the Gatekeeper. "You need one who says to me that we have a common interest in improving efficiency and that he or she understands I'm trying very hard but there may be some room for improvement. The Inspector should be able to give me the means to be more efficient. I need a helper, not a police officer, because efficiency is about learning—not rooting out 'bad apples.' You see, punishing 'bad apples' doesn't make the system work more efficiently, nor does it save much money!"

The Gatekeeper paused briefly. "There's another problem, too, because you cannot define my efficiency in terms of the number of poorly people I send to the Wizard or the number of spells I cast. To measure my efficiency you need to find out how much healthier the people are as a result of what I do."[5]

"Oh dear," said the King, "it all seems so terribly complicated. What shall we do, Minister?"

"Well, Sire," the Minister looked shifty, "we should keep quiet. In a few weeks' time we have to ask the people their opinion of us. We won't mention the Charter any more and we can tell them about our talks with the Kings in the lands over the sea."

"Excellent, Minister," said the King.

And what did the people think? That's another story.

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3 Dudley HAF. *Queuing theory and the waiting list*. London: Royal College of Surgeons, 1985.
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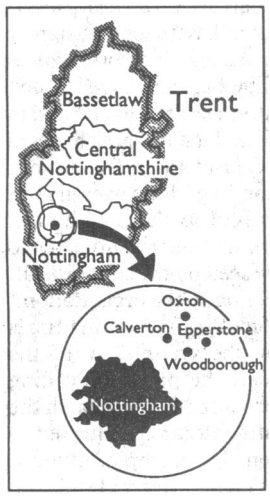
The New NHS: first year's experience

Budget holding in Calverton: one year on

John Bain



A year ago, the Calverton practice was stepping into the unknown of budget holding. The five partners in a practice of just over 9000 patients had not been enthusiastic about the content of the new general practitioner contract but saw budget holding as a means of developing their services to patients. By adopting a fundholding scheme they saw opportunities for decision making in patient care which would be much more under their own control.[1]

At the beginning of 1991, just weeks before the official introduction of a practice held budget for hospital care, prescribing, and staffing, they were still awaiting details of what their actual budget would be. They were unsure how the new methods of operating services would work, demands on doctors and support staff were high, and a new business manager had just been appointed. The creation of a business plan had brought together the shared aims of the partnership and central to this plan was the objective of "having control over our own destiny." What has happened in the past year?

Progress in Calverton

Getting agreement on the budget for the Calverton practice was a tortuous process but eventually £1 017 084 was allocated (table I). Subsequent review of the prescribing budget (originally £374 920) indicated that the projected annual prescribing costs were £398 652 and the prescribing budget was increased by £30 000, giving a final working budget for 1991-2 of £1 047 084.

The practice has not negotiated block contracts for specified hospital services and has been working on the basis of "cost per case," which according to senior partner Norman Stoddart allows greater flexibility: "After receiving a bill for an individual case we vet it and if not satisfied we can renegotiate." At a time when both the practice and the hospital are feeling their way in the new system, the cost per case approach seems satisfactory, although it leads to rather cumbersome administration as a member of staff has to check every patient procedure relating to hospital services. To date, most of the practice team's energy has been channelled towards the hospital and specialist services component of the budget.

The variation in the prices for hospital procedures (table II) had been an eye opener to the partners. For example, three centres quoted £19, £23, and £70 for outpatient ultrasound investigations, showing early on how the price of a procedure would determine where patients would be referred to.

TABLE I—*In budget allocation for Calverton practice (9184 patients), 1991-2*

Hospital services	Annual budget (£)	Budget per patient on list (£)
Inpatient services	277 354	30·20
Outpatient services	271 528	30·00
Clinics	206 859	22·5
Pathology	48 304	5·26
Radiology	12 295	1·34
Physiotherapy		
Occupational therapy	1 738	0·19
Speech therapy		
Audiology		
Domiciliary visits	2 332	0·25
Total hospital services	548 882 (52·4%)	59·77
Drus and appliances	404 920 (38·6%)	43·99
Practice staff	93 282 (8·9%)	10·16
Total budget 1991-2	1 047 084 (100·0%)	113·91

TABLE II—*Prices for common surgical procedures in hospitals A and B*

Procedure	Hospital A (£)	Hospital B (£)
Repair of inguinal hernia	567·90	528·38
Varicose veins	428·40	510·92
Endoscopy	579·70	1017·51
Laparoscopy with or without biopsy	301·30	406·10
Dilatation and curettage with or without polypectomy	275·60	406·70

Towards the end of 1991 the stress among staff was considerable, with the combination of providing routine services and unravelling the complexities of budget holding having a major effect on everyone's time and energy. A decision to hold a "practice retreat" for the partners and the business manager proved to be a watershed. With the help of a management consultant, protected time away from the hustle and bustle of daily practice provided clarity about the group's aims and achievements with the result that the cohesiveness of the partnership was strengthened.

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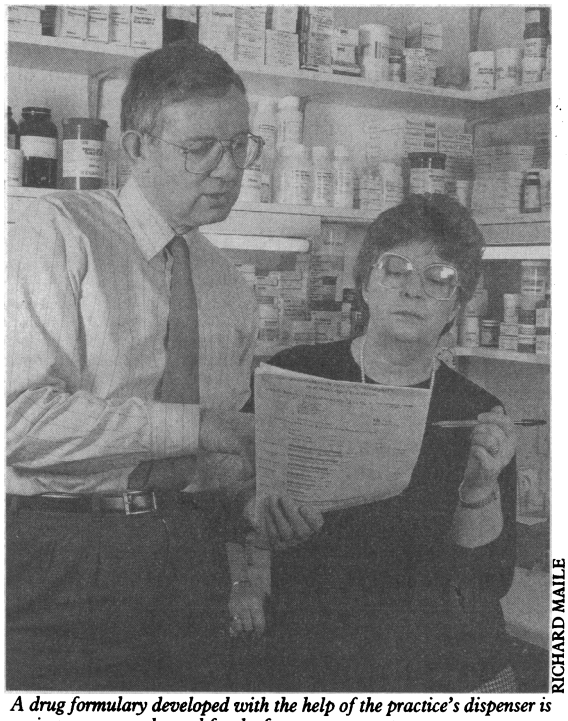
BMJ 1992;**304**:971-3



RICHARD MAILE

A drug formulary developed with the help of the practice's dispenser is an improvement planned for the future

IMPROVING SERVICES

The partners and support staff all agreed that introducing budget holding had produced several improvements in secondary care services for patients. The original aim of "bringing services to patients" has been met by starting monthly health centre based clinics in neurology and geriatric medicine. A physiotherapy clinic will be introduced when an extension to the health centre is completed.

Staff mentioned two success stories in the specialties dermatology and ophthalmology. With the inception of fundholding arrangements had been made with a consultant dermatologist who conducted a monthly clinic in a neighbouring private hospital, and around 50 patients a year are now being seen within two weeks of referral. Patients have to travel a much shorter distance and the costs per case are notably lower than for continuous use of the dermatology clinic in one of Nottingham's main hospitals. In ophthalmology, the general practitioners had been continually frustrated by waiting times for surgical procedures of up to 18 months, and lack of information received about patients reattending outpatient departments. Five patients were identified who had been waiting for cataract operations and they were seen at the health centre by an ophthalmologist and had their operations within four weeks.

Similar experiences were recounted for orthopaedics. Four patients awaiting hip replacements had times allocated for their operations which were much earlier than the dates that would have been expected before budget holding started.

The capacity to negotiate a "better deal for vulnerable patients" is proving attractive to the doctors, who firmly believe that "the practice has provided a better service to patients and we don't want to go back to the old system." At the heart of negotiations about patient care is the greater freedom of the general practitioners to decide standards for delivery of care with "hospitals now accountable to us as opposed to the reverse."

Despite the freedom to widen the scope of patient services referrals to outpatient departments have not increased. Budget holding has led the partners to look more critically at their referral policies, and so far it seems that new referrals to medical and surgical specialists have fallen in 1991-2 compared with 1990-1 (table III). The figures for 1991-2 are an estimate based on the first nine months of budget holding and may not be sufficiently accurate for true comparisons. However, there seems to have been no substantial shift towards private referrals, and the general practitioners are convinced that they are adopting a more critical approach to referrals for specialist opinion.

For the nurses and administrative staff in the practice budget holding has increased their involvement in providing services for patients. Receptionists noted "that patients moving into the area became aware of the fact that hospital appointments can be arranged more quickly than they had been used to elsewhere." The business manager, David Parton, has enjoyed "being privy to all the pleasures which doctors and patients had experienced in seeing changes leading to improvements in our service."

Problem areas

Despite the general air of confidence about the general thrust of budget holding the past year has not been without its problems. With no established ground rules for operating the new system, all the staff have been under considerable pressure. The day to day demands of working within a new contract plus the added complexity of handling a budget of £1m is a large task. The assumption that a business manager could take the administrative load off the medical staff, who could then concentrate on patient care, has proved unrealistic. The senior partner has to be constantly available to help the business manager interpret figures about services for patients. The partners have learned that delegation to administrative staff has to go hand in hand with helping these staff understand how hospital care has to be negotiated. Considerable frustrations have arisen from misunderstanding of the overall aims of the whole exercise, and it is clear that in a budget holding practice the general practitioners cannot avoid a management role as they are seen by the support staff as responsible for giving direction to the organisation.

The immediate gratification of seeing waiting times reduced has been offset by the complexity of the information systems available. The practice's coding system for diagnoses and procedures did not match the system produced by the health authority. This led to confusion about coding when, for example, thyroidectomy could be coded under eight different headings. Here was but one example of the "Procustean bed of medical nomenclature" leading to administrative and communication problems. There have been frequent demands from the health authority for information which was not immediately available, and the pressure on health service managers to report on progress constantly filtered down to the practice.

One of the objectives of budget holding was to stimulate a practice to work within a specific allocation and make savings for future investment, so there was a natural desire to find out how well the practice was succeeding. Initial predictions about the first year's achievements suggest an "underspend" in five figures, but this is likely to be extremely inaccurate. Considerable variations existed among hospital groups in billing for services, and monthly financial statements received

TABLE III—*Number of referrals to hospital specialists, 1990-1 and 1991-2*

	1990-1		1991-2 (estimate)	
	Total	No (%) private	Total	No (%) private
Medical specialist	397	19 (4·8)	320	20 (6·3)
Surgical specialist	975	108 (11·0)	812	92 (8·1)
Total	1372	127 (9·3)	1132	112 (9·9)
Rate/1000 patients	149		123	

by the practice reflected only payments for bills received. No doubt this will improve, but the practice will not know what the estimated underspend (or overspend) will be when planning services for next year. Prescribing costs have been reviewed, resulting in an increased prescribing budget, but the expected cost of hospital services has yet to be calculated.

Prescribing accounts for 39% of the total budget, and the practice plans to develop a drug formulary. As a part dispensing practice with a dispenser in the health centre, the opportunity to develop prescribing policies is there to be grasped. The dispenser was keen to be more active in budget holding but her role in prescribing policies is not yet defined.

The initial successes of reducing waiting times for patients has not meant that large numbers of specialist groups are seeking business from the Calverton practice. Many local consultants are still sceptical of this method of providing care and as one of only four budget holding practices in the area, a sense of isolation still prevails. All the staff expressed concern about what might happen with any change in government as none wanted any further upheaval.

Conclusions

In the early months of budget holding, the partners still had some doubts about the direction they were taking, but they are now convinced that their decision had been correct. The satisfaction of being in control of hospital services for their patients was the main driving force behind the momentum of budget holding. All the staff take pride in their work because they are genuinely attempting to analyse and resolve aspects of clinical work that have been mainly outside their control. Dr Silcock, the trainee in the practice, has come to the view that budget holding is the way ahead for his generation, who are setting out on their careers in practice.

Calverton practice, having been given the power to overcome problems, is beginning to take initiatives and assume new responsibilities. In the words of Tom O'Dowd, one of the partners, budget holding is both "excitement led and project led" with the early examples of improvement in services in ophthalmology, dermatology, and orthopaedics providing evidence of the system of benefiting certain groups of patients. Budget holding has provided the means to break down previous barriers. Although money is not the main driving force in Calverton, on the whole, common surgical procedures and investigations are carried out in the hospital quoting the lower prices.

Being a budget holding practice attracts attention and resources. Successful outcomes for patients and providers seem to depend greatly on the extent to which a practice team can work in harmony towards shared aims. Inevitably, a budget holding practice concentrates on the needs of its own patient population and may not consider the implications for those who have and those who have not. Calverton has not formally consulted its patients about their views and unmet needs. Anecdotal evidence implies that small groups of patients are delighted about the changes which are to their benefit, but most patients are probably unaware of any notable changes to the care they have been used to receiving. "Doctor knows best" is the rule that still applies and seems likely to continue for some time to come.

Budget holding has certainly shown that changes in the delivery of hospital care will occur and Glennerster *et al* have argued that fundholding practices who can shop around for patient care will stimulate inefficient hospitals to use their resources more productively.[2] Calverton is one of just over 300 fundholding practices nationwide and there are only three other fundholding practices in the Nottingham area. Though gains for patients have been achieved, the numbers in one practice are still small. The direct impact of budget holding in Calverton has to date affected only around 2% of the practice population, and questions remain to be answered about the cost and effort required to bring about these changes for a small proportion of patients in any one practice. With time, the overall impact is bound to increase and it will be at least five years before any firm conclusions can be made.

Among the problems facing the Calverton practice is the different roles members of the practice team are expected to fill. The stimulus of "making it happen" has ensured that morale is high but continual attention to teamwork and teambuilding will be required to ensure the cohesiveness of the group. For the foreseeable future the practice will have to learn to live with the frustrations of complicated coding systems, delays in payments, disagreements with health authority managers about priorities, and insufficient information on which to make longer term plans.

Budget holding remains experimental. In Calverton it is still being vigorously pursued. In an environment where innovation is encouraged, the energy to maintain vigour is still high. Any practice which is considering budget holding will have to look closely at the level of skills throughout its staff. Merely having computer assisted records and adding to current staff will not be enough. Calverton has been fortunate in being in a position of readiness, and even then has had to face up to methods of working which lay great emphasis on teamwork. The combination of motivation, opportunity, and a strategy for patient care has ensured that any stumbling blocks to progress have been overcome during the first year of a completely new approach to organising services for patients.

I thank all the staff at Calverton practice who gave up their time to provide information and describe their experiences during the past year.

1 Bain J. Budget holding: a step into the unknown. *BMJ* 1991;**302**:771-3.
2 Glennerster H, Matsaganis M, Owens P. *A foothold for fundholding*. London: King's Fund Institute, 1992.