Non-fundholding in Nottingham: a vision of the future

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See editorial by R Chapman

The 1991 health service reforms introduced the internal market and gave individual fundholding practices budgets with which they could attempt to secure preferential access to secondary health care for their patients. In the view of many doctors this undermined the principle of equity on which the NHS was founded. In Nottingham 200 non-fundholding general practitioners have joined together to act in liaison with their purchasing health authority. A committed representative group of general practitioners can collectively offer more time and knowledge to the contracting process while minimising the impact on clinical workload. As a large purchaser with low management costs the group has secured access to quality secondary care which is equitably available to all patients, preventing the development of a local two tier service. Nottingham's non-fundholding model of commissioning is equitable and efficient.

"Non-fundholding" is an implicitly negative term. It suggests undermotivated, uninterested, iconoclastic general practitioners resisting the rising tide of fundholding. Such interpretations fail to appreciate that if viewed as a positive proactive concept non-fundholding transforms into a remarkably powerful force in the developing NHS marketplace.

In the past 18 months Nottingham Non-fundholders has successfully promoted non-fundholding as a positive influential choice for general practitioners who wish to obtain equitable access to quality secondary care for their patients while avoiding the bureaucracy and conflicts of interest which arise from fundholding.

We describe the principles of our non-fundholding model); how Nottingham Non-fundholders was formed; the history and structure of the organisation; and its aims, achievements, and vision of the future.

Background and early development

Contemporary events need to be seen in their historical context if they are to be fully understood. It seems difficult today, with 95% of hospitals having trust status and over 40% of the population covered by fundholding general practitioners, to recall the mood of late spring 1992.

At that time many general practitioners were bewildered by the pace of change and were struggling to come to terms with the new contract, which had been in place for two years. Fundholding itself was still embryonic: there were only four fundholding practices in Nottinghamshire. These practices were all in rural or semirural areas and had historically used a choice of providers, while being virtual monopoly providers for their geographical areas; they could seek competitive contracts for secondary care while having no competition from neighbouring practices. In contrast, practices in urban Nottingham obtained virtually all their services from two major provider units offering complementary services, and their practice areas overlapped. There was little incentive for urban practices to sign up.

In addition, there was tremendous political uncertainty: a general election was imminent and the likely outcome seemed to be a hung parliament or Conservative defeat. What would become of fundholding under a different government? The election result in April 1992 resolved any doubts: fundholding now seemed inevitable. Despite moral and practical objections many practices now considered signing up for fear of "losing out"—missing out on attractive reimbursements for management and computers, which might later be withdrawn, or forfeiting patients to neighbouring practices. These hardly seemed positive or even appropriate reasons for joining a scheme we considered to be seriously flawed. A group of Nottingham general practitioners met in August 1992 to consider the way forward.

Basic principles

In 1948 the NHS was founded on the principle of providing equitable access to comprehensive health care. The 1991 reforms introduced the purchaser-provider split. It also introduced the concept of giving practices budgets with which they could attempt to secure preferential access to secondary health care for their patients. In the view of many doctors this underminded the principle of equity on which the NHS was founded.

Many general practitioners were excluded from the fundholding scheme by virtue of practice size, while others chose to remain outside it. For these practices the district health authority continued to purchase secondary care. By grouping together and liaising with the authority, non-fundholding general practitioners in Nottingham thought that they had greater potential for effecting changes in secondary healthcare provision than if they joined the fundholding scheme. A committed representative group of general practitioners could collectively offer more time and expertise to the contracting process while the impact on clinical workload would be minimised. The district health authority employs staff of a higher calibre than could be afforded by individual fundholders but, since their skills are shared, costs are reduced; Nottingham Health Authority spends less than 1·5% of its budget on management costs.

Getting started

By mid-autumn 1992 the need for a purchasing group to represent non-fundholding general practitioners was established, but it required the power to act. Such power came from three sources.

District health authority—As any large scale movement into fundholding would diminish their budget the district health authority was, understandably, supportive.

Local medical committee—The committee had for

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many years been advising the district health authority about the provision of secondary services and was initially ambivalent as it thought its role was being undermined. As fundholders were making their purchasing choices without reference to the local medical committee and as the local medical committee represents all local general practitioners and is constitutionally unable to represent only non-fundholders, a new purchasing group was clearly required.

Non-fundholding general practitioners—An open meeting was held to ascertain the level of support: 39 general practitioners attended. In addition to the arguments outlined in the box, those present agreed that they would if necessary refer patients outside Nottingham and that they would collect data about such referrals.

Summary of inaugural meeting of non-fundholding general practitioners

Position:
- Fundholders purchase some secondary care directly
- District health authority acts as purchaser for non-fundholders
- Local medical committee unable to purchase for non-fundholders only

Problem:
- Preferential access for patients of fundholders
- Difficulties in otorhinolaryngology, orthopaedics, and ophthalmology

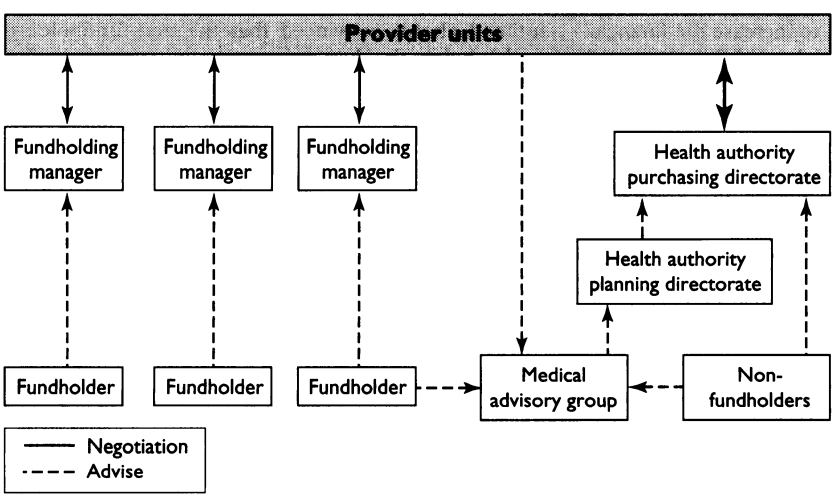
Aims:
- Ensure equitable access
- Improve local provision

Proposal:
- Liaison between non-fundholders and district health authority as a purchasing group
- Focus on otorhinolaryngology, orthopaedics, and ophthalmology

A working group was subsequently established to represent Nottingham Non-fundholders, and at its initial meeting the group constructed the mission statement:

To ensure the purchasing of quality secondary care which is equitably available to the patients of all general practitioners, and to cooperate in this endeavour with all interested bodies.

It was agreed that to elicit opinion from and disseminate information to a large number of local general practitioners Nottingham Non-fundholders should be constituency based, with constituencies approximating to local social service boundaries. All non-fundholding general practitioners in Nottingham were sent a questionnaire asking whether they supported the initiative and whether they were prepared to collect data and refer outside Nottingham. Two hundred general practitioners, representing over 400 000 patients (68% of the population) replied in support.



Nottingham model. Fundholding and non-fundholding general practitioners combine to advise on planning but continue to purchase separately

Purchasing strategy

There is no sense in referring all the patients for one specialty to a distant provider as the local service will simply collapse. Similarly, referring all cases to the local provider irrespective of the quality of that service gives no incentive to the provider to improve. A balance has to be found.

Placing the major contract with the local provider and an assortment of contracts with distant providers encourages the local provider to examine the quality of service provided and to take appropriate remedial action, including virement of financial and human resources. It also gives maximum flexibility to individual general practitioners and their patients.

To obtain the capital for major projects a trust must show that the resulting services will be purchased. By expressing clear purchasing intent a large purchaser can facilitate improvements in provision of local service on a scale that dwarfs the efforts of individual fundholding practices.

Equity of access to a trust's services can be guaranteed by negotiating explicit statements into the contract together with appropriate penalties for transgression.

Purchasing and planning

We recognised early on that purchasing and planning were separate though interdependent issues. While purchasing is an activity conducted on a practice by practice basis by fundholders or in concert by commissioning groups, planning is an activity which should concern clinicians on both sides of the purchaser-provider split together with advisers from public health.

Nottingham Non-fundholders is primarily a purchasing group, though members are also represented along with fundholders on the recently established medical advisory group, which advises on planning future needs in health care (figure).

Achievements

Within a year of inception Nottingham Non-fundholders has:

- Established a constitutency based system and established the support of 200 non-fundholding general practitioners (67% of all Nottingham general practitioners) representing over 400 000 patients
- Established an excellent working relationship with Nottingham Health Authority. The working group are contracted and paid a sessional rate to advise on purchasing. The executive meets with the authority on a regular monthly basis. We have advised on purchasing priorities and contract setting for 1994-5
- By showing clear purchasing intent on a major scale, facilitated the approval of a large (£8·3m) capital investment at the Queen's Medical Centre, Nottingham, to improve service provision in three historically underfunded specialties: otorhinolaryngology, ophthalmology, and orthopaedics
- Circulated regular bulletins giving comparative waiting times for contracts held by Nottingham Health Authority and details of waiting list initiatives. We have tested the effectiveness of our communications by

Total number of patients waiting for first non-urgent outpatient appointment at Queen's Medical Centre during second half of 1993

Specialty	June	July	August	September	October	November	December
Otorhinolaryngology	3718	3137	3515	2795	2748	2611	2453
Ophthalmology	2699	2769	2545	2212	2007	1707	1384
Orthopaedics	2369	2557	2914	2734	2495	2436	2071
All others	6425	6392	7292	7058	6805	6176	6181
Total	15211	14855	16266	14799	14055	12930	12089

means of a questionnaire: all 138 out of 246 (56%) local general practitioners who responded stated that they were satisfied with the correspondence they had received

- Given a clear signal to local providers that unless their service is adequate local general practitioners will take their business elsewhere. Our survey revealed that over three quarters of general practitioners had already made use of waiting list initiatives which entailed referring patients elsewhere. This in turn has contributed to a reduction in the total number of patients waiting for outpatient appointments at our large local provider unit (table)
- Secured elected representation on both the local medical committee and the local medical advisory group and established links with local provider units and clinical directorates
- Maintained a large non-fundholding base. Although we have not actively dissuaded any practice from fundholding, we have promoted our own efforts and achievements to our constituents. Relatively few practices in Nottingham are subscribing to fundholding: seven practices (11 general practitioners) have joined the fourth wave and 12 (16 general practitioners) are preparing for the fifth wave
- Contributed to the development of an electronic outpatient booking system. This will enable general practitioners to choose appointments in a way analogous to a travel agent booking a holiday and will facilitate accurate scrutiny of activity and referral patterns for future planning. An initial prototype has already been tested. Nottingham Health Authority is now seeking collaboration with a commercial company before proceeding further
- Begun to establish links with other non-fundholding groups around the country. The secretary of our group is also the secretary of the newly established National Association of Commissioning General Practitioners.

The future

The purchaser-provider split is here to stay. Even if there were to be a change of government it is now quite clear that the principle is firmly established, as the Labour party has recenty affirmed.[1] The major thrust of the health reforms has been to increase the financial accountability of clinical decisions. Ultimately, the money available is limited and resources will have to be rationed. The government refers to this as "prioritisation" of local health needs.[2]

Budgets for purchasing secondary care and drugs will become explicitly linked by the health authority on a per capita basis. Nottingham Health Authority have confirmed that Nottingham will probably be a "net gainer" under the move to capitation funding; areas with historically low spending and with efficient purchasing models, such as Nottingham, stand to gain most.

The forthcoming merger of district health authorities and family health services authorities is going to have a major impact on the commissioning of primary and secondary care. We have already held tripartite meetings with the district health authority and the family health services authority to discuss the issues arising. In commissioning future health care provision we are likely to be considering programmes of care—for instance, in the case of cardiovascular disease we will consider the relative spending on health promotion, hospital provision, secondary prevention, and rehabilitation.

The efficiency of our local purchasing arrangement has already led to our being able potentially to reduce waiting lists to nominal levels within one year. As elsewhere, however, the bed space within our local hospitals has been affected by the rising tide of emergency admissions, principally in the acute medical specialties. We intend to open discussions with the medical directorates and, using our constituency system, try to implement more efficient admission and discharge protocols. We believe an advantage of the non-fundholding system is that we stand a greater chance of working with our hospital colleagues to implement such procedures across the locality.

In the longer term, evaluation of clinical outcomes will probably lead to a continuation of the trend towards fewer large hospitals performing increasingly specialised and complex treatments. The remaining outlying hospitals will provide facilities for day cases, outpatients, and immediate trauma. The value of services to which internal market forces apply will decline and the planning role of commissioning bodies will increase. This will be facilitated by having a coherent purchasing strategy. The fundholding model, with its many disparate purchasers, will become less relevant.

The internal market is still in its infancy and is evolving rapidly. While it is too early to proclaim that any one model will predominate we are, for the reasons outlined above, convinced that the non-fundholding model holds the key to success in commissioning health care now and in the future.

1 Labour Party. *Health 2000. The health and wealth of the nation in the 21st century.* London: Labour Party, 1994.
2 Bottomley V. Rationing in action. *BMJ* 1994;308:338.

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