practices in the same way and data collected in these areas are relatively accurate. Budgets reflect a practice's past prescribing patterns and historical levels of practice staffing and attached community staff rather than the need for care. While fundholding practices are given an actual cash limited budget to manage, non-fundholders are given a notional budget for drugs and staffing managed by the local family health services authority. Community services for non-fundholders are purchased by the local district health authority.

By contrast, setting budgets for hospital care has been difficult and controversial. Firstly, budgets for fundholders and district health authorities (and therefore the non-fundholders) are calculated differently. Fundholding practices are funded according to the services historically used by their patients, irrespective of total funds available. However, districts are funded by using a capitation formula to divide up a fixed pot of resources allocated to regions. Secondly, the routine hospital data needed to calculate budgets for fundholders are not reliable and in some cases are nonexistent—for example, outpatient data.

Funding fundholders and health authorities differently

In 1989 *Working for Patients* advised that fundholders would be funded for hospital care in a similar way to districts—on a capitation basis taking into account the health and age distribution of a population and other local factors[4] rather than just reflecting the historical supply of services. However, national work to develop a capitation formula is taking longer than expected, and it is still not available. Without this "top down" method, national guidance recommended that regional health authorities should fund fundholders according to their past activity.[5] Because routine hospital data had shortcomings, it was recommended

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The capitation formula for funding hospital care should take into account the health and age distribution of a population and other local factors; such a formula is not yet available

that potential fundholding practices themselves collect data on inpatient, day case, and outpatient activity and that regions should combine these data with prices to come up with a budget.

Because of the delay in developing a capitation formula, in November 1992 the Department of Health came up with another approach. It published both national average activity rates and national average prices for inpatient services covered by the fundholding scheme.[6] Regional health authorities were to apply these rates to a practice population and multiply the resulting activity with national average prices to estimate a budget for each practice. This approach applied only to inpatient and day case care, not outpatient care. Because it was crude, the Department of Health suggested that the results should be used only as a benchmark in budget negotiations with practices.

However, North West Thames, like other regions, has continued to base the budget for hospital care on multiplying a practice's past activity with prices. Many regions, like North West Thames, simply increase these budgets each year for existing fundholders in proportion to inflation and the growth in resources allocated to the region or local district health authority. Because this means that fundholders and non-fundholders are funded on different bases, inequities in funding are guaranteed.

Problems with calculating budgets using past activity

Even the relatively simple approach of multiplying a practice's activity with price to form a budget has been a problem. In North West Thames, every potential fundholding practice collected activity data during a preparatory period (usually six months) before entering the scheme. But it has been difficult to verify the activity collected by practices without a reliable source to validate it. Activity recorded by practices has been consistently higher than that recorded by the hospitals—over 30% higher in many practices.

Why has this happened? Hospital activity may appear artificially low because of incomplete or inaccurate data. For example, in 1991-2 in North West Thames region's acute hospitals, 9·4% of all finished consultant episodes were not coded for diagnosis, 17% had no general practitioner listed (required to trace activity back to an individual fundholding practice), and in 5·5% no purchaser was listed (unpublished data). By 1992-3 the level of diagnostic coding was unchanged, although the shortfall in general practitioner codes had reduced to 6·4% and in purchaser codes to 2·8%. The accuracy of hospital data is not known. Outpatient data are poorly recorded and activity occurring outside of the region is often difficult to trace back to practices.

Also, practices' recorded activity data may be inaccurately high because discharge information sent from hospitals is poor. Despite regional guidelines, the practice may have mistakenly recorded activity more than once; recorded activity which is not in the fundholding scheme, emergency treatment (the distinction between emergency and urgent treatment is often unclear), procedures taking place in outpatients (in most cases these are covered by the cost of the outpatient visit and should not be counted separately), *all* procedures which patients have undergone instead of the *main* procedure (hospitals bill practices for main procedure only, therefore only this should be recorded), and *all* outpatient attendances when some hospitals bill fundholders for first attendance only. These problems may be exacerbated by the fact that if a practice records more activity, a higher budget is secured.

Problems with prices

Even if the activity recorded by each practice was accurate and verifiable, combining this with price to form a budget gives more scope for inequity.

Firstly, determining what clinical services actually cost is an imprecise science. Costing methods used by hospitals are variable, and the activity data on which costs are based are weak.[7] For example, prices quoted to fundholders in 1993 varied from £371 to £1809 for arthroscopy within North West Thames region and from £255 to £1115 for excision or biopsy of skin—differences that are hard to justify on cost grounds.

Secondly, hospitals calculate costs differently for fundholders and district health authorities—on a cost per case basis for fundholders but mostly on block contract basis for districts—which leads to a different price for each purchaser. When districts are quoted prices on a cost per case basis, these are for extra-contractual referrals. But here the price is usually based on average specialty cost, not the actual cost of the procedure itself, making comparisons meaningless.

Both factors mean that the relation between the prices quoted to fundholders and districts and the true cost of carrying out a procedure is unclear. This gives hospitals scope to raise prices differently for fundholders, adding pressure to the regions to compensate fundholders with higher budgets. Inequity arises when fundholders are awarded larger budgets—less funding is then available for the district health authorities, which must negotiate lower prices with providers or agree to buy less activity. A stark example of this occurred in North West Thames in January 1993 when three hospitals put up prices for fundholders 20-30%. Compensating fundholders for these price hikes required £1·9 m—money which was found from a regional fund for "transitional relief" meant to cushion the effects of the market on providers and purchasers. While transitional relief for hospitals would be a one off payment, compensating fundholders will be a recurrent expenditure. Next year this money will need to be topsliced from allocations to district health authorities.

Budget negotiations and outcome in North West Thames

Intense negotiation between the region (and local family health services authority) and each fundholding practice occurs before the final budget offers are made in February of each year. Not surprisingly, in North

TABLE I—*Allocations to health agencies and general practice fundholders for hospital and community health services (HCHS) in North West Thames region 1993-4 and estimated percentage of health agency population covered by fundholding practices. (Source: North West Thames RHA Information Department, 1993)*

Commissioning agency	Budget for NCHS (£000)	GP fundholder budgets for HCHS (£000)	GP fundholder budget as % of commissioning agency budget	Estimated % of population covered*
Bedfordshire	165 775	11 309	6·9	24·5
Hertfordshire	358 432	44 703	12·5	48·5
Barnet	122 692	3 381	2·8	12·4
Brent and Harrow	197 254	10 308	5·2	20·7
Hillingdon	84 870	3 173	3·7	10·4
Ealing, Hammersmith, and Hounslow	235 196	5 870	2·5	14·9
Kensington, Chelsea, and Westminster	187 908	6 356	3·4	21·8
Region	1 352 127	85 100	6·3	26·3

*Percentages are estimates because the numerator refers to the number of people registered with a fundholding practice in each health agency (using data from FHSAs) and the denominator refers to the number of persons resident in the commissioning agency (using census data). Because of list inflation, and because some patients registered with a fundholding practice will not be resident in the health agency, the percentages shown are likely to be overestimated, particularly in London (especially in Kensington, Chelsea, and Westminster Health Agency).

TABLE II—*Per capita allocations (£) to patients of first, second, and third wave general practice fundholders in North West Thames region for hospital and community services compared with average for fundholders in England 1993-4. (Source: North West Thames RHA Finance Department, 1993)*

Element	North West Thames region	England
Hospital care:		
First and second wave	72	67
Third wave	79	70
Community:		
First and second wave	18	16
Third wave	20	16

West Thames most debate has centred on setting the budget for hospital care.

For new fundholders, agreeing the hospital activity to be funded has been difficult, time consuming, and politically charged. Practices argue that the data they collected are accurate and that they can justify variations in activity in relation to other practices. The absence of a reliable source to verify activity against, of information on what are "appropriate" activity rates or prices, plus the widespread political pressure to encourage more general practitioners to join the scheme has meant that practices have held a strong bargaining position on funding with the region.

But North West Thames has been reluctant to fund activity at face value also because of the incentive for practices to increase referrals during the period of data collection. For first wave fundholders (those entering the scheme in 1991) a ceiling on outpatient activity was imposed—no practice was funded to more than 160 referrals per 1000 registered population. For second and third wave fundholders, ceilings were also imposed for inpatient activity, and guidelines for recording activity in practices were tightened up.

Still worried about the potential for error, by spring 1993 North West Thames had also calculated three benchmark budgets for hospital care for each practice to compare with those calculated by using practices' recorded activity. The first benchmark was calculated with the national average inpatient activity rates and prices suggested by the Department of Health,[6] although this was later discounted because the department had included the rates for emergency care—care not covered by the scheme. The second benchmark used the same method but substituted regional average activity rates and prices. For the third benchmark, the region used a capitation formula that had been developed by the department of general practice at St Mary's Medical School (unpublished data). This formula essentially predicted inpatient and day case activity for "fundholding procedures" in each fundholding practice after taking account of local factors such as mortality and socioeconomic deprivation. The predicted activity for each practice was multiplied with regional average prices for fundholding procedures to come up with a budget.

The budgets predicted by using the second benchmark were 6% lower than those calculated with practices' recorded activity across the region as a whole and 12% lower when the third benchmark was used. This compares with the average underspend of the hospital care budget for North West Thames fundholders of 7·5% in 1992-3 and 9% in 1991-2.

The benchmark information was used during the budget negotiations with each fundholding practice in spring 1993 and resulted in a reduction in the budgets for inpatient hospital care which totalled £0·9m across the region. Table I shows the final budgets for hospital and community services for fundholders totalled by commissioning agency (local district health authorities grouped with the local family health services authority) and the proportion of the agency budget and population they represent. Table II shows that, despite the reductions, per capita allocations for patients of fundholders are still higher for hospital care than the national average. As also shown, third wave practices have been funded at a higher rate than first and second waves, although in North West Thames this is reversed in Hertfordshire—the commissioning agency with the highest proportion of fundholding practices. Others have shown that the variations in per capita allocations to fundholders across regions are large.[8]

Why inequity is difficult to measure

Worries about inequitable funding have centred on budgets for hospital care since fundholders and non-fundholders are funded on a similar basis for drugs, staffing, and community services. One way of measuring inequity would be to compare how much money is allocated to the patients of fundholders and non-fundholders for the specific hospital care covered by the fund. This sounds simple but has been difficult for two reasons.

Firstly, it is difficult to calculate the resources allocated for patients of non-fundholding general practitioners for the hospital services covered by the fundholding scheme. When district health authorities purchase care on behalf of non-fundholders, they do so within a block contract that does not specify the individual procedures to be carried out. Therefore it is impossible to know exactly how much is allocated for "fundholding" services in advance. It may be possible to estimate how much money was actually spent on (rather than simply allocated to) the patients of non-fundholders for these services. This could be done by using routine hospital activity data to trace the procedures carried out on patients of non-fundholders and multiplying this with a price. While this method relies on the known shortcomings of hospital activity and cost data, as discussed earlier, it is being carried out this year in North West Thames.

Secondly, even if these estimations show that the funding of patients of fundholders and non-fundholders is unequal, this may simply reflect the different priorities of the local health authority purchaser. For example, the district may have decided to spend less on acute care and more on community services, resulting in fewer funds spent on hospital "fundholding services" for non-fundholders.

Reducing the potential for funding inequity in future

Until fundholders and non-fundholders are allocated resources on a similar basis, inequities in funding are inevitable. This means that work to develop a capitation formula for funding hospital care equitably across fundholding and non-fundholding practices is crucial. This task is currently being undertaken by the national resource allocation working party, but whether or when a workable formula will be found is unclear. Until then, regions could be much more active in developing alternative methods of calculating practice budgets for inpatient and outpatient care. Most importantly, new methods should focus on the need for care rather than the historical supply of care. Crucially, regions should work with district health authorities to calculate the total funds available for "fundholding procedures," divide these funds equitably, and make allocations to all practices (fundholding and non-fundholding) explicit. Last year most

Policy implications

- Current methods of funding fundholders make funding inequities between fundholding and non-fundholding practices inevitable
- Regional health authorities should be developing new methods of funding fundholding practices which do not rely on their historical use of services
- New methods of funding should take account of the total amount of resources available
- Health authority purchasers could be investigating more actively how much money is spent on non-fundholding practices for equivalent "fundholding services"
- How far fundholders' budgets should be compensated for provider price rises needs to be resolved urgently at a regional or national level

regions simply used practice activity to set budgets. Experience in North West Thames has shown how useful benchmark comparisons can be.

Any method of resource allocation depends on accurate data. Both the completeness and accuracy of routine hospital activity data must be improved. This means inquiry and investment by both purchasers and providers, particularly in the area of diagnostic coding. Since this is unlikely to happen overnight, procedures for collecting data in practices preparing to enter the scheme must be tightened up, including constant validation with providers to reduce double or wrong counting. To help, hospitals should fully code all discharge information sent to practices. In North West Thames, practice staff who record activity used for setting the budget have been given basic training in clinical coding. This could be useful in other regions.

Hospital prices and costing procedures need to be scrutinised and clarified. The principles of costing services for fundholders and district health authorities should clearly be the same even if prices are different. The national steering group on costing is addressing this,[9] but there is much more room for local inquiry and pressure from purchasers. The thorny issue of if or how far regions should compensate price increases for fundholders needs to be debated and the opportunity cost made explicit. The pros and cons of introducing price regulation within the NHS need to be thoroughly examined at a national level.

Setting the budget for community services, drugs, and staffing also needs to be refined to reflect need for care rather than historical patterns of spending, which simply perpetuate historical inequities. This means funding these services on a capitated basis that includes local factors which may reflect need (such as age, deprivation, prevalence of long term illness). Many regions, like North West Thames, are already working towards this, although they are hampered by the lack of accurate data on activity carried out in the community. To help, information such as the number and type of contacts per age group must be improved.

Much more work should be done to estimate how far funding inequities exist between fundholders and non-fundholders, and their impact on access to and the outcome of care. Finding out how much district health authorities have spent on "fundholding hospital services" on behalf of non-fundholding practices is crucial. Without this knowledge the reported benefits of the scheme[10-12] will be marred by accusations of overfunding, and district purchasers will use claims of underfunding as a convenient smokescreen to hide local inefficiencies.

Conclusions

The current method of funding fundholders makes funding inequities between fundholding and non-fundholding practices inevitable, even though inequity is difficult to measure. This is because the fundholding scheme started and gathered pace before a suitable funding method could be developed and, crucially, before routine hospital data and pricing could be made more accurate. As more fundholders enter the scheme, funding for the patients of non-fundholders will be squeezed further. Without swift changes, more tiers are likely.

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A PATIENT WHO CHANGED MY PRACTICE

An instance of change

In 1940 I became the first female house surgeon to work in a large hospital in the north west. I was also responsible for the initial treatment of 1000 elderly patients and inmates of a poor law hospital across the road. On arrival anyone who was over 70 was automatically sent to the poor law section and I would examine the patient later on the ward.

One night a woman of 72 arrived with haematemesis. She was accompanied by caring relatives who definitely wanted her to recover. She was already in bed in the old people's section of the hospital when I saw her. Being young and eager I decided to do my best for her and put up a transfusion. Next morning I was called to the superintendent's office. The ward sister had seen the transfusion and made haste to report me. "She had never had such interference on her ward before. What was she to do with the transfusion?" The sister had never seen a transfusion before and seemed to me to be about the same age as her patients. The drip was finished and I took it down and the patient finally improved and returned home to grateful relatives.

After this the age of 70 was never mentioned and each admission came through the main hospital and was treated as an individual case, if necessary staying in the short stay section of the hospital.—IDA KENYON *is a retired medical practitioner in Sale, Cheshire*