In praise of non-fundholding practices

Rosalind Eve, Paul Hodgkin

Most discussion of the NHS reforms has bypassed the issue of non-fundholding practices. Development of services and creative use of resources are considered to be the preserves of fundholders. Non-fundholders need district health authorities and family health services authorities to manage their resources for them. Even district health authorities are in danger of becoming yesterday's powerbrokers, struggling to provide for all citizens while their budget is cut to fund fundholding practices.

We believe that non-fundholders, far from being the poor relation in the new NHS, may be best placed to make the most efficient use of public resources in the new internal market. The key to this unorthodox view is the ease with which a coordinated group of non-fundholding practices can assess the quality of service their patients receive from hospitals and other providers. The information generated can then be used to influence and inform their purchaser (district health authority or health board) about how service agreements with providers should be developed and where they should be placed.

The managed market

The essence of the reforms is the split between purchasers and providers. The formal relationship between any purchaser and provider is defined by a service agreement, which defines and prices care given by providers. Purchasers choose between different providers on the basis of cost, convenience, and quality. This system is intended to promote continuous service review as purchasers renegotiate service agreements in the search for better value.

This system requires that purchasers make rational and informed choices between different providers. But is this possible? Although detailed cost analyses of services given by provider units may be just around the corner, other elements crucial for informed choice—that is, measures of patient needs and clinical outcomes—are largely unavailable. District health authorities plan to remedy this by using statistics from provider units together with surveys of patient satisfaction. These measures ignore two factors: firstly, that most clinical outcomes occur in the community not in hospitals; thus statistics from secondary care (such as readmission rates) will always be poor proxies for true outcomes and, secondly, that feedback from general practitioners, who initiate and follow up most episodes of hospital care, is not routinely built into the system.

Fundholders might at first seem better placed to make innovative and good quality purchases, but they have such a small patient base that collecting anything other than an anecdotal sense of quality of service and clinical outcome will be hard. Price and perceived convenience form the basis of choice for both district health authorities and fundholders. We believe that the solution to this problem lies with independent groupings of non-fundholding practices.

Towards Coordinated Practice

The Towards Coordinated Practice project currently includes eight practices in different parts of Sheffield, which cover 7% of the population (about 38 000 patients). For the past 18 months it has had a full time coordinator (RE) paid for by Sheffield Family Health Services Authority. The project explores the benefits of working collaboratively:

- To share information: prescribing and cost analysis (PACT) data, referral patterns, utilisation rates, and hours of ancillary staff are shared between practices
- To develop the existing home birth service in Sheffield
- To share skills, learn from each other's experience, and provide mutual support in all areas of practice work
- To provide a forum for experimentation in developing primary care services. For example, the art therapy for the elderly project. (Previous successes include the Sheffield occupational health project.)

Monitoring provider services

For the past year we have been working as part of a group of eight practices in the Towards Coordinated Practice project (box). We asked members of the project to review their data on referrals to assess the feasibility of collecting information about the quality of care received by our patients.

The practices in the project made 49 referrals to general medical outpatient departments in August 1990. The first letter received from the hospital about these referrals was examined for basic data about quality (table). The practitioners considered that information about drugs in the letter was adequate in 39 cases and inadequate in the remainder. The mean (range) time from referral to receiving the letter was 47.2 (4-120) days.

Collecting data about quality from hospital letters about referrals is practicable and places minimal demands on practices. In this study each set of records took less than two minutes to audit, and the number of referrals per practice averaged one per 1000 list patients. The letters also gave important measures of quality. For example, although we do not know how many of the patients should ideally have been seen by a consultant, information on who sees patients will form a valid indicator of change within a particular service or provider unit. If the proportion of newly referred patients seen by consultants fell too low we would want to take steps with our purchaser to reverse this. Monitoring quality in this way provides an independent source of objective, valid information which will eventually encompass the views of both the referring practitioner and the patient.

We intend to extend this pilot audit to other areas of practice. Initially we will concentrate on measures of

Grade of doctor first seen by 49 patients referred to general medical outpatients department as determined from hospital letter

	No of patients
Consultant	24
Senior registrar	1
Registrar	8
Senior house officer	14
Clinical assistant	2

Sheffield Family Health Services Authority, Sheffield S11 9BD

Rosalind Eve, coordinator of Towards Coordinated Practice

Department of General Practice, Medical School, Sheffield S10

Paul Hodgkin, MRCP, lecturer

Correspondence to: Ms Eve.

BMJ 1991;303:167-8

process (waiting times in clinics, liaison at discharge, quality of explanation to patients, etc), but we hope to extend our approach to include both our performance and health outcomes.

The information generated by monitoring services complements the canvassing of general practitioners' opinions of services advocated by Hicks and Baker.¹ It will provide a measure of quality in service agreements, without which price will tend to dominate the purchase of care.

Provision for all

Current legislation obliges directors of public health to define health needs and advise the district health authority. Yet the authorities' power to purchase adequate services for the whole population is likely to be increasingly weakened. Fundholders do not have to follow public health directors' advice and could even discriminate against vulnerable and high cost patients.

Fundholding practices have shown their capacity to promote imaginative change in service development. But they are small economic units; if they proliferate their novelty will diminish and with it their power to improve quality and promote innovation. This same proliferation will undermine the capacity of district health authorities to develop planned health care.

How then can a planned approach to public health be safeguarded? The best use of resources is likely when valid and independent measures of quality inform a purchaser, who is specifically charged with overall provision of health care. Monitoring quality in groups of non-fundholding practices is one way of

achieving this aim. We believe it has the following advantages. Firstly, assessments of quality of service as perceived by both patients and general practitioners will be independent of both purchaser and provider, reducing the conflicts of interest of purchasers (more care versus better care) and the likelihood of cartels among providers. Secondly, with certain safeguards the information gathered can be generalised to all non-fundholding practices in a district. Thus information from a few practices can inform the service agreements for all non-fundholders in a district. Thirdly, the ability of directors of public health to discharge their obligations to all residents is enhanced. And, lastly, a powerful and skilled central purchasing agency allows general practitioners to concentrate on medicine without the hassle, additional costs, and ethical dilemmas incurred by fundholding.

District health authorities are the logical purchasers of health care, although it is likely that family health services authorities will have an increasing role. Large independent groupings of non-fundholding practices are the logical quality control mechanism for the internal market. The resulting alliance will be built on mutual respect and need. We believe it will be sustainable, powerful, and in the public interest.

We thank everyone in Towards Coordinated Practice and the department of general practice for their help. The views expressed are our own.

¹ Hicks NR, Baker IA. General practitioners' opinions about health services available to their patients. *BMJ* 1991;302:991-3.

(Accepted 4 June 1991)

Variations in budgets of fundholding practices

Patricia Day, Rudolf Klein

Among all the changes that have recently occurred in the NHS, the introduction of fundholding has perhaps the most important long term implication. If fundholding was taken up by most practices, there would be a massive transfer of spending power from district health authorities to general practitioners. The role of general practitioners in controlling the use of NHS resources would be greatly enhanced; conversely, the ability of health authorities to determine the pattern of services would be diminished. It will be a long time before the experiment can be evaluated in terms of its impact on patient care. But the first wave provides some clues about the financial implications for the fundholders and for the NHS. Who has got how much? What are the patterns of allocation to individual fundholders? What transfer of resources is involved? And what are the issues raised by the process of determining the budgets?

To answer these questions we asked regional health authorities about the budgets of fundholding practices; 12 out of 14 provided information. In all we collected data on more than 80% of the first wave of fundholders (251 practices) with a patient population of over 3.1 million. In all cases, the information came in a form that made it impossible to identify the practices concerned. Further, in our analysis we have anonymised the regions and avoided any details that might have provided a clue about their identity.

Pattern of spending

Table I shows the budgets of each region and the range of allocations to individual practices. Purchasing

power of £207m for hospital services has been transferred from the health authorities to general practitioners in the 12 regions. This would imply a total of about £250m for the country as a whole. By extrapolation on the basis of the proportion of the population covered if all general practitioners were to become fundholders about £3200m would be transferred—about 20% of the NHS hospital and community services budget for England. Although this is unlikely to occur, the calculation emphasises the potential challenge to the distribution of resources (and power) in the NHS posed by fundholding and the importance of the way in which allocations to individual practices are made.

The budget for hospital services allocated to individual practices varies from £261 000 to £1 883 000 (table I). If the allocations for staff and drugs are added to this, the range in total practice budgets is £550 000 to £3 400 000. These figures, however, do not account for practice size. The smallest practice in the survey had 6000 patients (less than the official threshold for fundholding), the largest 31 500; this represents a fivefold variation compared with the sixfold variation in the budgets for hospital services. Of the 251 fundholders covered by our survey, 43% had fewer than 11 000 patients, 49% had 11 000-16 000, and 9% had more than 16 000. Of the 108 practices with less than 11 000 patients (less than the original threshold), 12 had less than 9000 patients (the revised threshold). The crude budget figures therefore show only the range in the organisational and financial challenges faced by fundholders: managing a £3.4m a year business is clearly different from running one with a turnover of £0.5m.

Centre for the Analysis of
Social Policy, School of
Social Sciences,
University of Bath, Bath
BA2 7AY
Patricia Day, BSc, senior
research officer
Rudolf Klein, MA, professor
of social policy

Correspondence to:
Ms Day.

BMJ 1991;303:168-70