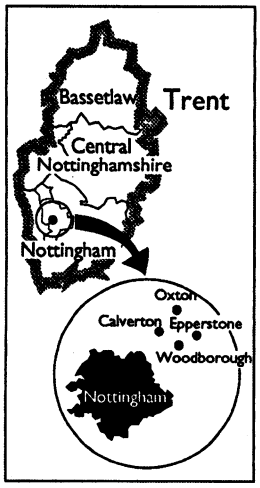
Fundholding: a two tier system?

John Bain



Since the start of the NHS reforms in 1991 the BMJ has been visiting four parts of England to see how health authorities, hospitals, and general practitioners have been coping with the NHS reforms. Over the next few weeks we will be describing how each of these places finds itself at the end of the third year or beginning of the fourth year of the reforms. In this first article John Bain describes what he found on his fourth visit to a fundholding practice in Nottinghamshire and includes an interview with a former member of the practice

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BMJ 1994;309:396-9

The Calverton practice is one of 30 fundholding practices in Nottinghamshire. Three years after the inception of fundholding, it has achieved a lower outpatient waiting time for its specialist clinics than non-fundholding practices in the region. Its district nursing and health visiting services have been strengthened. Prescribing costs remain below the national average, and making further cost reductions has not been easy. The business plan has allowed the practice to work within a defined budget and develop expertise in the purchasing of services. Through the provision of specialist clinics and increased patient demand the workload of general practitioners has risen by 15% in the past year. But fundholding is still a minority activity in Nottinghamshire—a non-fundholders' group has been set up to ensure that purchasing of good quality secondary care is equitably distributed among all patients, and this group is extremely active.

In 1990 the Calverton practice became one of the first wave fundholding practices in England, with the intention of gaining control over patient care services to offset the shackles of a new contract that was seen as restricting opportunities for change. There are now 30 fundholding practices in Nottinghamshire, which represent 15% of practices, and 23% of the population is now attached to fundholding practices. The Calverton practice has a stable population of 9250 patients, and there are now four partners, two part time assistants, and a vocational trainee. Previous visits to the practice provided information about plans for creating new services, many of which were in the early stages of development. Three years after the inception of fundholding, in spring this year, I revisited the practice and reviewed progress.

Specialist services to patients

For many years the general practitioners in the Calverton practice were frustrated by their inability to have any influence on long waiting times and lack of provision for specific services. This led the practice into concentrating most of its fundholding activities into creating health centre based clinics for a range of specialties. Eight specialist clinics are now firmly established within the health centre, and an additional four are available elsewhere. Table I shows the range of services for the 1221 patients who have been referred to these clinics. The average outpatient waiting time for attendance at the clinics is two weeks, which contrasts with much longer waiting times for patients attending non-fundholding practices in the region. Inpatient waiting times in ophthalmology and orthopaedics have also been reduced, but in other surgical specialties inpatient waiting times remain similar to those of non-fundholding practices. For Norman Stoddart, the senior partner, "this has been the realisation of our original plans and has resulted in a much closer working relationship with visiting consultants." These views were echoed by Dr Don Simpson, who is no longer in any doubt about "our ability to make things happen in the interests of patients with chronic conditions and the opportunity to solve problems as they arise."

TABLE I—*Specialist clinics in Calverton practice since inception of fundholding, and average waiting time for referral to outpatient clinics in Nottinghamshire*

Specialty	Months of operation	No of new patients referred	Average waiting time (weeks)	
			Calverton practice	Non-fundholding practices (range)
Geriatrics	28	48	3	3 (1-4)
Neurology	28	84	2	12 (8-15)
Ophthalmology	26	218	1	17 (4-39)
Diabetes	24	33	2	2 (1-2)
Gynaecology	20	191	2	8 (4-13)
Orthopaedics	20	115	2	42 (10-84)
Rheumatology	15	57	2	6 (11-13)
Ear, nose, and throat	16	61	2	31 (16-47)
Physiotherapy	28	293	1	
Counselling	20	101	1	

Nursing services

In years gone by there was dissatisfaction with certain aspects of community nursing, but the existence of a fund to bring in services based on identified needs has been extremely rewarding. The past year has seen a major breakthrough in negotiations with two community trusts, which has resulted in the strengthening of district nursing and health visiting services, augmented by the appointment of a part time community psychiatric nurse and a health care assistant.

In the past the health visitor services were shared with another practice. The new arrangements mean that two part time health visitors are dedicated to the Calverton practice alone. All members of the team of 10 nurses—two district nurses, four practice nurses (three part time), one community psychiatric nurse (part time), two health visitors (both part time), and one health care assistant (part time) are, without exception, enthusiastic about their new roles within a primary care team responsible for a defined population. Despite differences in line management for the district nurses and the health visitor and community psychiatric nurse, there have been no major conflicts and in the words of Gill Whitworth, one of the district nurses, "team work is a reality here and we can work with the doctors in providing a first class primary care service."

Prescribing

In 1993-4, the prescribing budget was £500 875 and the latest prescribing analysis and cost (PACT) figures show that the practice's prescribing costs remain 2% below the family health services authority's average and 7% below the national average, and this comparison has not changed greatly in the past three years. From this base making further reductions in costs has not been easy; this is complicated by the fact that dispensing accounts for a third of all prescriptions.

During the past year a prescribing adviser has been helping to create a drug formulary, but as in many practices which embark on attempts to limit the range and cost of drugs prescribed, achieving savings is less easy in practice than in theory. One particular example is respiratory preparations—their cost is 38% above the average in the family health services authority. With developments in health promotion and increases in the

TABLE II—*Budget allocations and savings (£) in Calverton practice*

	1991-2	1992-3	1993-4
Hospital services	548 882	590 931	557 368
Drugs and appliances	404 920	430 726	500 875
Practice staff	93 282	123 291	137 609
Community nursing			75 697
Total	1 047 084	1 144 948	1 271 549
Estimated savings	50 777	18 874	0

use of certain preparations for the treatment of asthma, it is difficult for the practice to find a balance between improving care, which inevitably raises cost in some circumstances, and at the same time trying to reduce prescribing costs in other areas. The production of a formulary is a laborious process, but agreement has been reached about first line drugs for certain sections of the *British National Formulary*, and a gradual shift to generic prescribing is planned.

Finance

Table II outlines the current distribution of finances directly related to fundholding in the practice. Most of the accumulated savings between 1991 and 1993 have been spent on improvements to premises, but for the 1993-4 financial year the practice expects only to break even on the budget allocation.

According to Norman Stoddart, "the main aim in our first few years has been to set up new services and ensure that we do not overspend—any underspend has been a welcome bonus." Working on annual budgets within a cost per case method of purchasing services is still cumbersome, but there were no signs of a move towards cost per volume contracts or a capitation system.

Administrative costs were still high, with a requirement to have four additional part time staff for arranging hospital services and the financial transactions involved. There seems little doubt that the business plan of the practice has allowed it to work within a defined budget and develop expertise in the purchasing of services.

Workload and management of staff

Throughout my visit to the practice the issue of workload was often raised. The general practitioners' workload relating to surgery consultations and home visits had risen by 15% during the past year. Pauline Hansler, the practice manager, was only too aware of the stress that accompanied the increase in patient demand and the provision of clinics within the health centre. The existence of these clinics and an increase in community nursing services has resulted in around a third of the practice population now receiving direct benefits from being in a fundholding practice. Tensions could occur between staff employed primarily for fundholding purposes and those who are responsible for routine practice commitments, but Pauline Hansler did not perceive this as a major problem.

The development manager, Gillian Halliday, had found that "experience gained in this practice has been invaluable in advising other practices who are now about to become fundholders." Part of her job is to advise a consortium of three singlehanded practices who are to become fundholders in 1994-5. She has found that a fund manager can work for more than one practice. In the past, the boundaries between the roles of practice manager and fundholding manager had been insufficiently clear, but now that there were two clearly distinct functions, conflicts about lines of accountability had been resolved.

Non-fundholders in Nottingham

Despite the success of the Calverton practice and other fundholding practices in the area, fundholding is still a minority activity in Nottinghamshire. Dr Alan Birchall, a general practitioner in Nottingham, has been at the forefront of the formation of the Nottingham non-fundholders' group, which has a core of 13 general practitioners who represent Nottingham's non-fundholders on a consultancy basis. The aim of this group is to ensure that purchasing of good quality secondary care is equitably distributed among all patients. The group is targeting three specialties: ear, nose, and throat; ophthalmology; and orthopaedics; and it is advising on ways of reducing waiting times for both outpatients and inpatients. One interesting development is a prototype electronic outpatient booking system which enables general practitioners to choose appointments in a way analogous to a travel agent booking a holiday, and this will facilitate the accurate scrutiny of activity and referral patterns. The non-fundholding group in Nottingham is extremely active and cooperates with a variety of agencies including the district health authority, representatives of consultants, and management groups.

The impact of fundholding and the way ahead

The Calverton experience represents a practice based initiative that has resulted in a range of developments which have led to apparent improvements in services for patients in one community. To obtain an opinion about the impact of fundholding and what the future may hold, I sought the views of Dr Tom O'Dowd who, until 1993, was a partner in the Calverton practice but has recently moved to Dublin to take up the chair of general practice in Trinity College. While in Nottingham he was also a senior lecturer in general practice in the university, and he has been involved in the changes in the NHS since the publication of the *Working for Patients* white paper in 1989.

Reflections of a former member of the partnership

JB: You have been a member of a first wave fundholding practice. Can you recall how and why decisions to opt for fundholding were taken?

TO: I remember very clearly that there was enormous anxiety about the whole idea of fundholding. It was largely about fear of the unknown, no precedents, and uncertainty about whether the allocated funds would actually cover our costs. However, there was a strong desire to have more control over our own destiny as a practice, and fundholding was seen as the mechanism for achieving this.

JB: Can you give any examples of areas of control which were desired?

TO: The partners in the practice had over 100 years' aggregated general practice experience and nobody had any memory of ever being asked by their hospital colleagues if the services being provided satisfied our patients' needs. We saw quite clearly that the problem of waiting lists could be tackled by giving us the freedom to specify standards and negotiate new arrangements.

JB: How did you create the range of new services?

TO: By a lot of work and negotiation and not without a certain amount of criticism from colleagues in general practice and from hospital specialists. A lot of the developments in services and specialties such as orthopaedics, ophthalmology, and gynaecology were the result of opportunism, where we had good personal relationships with individual consultants.

JB: What have the outcomes of these services been?

RICHARD MAILE

Calverton: gaining benefits from developments in a fundholding practice

TO: All the staff in the practice have begun to feel that chronically ill patients are actually getting a service which previously had been drawn out for months and months. A very powerful image for me was seeing a patient with diabetes who was developing cataracts, who couldn't work, and seeing this man being escorted round the town by his wife. Within two months he was back at work, driving his tractor through the countryside. That's fairly powerful and to realise that we have been able to make it happen was very rewarding.

JB: The extension of services has not only included specialist clinics but an increase in community nursing services. Can you tell me more about that?

TO: The freedom to appoint a community psychiatric nurse and a health care assistant has had benefits not only for the patients involved but it has strengthened the primary care team, and the nurses are certainly in favour of this.

JB: Is there not a danger in getting carried away with the desire for quick results, and that expectations of patients could be raised to a level that the practice will not be able to maintain?

TO: One of the criticisms made of general practice is that general practitioners are too involved in one to one relationships with individual patients and will fight to achieve the best possible service for the individual without considering the population as a whole. I would defend this by saying that the general practitioner is the patient's advocate and by an accumulation of individual services we ultimately achieve improvements for a larger number of people. Over 1000 people have now been seen at health centre clinics and about one third of patients registered with the practice have benefited directly from fundholding.

TWO TIER SYSTEM OR LEVER FOR CHANGE?

JB: This leads on to the thorny issue of the "have's" and "have not's." Non-fundholding practices in Nottingham claim that they cannot obtain similar reductions in waiting times.

TO: I have always been uncomfortable about this aspect of the health care reforms, whereby those who choose —for good reasons—not to be fundholders feel that their patients are missing out. It's almost a lucky break for the patients who find themselves in fundholding practices. Yet, the arguments about a two tier system are flawed. There have always been inequalities within the health service and it is a multitier system with tremendous variations between districts and regions.

JB: Surely fundholding has made that situation even worse?

TO: In some ways that is true, and if people are looking for a service which applies to all practices then there is clearly a division between fundholders and non-fundholders. However, without the stimulus of fundholding, the non-fundholding groups may not have been formed. In Nottingham, the non-fundholding group is drawing up specifications for locality purchasing, and I admire and respect their efforts. Fundholding was the lever for change; without it, waiting lists may have continued as a major problem.

JB: In an interview in the *BMJ* in 1989, Professor Alain Enthoven expressed reservations about practices with around 10 000 patients being able to develop the management expertise required to purchase hospital services.

TO: Several people have made similar comments, suggesting that fundholding would only be cost effective with a consortium of practices looking after up to 50 000 patients. This is probably an approach that works in larger urban areas and may be the way ahead for practices that are capable of cooperating in this way. In our situation we have shown that a practice of around 10 000 patients can purchase services, and there are examples in Nottinghamshire of even smaller groups of practices coming together to negotiate services. Maybe Enthoven underestimated the ability of smaller practices to assess their patients' needs and negotiate appropriate services.

JB: What about the fear expressed in some quarters that the NHS is now top heavy with managers who know the cost of everything but the value of nothing?

TO: These are genuine concerns which cannot be ignored. I have to agree that in the hospital sector there are signs of bureaucratic overload resulting in large increases in management costs. From my experience in general practice, I would claim that general practitioners can run a business enterprise efficiently without ignoring the overall needs of patients. The results so far in Calverton speak for themselves.

JB: Despite the apparent enthusiasm that you have in Calverton, fundholding is still a minority activity in Nottinghamshire. Why is this so?

TO: The driving forces in different health authorities are not always the same, and I think a lot depends on the people who are in leadership positions, either within the authorities or within the profession in different areas of the country. Their views often prevail.

PRESCRIBING AND PAPERWORK

JB: From the evidence in Calverton it appears that prescribing habits have not changed much since the inception of fundholding. What are the reasons for this?

TO: Calverton was not a high cost prescribing practice before fundholding, and making any substantial savings from a starting point of moderate costs is extremely difficult. Increases in health centre based clinics and health promotion activities have led to increases in prescribing, and we have to remember that the prescriptions issued by general practitioners are not always initiated by them in the first place. We accept recommendations of consultants but carry the cost. A practice formulary is in the process of development, but its impact won't be seen overnight.

JB: During last year the practice will break even on its fund, while in previous years it had considerable underspends. Can you foresee any future difficulties in working within the budget allocation?

TO: I cannot speak for all my partners but the original intention was not merely to be a profit making concern. I am sure that further savings will occur in the future

and that it is to the practice's credit that it has demonstrated its ability to work within budgetary limits.

JB: What about the level of administrative staff and the enormous amount of paperwork that appears to prevail?

TO: It would be naive to assume that fundholding can be run on a shoestring, and there are inevitable increases in staffing to handle the increase in activities. There is no doubt that the practice has a problem with relation to information management systems whereby there is a dual record system—a paper based system and a computer based system. It will be a long time before we can get away from paper based records. The software systems for computer assisted records for fundholding practices have just not caught up.

JB: A recent editorial in the *BMJ* suggested that there should be a moratorium on fundholding until it is properly evaluated. What methods can be used to evaluate the impact of fundholding?

TO: From the vantage point of the individual practice the facts speak for themselves: a range of new services is providing previously unmet needs for patients; waiting times are down; and management skills have been demonstrated. Beyond that there is an aspect of fundholding which is more difficult to measure by traditional methods and that is the enthusiasm of the staff for the jobs that they do. Morale has been low in general practice—fundholding gave us a lift. It could be a short term lift, but it allowed us to cope and it also allowed the practice to retain its flair for innovation. Without that some of the doctors may have gone off and done something else. What may be missing in evaluation are outcome measures that public health medicine specialists could apply. Public health medicine specialists seem to have been conspicuous by their absence in evaluating outcomes of fundholding.

JB: You mean epidemiological measures of outcome?

TO: Yes, they could measure the impact on patients' lives, health profiles, reduced time off work, and variables like that.

ACCOUNTABILITY

JB: What about accountability for the large amounts of public money allocated to fundholding practices?

TO: General practice fundholders are responsible people and from what I have experienced and observed are prepared to be open about what they are doing. The FHSA knows what we are about and if we were being irresponsible would probably tell us. If accountability is going to lead to more bureaucratic procedures with even more forms and reports then it could stifle innovations, and even more reporting sits uneasily with doctors who wish to organise their own clinical activities.

JB: But the services being developed could be inappropriate?

TO: The internal methods of review—lots of discussion and negotiation with a wide variety of people about what is appropriate for a particular community—results in reasonable and well thought through decisions being taken. The services developed in Calverton didn't happen overnight and were the result of a lot of discussion and debate.

JB: With patients as well?

TO: Well, the initial decisions didn't include too much consultation with patients, but during the last year there have been meetings with patient groups where doctors have listened to their views and have also explained what they are planning to do.

JB: It does seem that you enjoyed the whole experience of fundholding?

TO: Yes, it has been a great stimulus and allowed the practice, doctors, nurses, and all the support staff to become more cohesive and think about what they were attempting to do.

JB: And the future?

NO RETREAT

TO: The genie is out of the bottle and fundholding has been a means of bringing about change. I doubt if there can be a retreat from what has happened. The principle of fundholding can remain but may take different forms. The non-fundholders can learn from the mistakes we have made, and I hope they can benefit from the way we have opened up areas for changing methods of delivery of care which were previously beyond the control of general practice. After all, the development of locality purchasing is merely an extension of fundholding—the methods used may be different but the principles are the same.

JB: Any specific suggestions about how people can learn from fundholding?

TO: There is an urgent need to address the question of management training in primary care. We pay lip service to this and vocational trainees get the odd practice management seminar, but continuing education and training for doctors and their staff has to be a priority. A fundholding practice is a great training ground for medical students, doctors in training, and other health care professionals. There is a lot of expertise around in fundholding practices just waiting to be tapped.

JB: You're not one of the people who consider that the comprehensiveness of the Health Service is being eroded?

TO: I am aware of the doom and gloom that has sadly pervaded much of the health service in recent years. I know that hospitals are having a difficult time adapting. What fundholding has drawn attention to is the need for the health service to define its core services and that is beginning to happen. The transition between the old and the new is not without pain, but the days of merely going on expanding the health service are probably gone—it has to be about defining core services, giving general practitioners more responsibility in deciding priorities for development; fundholding has been one of the methods of helping this process occur. Practices, be they fundholders or locality purchasing groups, have the chance to specify services and identify priorities. For too long the views of general practitioners were ignored while specialist units in hospitals were constantly expanded without any real consideration of the overall needs of a local community. Primary care is now in the driving seat. It would be nice to think of a day when general practice was unfettered by the small print regulations about fees and allowances. Scrapping the "red book" and replacing it with practice based contracts would release the potential of practices to provide a service based on patients' needs, as opposed to doctors being trapped by the current inadequacies of the general practitioner contract. Fundholding has shown that practices can define aims and objectives for a defined population and that has been a notable achievement.

My thanks are due to all the members of the Calverton practice who gave up time to answer questions about the impact of fundholding on the practice. Dr Norman Stoddart has allowed access to a variety of material which has been invaluable in reporting on changes which have occurred since the inception of fundholding. I am also extremely grateful to Dr Alan Birchall of the Nottingham non-fundholders and Mr Robert Carter, fundholding manager, Nottinghamshire Family Health Services Authority, who have provided information on patient care services.

Correction

Grand Rounds—Hammersmith Hospital: Clinicopathological conference

An authors' error occurred in this case conference presented by Denise O'Shaughnessy and colleagues (23 July, pp 262-5). JC polyoma virus was incorrectly referred to as Jakob Creutzfeldt polyoma virus throughout the text, in the table, and in the legend to figure 3.