Heartsink hotel revisited

Brian R McAvoy

Three and a half years ago I described my experience of a meeting I attended for briefing on the brave new world of budget holding, the wild card of the recently published NHS Review.¹ Since then over 3000 family doctors have become fundholders, John Major has replaced Margaret Thatcher and Virginia Bottomley, Kenneth Clarke, and I now practise in the city of sails (Auckland) instead of the city of socks (Leicester). There is no causal relation between these various events.

In September, after three years in New Zealand, I had the opportunity to spend one month back in Britain and was able to review the changes I had heard previewed in March 1989. What follows is a personal observation based on visits in three regions of England to four fundholding and two non-fundholding practices and one poised to join the third wave. I also talked to general practitioners, practice staff, officers of family health services authorities and district and regional health authorities, hospital consultants, academics, nurses, and patients.

Impact of fundholding

Has fundholding been a success? As a more formal evaluation has suggested,² it is too early to judge, but certainly there have been gains and losses. I sensed real enthusiasm and empowerment among some of the fundholders and discovered tangible improvements in patient care. I also learnt of untoward knock on effects and serious concerns about fragmentation and disenfranchisement.

The fundholding practices I visited ranged in size from 12 000 patients (six partners) to 17 000 patients (seven partners). One was in an inner city, one an industrial town, one a country town, and one a county

capital. All practices agreed that preparing for and implementing fundholding was an enormous administrative task. On average each practice had employed two additional full time staff to cope with this workload—usually a fund manager and a secretary or data entry person. In addition, one partner had taken responsibility for overseeing the whole process. Not surprisingly, the enthusiasm was greatest in the first wave practices. Attitudes in second and especially third wave practices were more lukewarm, and I often encountered a sense of resigned determination—"if we don't go in now, we'll get left behind."

There was a palpable sense of excitement, dynamism, and innovation among the fundholders, especially those in the first wave. This was also apparent in the family health services authority officers I met—I was impressed by their commitment, vision, and leadership qualities. The authorities were taking a proactive role, acting as the mainspring of change not only in fundholding but in other areas such as consumer surveys and information systems. They were also organising business planning courses for their doctors and dentists.

I heard of some spectacular changes in services available to patients in fundholding practices. One practice has used last year's savings to clear its waiting list totally for eye, orthopaedic, and ear, nose, and throat surgery by purchasing the operations from the private sector. In another area the sole consultant ophthalmologist has resigned from the district general hospital and bought a caravan which he is using to provide private consultations at fundholding practices. Patients are seen within one week, do not have to travel to the hospital, and, if requiring surgery, are operated on promptly and privately. However, the patients of non-fundholding practices now have no ophthalmology service available at their local hospital and have to travel up to 50 miles (80 km) to their regional hospital.

More modest examples of improved services included provision of physiotherapy and specialist consultations in the practice premises. One practice was considering using its surplus to employ an additional orthopaedic surgeon at the district general hospital to clear the practice's long orthopaedic waiting list. Where fundholders had encouraged local hospitals to improve the services for their own patients, other patients attending the hospital also benefited. For example, one practice with a predominantly Asian population had persuaded the hospital to subscribe to Language Line, a telephone interpreting service which is now available to all patients attending the hospital.

The purchasing clout of the fundholders seems to be encouraging the hospitals to become more patient centred—who would have thought two or three years ago that evening or weekend clinics and operating sessions would be contemplated? A clear shift of power away from the hospital consultants was apparent. Although this is thought to be long overdue by some of my colleagues, will there be a backlash at some point?

Department of General Practice, School of Medicine University of Auckland, Auckland, New Zealand
Brian R McAvoy, head of department

BMJ 1993;306:694-5

Fundholding has produced tangible improvements in patient care

The district general hospital in Leicester has undergone a facelift since I was last there, replacing the previous institutional look with touches of humanity, colour, and interest—preparation for trust status perhaps?

Fair and representative service?

On the downside there was evidence of polarisation between fundholders and non-fundholders. Some practitioners whose practices were too small to qualify for the scheme felt bitter, excluded, and frustrated that their patients were being disadvantaged by a system over which they had no control. Such divisions of opinion were causing difficulties in the functioning of local medical committees.

In at least two of the areas I visited the regional health authority and some of the first wave fundholders were wrangling over the savings accrued during the first year. Over £100 000 was at stake in two cases, and the authority's attempts to claw back some of this were being resisted fiercely. Even the enthusiasts for fundholding realised that the lid was sinking on health expenditure. As the system beds down and budgets tighten the opportunities for innovation and experimentation will steadily diminish. In a few years time the fundholders may have very little room to manoeuvre but will still have to cope with the burden of administering their fund. All the fundholders I spoke to admitted that the scheme had increased the number of meetings they had to attend, both within and without the practice. In some areas fundholders had formed liaison groups and were meeting regularly to share experiences and develop their collective expertise. In one town, however, second wave fundholders had been told to fend for themselves by those in the first wave.

I became aware of two further concerns, one from regional and district health planners and one from patients; both related to the increased power of the fundholders. *The Health of the Nation* spells out a clear strategy for public health policy,³ and many regional and district health authorities have mapped out their local plans. Conflict may arise if a large fundholding practice decides to pursue its own health priorities or ignore those of the local district health authority. Similarly, there is no obligation on fundholding practices to consult with their patients over how they will manage their fund and how any savings will be used. Yet the consequences of these decisions, as in the ophthalmology example mentioned above, can have profound effects on patients both inside and outside the practice. I became slightly unnerved by the frequent reassurances I was given by fundholders that they wouldn't do anything to "upset the applecart" or disadvantage their colleagues' patients.

Nobody really knows what the patients think about all this. A recent survey showed that over 40% of patients did not even know about the NHS reforms, let alone fundholding. Indeed in one practice I visited the patients held a Tupperware party to raise money to "help" their practice—believing that fundholding meant that the practitioners had to raise their own funds. Fundholding has acted as a catalyst for change in Britain's general practice community—the ultimate outcome of the experiment remains to be seen.

1 McAvoy BR. Heartsink Hotel. *BMJ* 1989;298:968.

2 Glennerster H, Matsaganis M, Owens P. *A foothold for fundholding. A preliminary report on the introduction of GP fundholding*. London: King's Fund Institute, 1992. (Research report 12.)

3 Department of Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986.)

General practitioner fundholding: experience in Grampian

I C F Wisely

Proposals for fundholding were greeted with scepticism by many general practitioners, and in Scotland the BMA persuaded the government to allow a scheme to test the arrangements as a demonstration project operating "shadow" practice funds. This allowed the six selected practices to set up administrative and computer systems without the worry of dealing with real money. The shadow fundholding scheme has since been extended to small practices and to a trial of fundholding for all services except accident and emergency. The six practices in the original pilot have all become fundholders and are beginning to effect improvements in the service to their patients. However, with more practices becoming fundholders negotiating contracts with providers is becoming increasingly complicated and more time and money needs to be put into this aspect.

When the radical proposals on general practitioner fundholding were put forward three years ago they were not enthusiastically received by most of the medical profession. The proposals were believed to be "an attempt to cash limit a demand led service which will damage the doctor/patient relationship and be detrimental to patient care."¹ In Scotland, however, the approach was different. A paper which I and colleagues in Grampian prepared for Scottish General Medical Services Committee posed the questions does this present an opportunity for general practice to have

greater influence in the provision of health care for our patients? does it put general practice in the driving seat in helping to determine the range and quality of health service provision? or might it constitute an intolerable administrative burden on the constrained resources of an increasingly cash limited primary care service?²

In a characteristically pragmatic way, the BMA in Scotland persuaded the government to allow the proposals to be tested. A shadow fundholding exercise was agreed that would be independently evaluated to assess the effects on the care of patients and look at the administration structures, consulting patterns, and use of doctors' time.

Shadow fundholding

Six groups of general practitioners in the north east of Scotland were identified for the exercise in the first three months of 1990—five in Grampian and one in Tayside. The evaluation was and continues to be conducted by the Department of General Practice of the University of Edinburgh under Professor John Howie. The exercise was regarded by the then minister for health in Scotland, Michael Forsyth, as a piece of "action" research, the results of which would be made known at intervals during the evaluation. In fact, the first report appeared in July 1992 and was mainly a description of the evaluation process.³ Its summary pointed out that around 10 years would be needed to appreciate the full implications of such a fundamental change in the organisation of health services—so much

Brimmond Medical Group,
Bucksburn, Aberdeen
AB2 9AT
I C F Wisely, general
practitioner

BMJ 1993;306:695-7