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# A Foothold for Fundholding

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King's Fund Institute

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*A preliminary report on the introduction of GP fundholding*

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# Acknowledgements

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# Preface

The NHS reforms which were launched through the white paper, *Working for Patients* in January 1989, represent the most fundamental change the service has seen in its 40 year history. In view of the sweeping and yet untried nature of many of these changes, the King's Fund found it surprising that the government made no formal provision for the monitoring and evaluation of progress. It was in the light of apparent official disinterest in monitoring that the Fund decided to make such evaluative work the focus of a major grants programme. During the summer of 1989, applications from interested researchers were invited through national advertisements in the specialist press; 78 were received and considered. Eventually, seven projects were selected for financial support, each to run over a three year period 1990-1993.

This research report describes progress to date on one of these projects. It is being undertaken by Professor Howard Glennerster and his colleagues at the London School of Economics. It deals with GP fundholding. As Professor Glennerster points out, fundholding was seen initially as a peripheral part of the NHS reforms. However, as time has passed, fundholding has been viewed as an increasingly important part of the reform programme and has attracted widespread interest. It is in the context of this heightened interest that the King's Fund Institute has decided to make available to a wider audience some of the interim findings of Professor Glennerster and his team. The Institute hopes that the information contained in this research report will offer an authoritative and timely contribution to debates about fundholding as policy is being developed.

**Ken Judge**
Director
King's Fund Institute

# Summary


- This study reports on the first preparatory year of general practice fundholding. It concentrates on three NHS regions, two metropolitan and one more rural. Ten sample practices were followed in detail.
- GP fundholding shifts the balance of power away from hospitals towards GPs and primary care. It replaces a top-down model of NHS resource allocation with a bottom-up model, driven by GPs acting as purchasers on behalf of patients.
- The origins of these ideas predate the white paper *Working for Patients* (DoH 1989a), but at the start of the reforms many commentators and managers saw fundholding as an experimental side-show. However, it provoked a lot more interest than most health managers expected.
- Regions relied primarily on judgemental criteria to choose participating practices. High motivation plus managerial and computer capacity were important. Size limits and the demanding selection procedure led to a very uneven spread of first wave practices. The highest concentration lay in the suburban ring around London and in areas where general practice is already good. If the scheme is not to be discredited this will need to be redressed in later rounds. That may mean practices combining for fundholding purposes, and additional help given to poorer practices with cramped premises and populations with high levels of morbidity.
- The white paper and subsequent legislation contained almost no practical detail about fundholding . The rules under which the scheme would operate had to be created as it went along and the administrative detail filled in very rapidly. This was well and very flexibly done by those in the Department of Health, working closely with the regional officers. There were frustrations while some problems were sorted out. The Department underestimated the complexity of the information demands on both purchasers and providers. Given the time available and the innovative nature of the task, the difficulties were inevitable. The greatest problems have arisen with hospitals who found it difficult to give itemised price lists, individualised billing and financial returns to practices.
- Setting the budgets was difficult in the absence of much relevant information. It was decided to set the first year's budgets on the basis of last year's levels of activity and referral patterns, putting a cost figure on the treatment given and giving the practices enough money to do the same again this year. This is likely to have rewarded high referring practices and to have penalised low-spending ones, whether efficient or not. Also it may give intending practices an incentive to increase their activity before fundholding. There was substantial variation in the level of budgets per patient on a doctor's lists. This reflected past referral patterns and wide variation in hospital costs. This diversity will be difficult to justify in the longer term. Formula funding, as originally proposed, may be difficult to do in practice, but is the long term answer.
- Family health service authorities played very different roles. Some had been very supportive of fundholders and in one case fundholders were collectively employing an officer's services to contract on their behalf.
- Contracting proved the most problematic of the stages. Providers were not used to contracting with small agents like GP practices. They were unprepared for offering cost per case contracts and sometimes displayed a 'take it or leave it' monopolist mentality.
- Before long fundholders had begun to use their market power effectively, in small but significant ways, to change and improve the services they received. Exercising the power of exit, exerting competitive pressure on hospitals and providing some erstwhile hospital services themselves were all strategies developed by fundholders. For the most part they had been careful not to reduce the capacity of other GPs to gain access to NHS facilities on equal terms.
- Patient consultation has largely been confined to the period after the practices had themselves decided to join the scheme. The extent and form of information given varied widely.
- A number of unresolved issues remain. There is still room for debate about whether districts or GPs represent the best form of purchaser. Critics of fundholding claim that excessive transactions costs, problems of achieving consistency and rationality in planning and the wrong kind of

incentives all make GPs unsuitable for the task. They also claim that the first year's experience may be misleading. However, the theory and evidence presented in this report suggest that there is no convincing case for claiming that districts will be better purchasers than GPs.

- It was clear from the outset that the issue of equity between the patients of fundholding and non-fundholding GPs was going to be critically sensitive. Would there be an efficiency versus equity trade-off? The arguments are to a large extent confused. Above all critics of fundholding have tended to adopt a static view of the consequences of competition. They ignore that what we may be seeing are first-round effects in a move from a forced static equilibrium to a new long-term outcome in which the equity consequences are difficult to predict. They also ignore the overall efficiency gains from which all patients may benefit.
- Fundholders' 'cream-skimming' through the exclusion of high risk patients has always been a troubling aspect of the scheme. The preliminary year could throw no light on this problem. Nonetheless, theoretical considerations — and evidence from abroad — suggests that careful attention will have to be given to the development of a funding formula which avoids this risk.
- This study has suggested a number of short-term and longer term changes that are required to keep the scheme developing, and to build on its strengths and eliminate its weaknesses. These are listed in the final section of the report.

# The study

# 1

Fundholding by general practices is the most innovative and potentially far reaching aspect of the NHS reforms. It also raises the most potential difficulties in implementation. We originally stated these views in our application for a King's Fund grant and have not revised them since.

The study falls into two parts. The first is a description of the preparatory period from January 1990, soon after practices were asked if they were interested in joining the scheme, to April 1991 when the practices took on their budgets. This report covers this first phase of the research and is essentially a preliminary look at the launch of the scheme. In fact, the process of GP's reaching agreed contracts with hospitals and other providers took longer than planned originally. To include an account of this year's contracting outcomes we have drawn on our interviews with practices up to the end of June 1991.

The second phase of the research will cover the first year of fundholding proper and will concentrate on the budget process, the management of the practices and the service outcomes in so far as we can measure them.

The research is concentrated in three regions, two cover parts of London and the Home Counties, while the other is a largely rural area in which we chose remote rural practices. To summarise:

- *Region A* covers London and the Home Counties, and had 13 first wave fundholders;
- *Region B* covers London and the Home Counties, and had 23 first wave fundholders;
- *Region C* covers a rural area with some medium-sized towns, and had 9 first wave fundholders.

We were able to interview – on a roughly three monthly basis – regional officers responsible for the scheme, and family practitioner committee (FPC) managers, especially those in areas with a large number of fundholders. Subsequently FPCs were redesignated as family health service authorities (FHSAs).

With the help of regional officers we were able to contact practices who were interested in adopting fundholding and in joining in the research. A research officer accompanied the regional facilitator to the initial discussions with a cross section of practices in one region. In the other regions, the initial trawl was undertaken from the practice profiles. From this initial list of potentially collaborating practices we chose 15 practices that reflected a cross section of the types of practice that had opted for fundholding status at that point. We included practices that differed in size, social situation, geography, the pull of London teaching hospitals, referral patterns and practice organisation.

These 15 practices were interviewed in the first few months of 1990. Five subsequently dropped out, roughly the number we were expecting, and we were left with ten practices with whom we have worked ever since. Six are in Region B, which had the highest number of practices applying to enter and entering the scheme of our three regions. Two each come from the other two regions. Table 1 outlines the characteristics of the sample practices.

*Table 1* Sample practices' characteristics

| Practice | Partners | Locations | Patients |
|---|---|---|---|
| 1 | 3 | Inner London (not poor) | 9,500 |
| 2 | 6 | Small town | 16,000 |
| 3 | 5 | Large town (deprived) | 12,800 |
| 4 | 6 | Large town | 12,500 |
| 5 | 5 | Village/rural | 9,100 |
| 6 | 6 | Small town | 13,500 |
| 7 | 6 | Village/rural (remote) | 13,500 |
| 8 | 6 | Village/rural | 11,000 |
| 9 | 6 | Outer London (mixed ethnic/poor) | 15,200 |
| 10 | 4 | Outer London | 10,500 |

These practices were visited every three months. They have sent us their contracts together with financial and statistical material dating from the beginning of fundholding. Officials at the Department of Health have also discussed the scheme as it developed. Everyone involved has been extremely helpful and we would like to acknowledge their assistance, their openness and their enormous good will in response to our requests for time and information.

# 2 The origins of the idea

The idea of fundholding for general practice predates the prime-ministerial, working party discussions on NHS reform which preceded the white paper *Working for Patients* (DoH, 1989a).

Professor Alan Maynard had proposed that general practitioners might be given powers to purchase services from hospitals on behalf of their patients as far back as 1984 at a meeting organised by the Office of Health Economics (Teeling-Smith, 1985; Maynard, 1986). There were particular characteristics of health care markets, he argued, which made it difficult for individuals to purchase care for themselves but that did not mean that medical care had to be provided, as in a command economy, by a single monopoly provider, funding and rationing services from above. The family doctor was, in the British system, the patient's advisor and guide through the whole complex system of health care, why not give him or her the financial power to act on behalf of the patient?

The basis of funding the NHS since 1948 had been to give cash to hospitals or community services. Until the general management reforms of the early 1980s those working in the facilities had been left to use the resources with little or no external accountability. The system worked on presumed dedication and good will. It gave no financial incentive to work harder, see more patients or improve the nature of service. Peer esteem might lead a consultant to use advanced methods but not to instigate an appointments system that worked in the patient's favour or speed up mundane operations or procedures. Numerous studies have shown how difficult it is to change consultants' practices in these regards.

The principle of fundholding is founded on the belief that the GP is nearer to the patient, knows more about the practical needs and family situation, and is in a good position to act as the proxy but expert consumer. If cash follows patients in ways that reflect the preferences of consumers as informed by their family doctor, it would be possible to combine the virtues of consumer choice and free access to health care while avoiding the high cost of the American system.

These ideas were picked up by those working in Mrs Thatcher's No. 10 Think Tank and fed into the review of primary health care that was under way in her second term.

The Treasury was independently concerned at the rising cost of primary health care which was the major part of the NHS budget that was not cash limited. An external investigation of the options for capping primary health care spending also looked at the Maynard idea. There was a suggestion that if GPs were offered more freedom in the use of a larger budget they might be prepared to accept a cash limit on their whole allocation of funds, including prescription costs.

Quite independently, work had been going on in the Department of Health on ways of improving the efficiency of general practice and encouraging a better preventative health care service which had to turn, in large part, on the family doctor. There was nothing particularly party-political about these concerns, they had been on the Labour Government's agenda too. What was new, and in tune with the times, was the recognition that financial incentives would be needed to change doctors' patterns of behaviour (Bosanquet and Leese, 1989).

Linked to this was an interest in the growing American literature on health maintenance organisations (HMOs). The essential characteristic of HMOs is the offer of a comprehensive range of health care to a member in return for a flat rate premium paid annually to the HMO. The HMO provides a family doctor service but also has to provide or purchase hospital or other specialist care when the member needs it. Since the costs have to come out of a total fixed budget for the year, the HMO had an incentive not to refer to the hospital unnecessarily and to encourage good health. These were, at least, the claims of the reformers in the United States in the early 1980s when the federal government began to encourage the spread of HMOs (Brown, 1983; for a more recent account and lessons for Britain see Weiner and Ferriss, 1990). A small team from the Department went on a study tour of the United States to learn more about HMOs. They came back doubtful that the idea was, as it stood, importable into the UK but they were impressed by the flexibility the system gave doctors in HMOs to buy in services or undertake services themselves. In addition, the flexibility enabled doctors to exercise some financial bargaining power over hospitals. This could provide a way of bringing efficiency incentives to bear on the production of hospital services.

## Balance of power

A more deep-seated motive lay behind some reformers' approach, namely redressing the balance of power between GPs and consultants.

This was to find a strong echo in the experience of the first year we have monitored. Giving a budget to a GP with power to buy hospital services might help begin to redress the loss of professional status and power, relative to hospital consultants, that family doctors had suffered for the best part of this century and certainly since 1948. Professor Richard Titmuss of the LSE used to joke that one of the important consequences of the introduction of the National Health Service in 1948 was that prior to that time consultants sent Christmas cards to GPs but after then the opposite happened. The consultant in the old voluntary hospitals depended for his income on patients referred by the GP. In the new NHS the consultant was paid a salary and had the power to pick and choose which patients to take from a long waiting list. The GP became the supplicant on behalf of his or her patient. We shall see later that many of those in the service representing the GP or primary care interest do see this particular reform as one way to redress the balance in favour of primary care. In doing so they see themselves ranged not only against consultants but also some general managers in the districts who have become associated with the interests of hospital-based care.

The general principle of giving GPs purchasing power over a wider range of services was written into the draft green paper on the future of primary health care in 1985 as the radical option. However, it was removed before publication. The green paper and the eventual white paper *Promoting Better Health* (DHSS, 1987) contained no vestige of the idea. They relied instead on financial incentives and a much tighter contract with GPs to undertake their traditional range of duties. This contract was eventually introduced, with much ill will, in 1990. However, the budget idea had been much discussed in the Department and the junior health minister at the time, Kenneth Clark, must have been aware of it.

## Purchaser/provider split

At much the same time, another American-inspired model for reform was launched by Alain Enthoven (1985). He also advocated a sharper distinction between the purchasers of health care and the providers, but in his model the district health authority would purchase services from hospitals and units in their own or other districts. They would, in the American terminology, choose a set of preferred providers who would compete for contracts to provide care for the district in question. This would define more clearly the management task at district level. District managers would have the job of defining clear service outputs and making sure that hospitals or other units achieved its contracted level of service. In this sense Enthoven was extending general management at district level to its logical conclusion. Indeed many district managers were moving in this direction. Enabling districts to purchase services beyond their boundary would give managers better control of cross district flows. It was an evolutionary model, essentially extending the logic of the Griffith's 1983 reforms and the introduction of general management. It would also distance the centre more clearly from operational considerations.

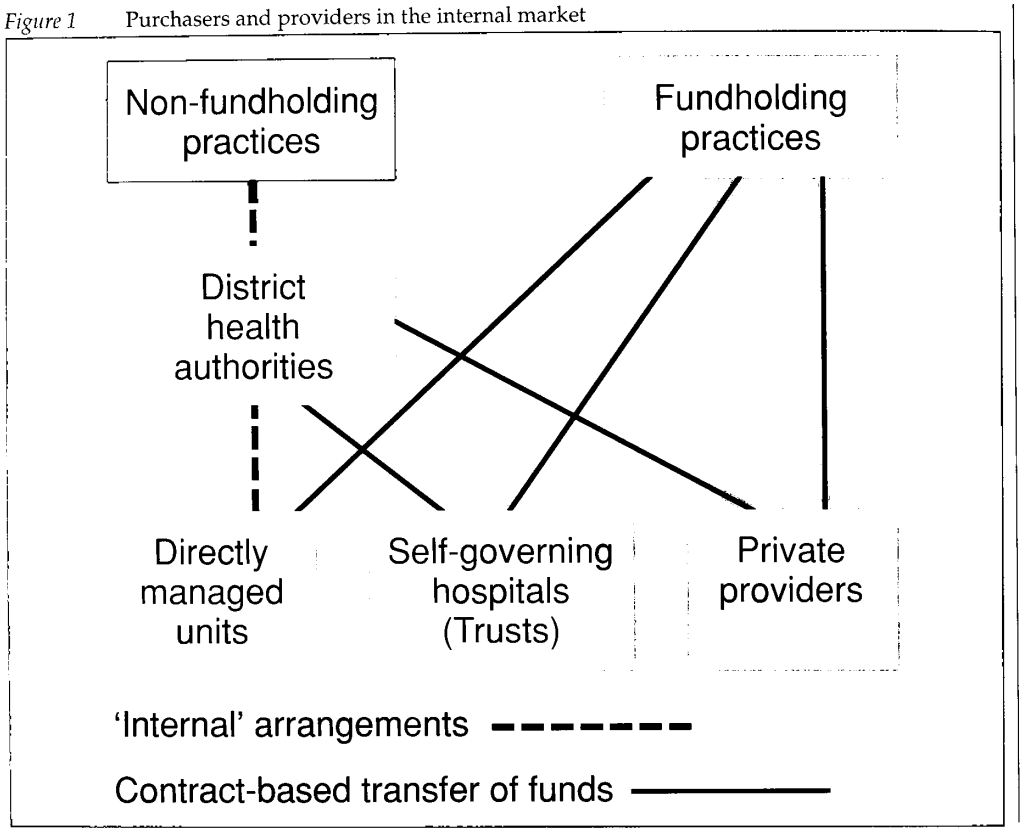
It is not surprising, therefore, that when Mrs Thatcher set up the National Health Service Review in 1987, it was the Enthoven model that was the front runner for change.

Some right-wing think tanks suggested radical reforms and discussed giving tax relief to private health insurance or shifting the basis of health care finance to private health insurance reimbursed from the public purse (Letwin and Redwood, 1988; Pirie and Butler, 1988). Most middle ground commentators, including the Institute of Health Services Management (1988) and Robinson (1988) from the King's Fund, opted for the Enthoven model. The alternative case for smaller scale HMOs was advanced by David Willets and Michael Goldsmith (1988), a former GP, writing for the Centre for Policy Studies. So far as it is possible to ascertain, this model got nowhere until very late in the discussions of the working party on NHS reform. It was not until John Moore was replaced as Secretary of State by Kenneth Clark in the summer of 1988 that the old idea, previously discussed in the run up to the primary care green paper, was taken out and dusted off. This was very much Mr Clark's initiative but the fact that it came as a late implant in the policy process explains why it was never fully integrated into the whole and why, from the beginning, it appeared as an appendage to the 'real' reform package.

## Adapting the scheme to the UK

Transposing the HMO idea to the UK situation posed major difficulties. There was simply no comparable institution. Most HMOs are very large by the standard of an average general practice. Some are, indeed, as large as a district health authority. It is generally accepted in the United States that the variations in annual spending and the possibility of having a very expensive case one year are such that the 'risk pool' must be fairly large. It was just too risky to have a population of less than 50,000 or so (Weiner and Ferriss, 1990). No UK practice approached that size. There was, moreover, a very large US literature on biased selection or cream-skimming. In short, health providers who are paid a flat sum to look after a given person have a strong incentive to keep out the potentially high cost patient. The literature on

*Figure 1* Purchasers and providers in the internal market




the impact of this perverse incentive on HMOs in the US was summarised by Luft and Miller (1988).

The working party were well aware of these difficulties. Safeguards had to be built into the scheme to mitigate them. First, if the scheme was to use existing practices as its basis these could only be the very large and well organised ones. Therefore, when the scheme emerged it was to be confined to practices with 'at least 11,000 patients' (DoH, 1989a, p.49). This limit was subsequently lowered to 9,000.

Secondly, the budget which the practices could handle should initially only cover standard, relatively inexpensive treatments without open ended treatment following on. The GP would have to be able to make a diagnosis and know what it would cost to treat. The costs would need to be relatively small. Heart transplants were obviously not going to be included. The more the range of procedures was limited, the smaller the risks became of over-spending annual budgets. Initially the white paper merely said that the range of services and procedures that the GPs would be able to purchase would cover outpatient treatment, diagnostic tests and certain inpatient and day case treatments 'such as hip replacements and cataract removals, for which there may be some choice over time and place of treatment'. It was not until a later working document that a fuller technical list of the treatments to be included was published. This is reproduced in the appendix to this report.

Finally, the scheme needed to be designed so that practices would not be 'bankrupted' by a very expensive patient. This led to the suggestion that there should be a limit to the costs that a practice would have to bear for any one patient. Therefore, practices were told that if any one patient cost them more than £5000, the district would pick up the bill over and above £5000.

In the event, then, the Government had to consider two competing models of reform (the Maynard model and the Enthoven model), one bottom-up funding, the other retaining the district as the sole purchaser. It went for both at once, with the result being an organisational structure illustrated in Figure 1. It was perhaps not surprising that many commentators and many of the managers with whom we talked early on saw the fundholding part of the reform package as an experimental sideshow.

# The scheme

# 3

*Working for Patients* (DoH, 1989a) put the case for GP fundholding in terms of incentives and choice, while not explaining or justifying why two kinds of purchasers were necessary. The main argument was that 'hospitals and their consultants need a stronger incentive to look on GPs as people whose confidence they must gain if patients are to be referred to them' (DoH, 1989a, p.48). Consultants needed to fear that they might lose custom and resources if they did not do a good job. The patient, through the GP, could exercise 'the power of exit'.

The white paper also argued that '... a GP who refers a patient to another district can cause financial problems for the hospital who accepts the referral. As a result waiting lists can grow' (DoH, 1989a, p.48). This was a reference to the complex ways by which districts were financed under the old system. This meant that a hospital which took patients from outside its district might gain no direct financial recompense and hence be reluctant to accept patients from outside its area. Under the fundholding scheme, if the GPs referred beyond their area, cash would follow referrals and benefit the hospitals involved.

In contrast, district contracting would make it more difficult for GPs to refer to hospitals with which their district had not made a contract. Eventually GPs were to be allowed to make extracontractual referrals to hospitals not covered by a district contract. This was, even so, a cumbersome and resented restriction. As we shall see, this was one reason for the attraction of fundholding which carried no such limits to GPs' referrals.

As we have seen, the scheme was to apply to larger practices who would be free to apply not just initially, but gradually over the years as they wished. Like trust status, fundholding was to be voluntary.

The budget was to cover the list of treatments set out in a later *Working Paper No 3* (DoH, 1989b), outpatient care and tests. The budget was to be set by and given by the regional health authority (DoH, 1989a, p.50). There would be three elements to the budget, which would cover:

- **Hospital services** that a practice would be able to buy. This would be 'based on the number of patients on its list, weighted for the same characteristics as are proposed for allocations to districts' (DoH, 1989a, p 51). This was to be modified later, as we shall see. The sum would be subtracted from the district's budget.
- **Practice staff** employed by GPs. This would be based on the sum which the FHSAs already allowed for staff. This would come from the FHSA budget.
- **Pharmaceuticals** prescribed by the practices. The drug budget would be calculated in the same way as the indicative budget for any practice. This would come through the FHSA in the normal way and come from its drug spend.

Unlike other practices, however, fundholders would be able to use the combined budget, comprising all these elements, flexibly. It would have the freedom to spend any money saved from the drugs budget for treatment or in any way it wanted so long as it was on patient care. Savings could be carried forward to the next year.

That was it. Almost none of the detail, none of the possible practical difficulties were sorted out in advance in traditional civil service cautionary style. In the model of the third Thatcher government a broad skeleton of an idea was in place. The practical operational detail was to be worked out in the first developmental year. The civil servants, FHSA and regional staff responsible would have to fly this new machine by the seat of their pants.

## Promoting the scheme

The circumstances did not look propitious. This was a voluntary scheme which individual doctors would have to join. Unlike hospital trusts, the initiative would have to come from doctors alone, not managers. The British Medical Association (BMA) had sworn its opposition. It pronounced the scheme doomed and wrote to all practices urging them not to participate. Critics from the General Medical Services Council of the BMA complained about the cost of the scheme. They also predicted the development of a two-tier system and a split between GPs in and out of the system. The climate produced by the government's decision to enforce a 'contract' on GPs had seriously soured the relationship between government and family doctors and did not help.

The Department decided to communicate directly with GPs. Every GP was sent a simple, well presented and produced outline of the scheme, answering the kinds of immediate questions that a GP might have (DoH, 1989c). Almost universally the GPs we interviewed thought it was well done and informative.

At the back of the document there was a list of the names, addresses and telephone numbers of one individual in each region who would be responsible for fundholding – the fundholding officer. This was a shrewd move. Regions were to be responsible for launching the scheme but GPs had never normally had any dealings with regions. The family health service authorities were their only contact with NHS bureaucracy. This gave a point of contact in a strange and faceless organisation, as most of our GPs saw it.

Equally important there was a tear-off slip at the back of the document which GPs could send in expressing a preliminary interest in joining the scheme 'without prejudice'. The regional officers would then be obliged to follow up all these expressions of intent.

The list size needed for a practice to be eligible was reduced from the originally announced 11,000 to 9,000. There were also financial inducements. GPs joining the scheme would be given 75 per cent of the costs of purchasing, leasing or upgrading a computer system needed to run the information side of fundholding. In addition, 70 per cent of the information staff costs of fundholding would be met. Moreover, in the preparatory year, an allowance would be paid to cover the extra administrative costs of preparing the practice for fundholding status.

The regional managers we spoke to in January 1990 really had no idea what to expect but they thought the response would be modest. Regions were in for a surprise. Table 2 shows the response from GPs in each of our three regions. In Region B, 78 practices made initial enquiries, 58 of whom were eligible as having over 9,000 patients, while in Region C, where we had been told GPs were largely hostile to the scheme, 36 showed an interest. Some applied who were under the 9,000 limit but, even excluding these, considerable numbers remained eligible and interested.

*Table 2* Practices applying for fundholding status (March 1990)

| Region | Practices enquiring | Practices with 9,000+ patients |
|---|---|---|
| A | 58 | 41 |
| B | 78 | 58 |
| C | 36 | 34 |

We interviewed a cross-section of fifteen of these practices, asking them why they were interested in applying for fundholding status. The most important reasons they gave are set out in Box 1.

We certainly came across some strong philosophical doubts and differences of opinion about fundholding amongst RHA managers within the service in these early days. At least one regional officer thought many GPs had not fully considered the consequences and were opting into unknown territory with abandon. Some thought it would upset the patient-doctor relationship. Others felt that it was unrealistic for GPs to change their provider units and some managers could not see the point of complicating the funding arrangements in what was going to be a difficult year anyway. Those NHS managers with experience of general practice felt most GPs would have enough to do coping with the new contract and its organisational demands. A practice would have to be very well organised to take on both at the same time. Practices in inner London were too small to benefit and this was where the highest priorities lay.

Managers at regional, district and FHSA level, therefore, had good reason to be apprehensive of the large number of practices that had applied. Districts feared the potential of the scheme to disrupt their budgets. On the other hand, the Department and ministers were making it clear that practices had a right to enter the scheme if they were fit to do so. This was the rather difficult course the regions had to steer in selecting practices to join the scheme.

The scheme's launch, in the hostile political and professional climate of 1989/90, had been more successful than most of those we interviewed originally expected. The positive interest expressed by a large number of practices meant that the scheme had got off to a good start.

## Selecting the practices

The Department of Health sent guidance to regions on the kind of criteria to use in selecting practices. They had to have a list size of 9,000 or more and have adequate managerial and computing capacity. Each of our regions elaborated their own more detailed criteria.

**In Region A** these were developed by the Regional Working Group. There was some lengthy debate about the level of methodological depth that the region needed to select practices with appropriate characteristics. Multi-variate statistical analysis was tried but proved too complex to undertake. It was finally abandoned. Instead, a more straightforward approach was adopted, based on a checklist of simple characteristics and judgemental criteria. The reasons given by practices for wanting to become fundholders, coupled with evidence of the partnership commitment, were of primary importance.

The management arrangements within the practices weighed heavily. Practices had to demonstrate that they had appropriate staff to cope with the demands of fundholding. Because so

1

## WHY DID PRACTICES APPLY?

### A desire to do something for patient care

In over eighteen months of interviewing and informal discussions with doctors it is impossible not to conclude that the predominant motive for the practices that survived in the scheme has been a desire to improve their quality of service. All the doctors felt a sense of frustration that patients were waiting for months or years for routine operations and they wanted the freedom and power to do something themselves to change the situation. They were not convinced that lack of resources was the only reason for long delays or poor care.

### Referral freedom

Most of the doctors who referred their patients to a wide range of hospitals were very anxious to retain that freedom. Under the new arrangements they feared they would only be able to send patients to hospitals with whom the district had a contract. They saw their own budget as a means of retaining their freedom to refer. To them, fundholding was a way of preserving the status quo. For about a quarter of our sample this was, perhaps, the predominant motive at the outset.

### Service development

Many hoped that they would be able in the long run to redirect their budgets that would pay for routine minor surgery and diagnostic tests and develop their own on-site facilities.

### Budgetary freedom

The capacity to be free from the need to seek approval from the family practitioner committees for each change of staff, and the ability to use savings generated in one area of work on another, appealed.

### The next mountain

For many, fundholding offered an opportunity to develop their practices in new ways and have more independence and control over their professional lives. Most of the moving spirits among the partners were in mid-career. Ordinary general practice had become something of a routine. The interest and excitement came from doing new things, expanding and improving their practice premises, helping educate student doctors, installing a computerised patient record system, running clinics. All our sample turned out to be innovators in one or other of these ways. They were not, mostly, borne down with high demands on their services in inner city areas. Some practices with poor populations remained in the scheme but all were well run and were not only coping, but were already eager to do new things for those populations. The sample as a whole had what might be called 'entrepreneurial space' and this looked like the next mountain to climb.

### Money and incentives to improve computing and management

It soon became evident that there was not going to be siginificant financial gain once practices took account of the extra work involved. The scheme did require the practices to put in a good computerised patient record system and improve their management and paid them to do so. Some practices said that even if the scheme closed tomorrow that alone would have been worth it.

### Changing hospitals for their patients' good

A small number of practices were thinking about major changes in their referral pattern. A few had been getting very poor service from their local hospital in one or two specialities. They were determined to use fundholding as a way of transferring their patients to another slightly more distant but better hospital consultant. They hoped to be able to get treatment in hospitals and other districts that had shorter waiting times. They had not been able to do so before because the hospitals had not been ready to take their patients. They hoped 'money would talk' in the future. Some discussed in rather general terms trying to insist on better service from the consultants, for example, in the speed with which they got discharge letters. However, in early 1990 this did not come very high on partners' list of reasons. We shall see that this became much more important later.

much time in Region A had been spent discussing criteria for choosing practices the actual selection was very late; it was towards the end of August before all the chosen practices knew of the decisions affecting them. By then many of the original number had dropped out. The region ended up with thirteen practices actually entering the scheme in April 1991 compared with a total of 41 practices that had shown an interest and were of eligible size.

**In Region B**, which had the largest number of intending practices, a decision was made at the outset that the selection would have to be purely judgemental. The factors taken into account were primarily the managerial and computing capacity of the practices, the commitment of all the partners and the advice of the FHSA on the general quality of the practice. All practices interested in joining the scheme were visited by RHA officers and FHSA managers, sometimes jointly. All selection processes were carried out in consultation with the relevant FHSAs. A letter was sent to practices showing an interest, explaining the main stages in the selection process. It envisaged a rolling programme of inclusion over a five-year period.

In visiting practices, regional officers were looking for several things. The existence of a computerised information system which was fully operational on 1st June 1990 was the first requirement. Accommodation for practices had to meet the FHSAs' minimum standards and should provide adequate space for additional staff and hardware required by fundholding. Any major

changes of premises in the year could affect this capacity and had to be taken into account.

Practice management had to be of a proven high standard. This would be judged by their track record with the FHSAs including, for example, their ability to send in claims on time. Future plans about the role of practice manager, and their ability to adapt to fundholding, or special appointments of business managers or outside expertise were also important to explore.

Partners had to give some evidence of their commitment as a group to fundholding and show, if possible, that they had an established system of regular practice meetings. Stability of the practice was another proof of unity between partners. Practices were expected to agree to provide a business plan by November 1990.

Following the visits and after discussion with the FHSA managers, regional officers wrote brief assessments of each practice and produced a list of 26 practices that it was felt were appropriate for the first wave.

In Region C the selection procedure relied far more on the FHSAs. Practices were invited to send in a short proposal which would form the basis of the assessment. However, it was stated that due to the limitation of resources, an incremental approach would be necessary. A rolling programme was envisaged so that, if not successful this year, a practice could well be included next year. The practices were sent an outline which identified areas which they should cover in their submissions. Brief statements were requested as to what GPs thought would be the benefits of fundholding to patients.

Practices were expected to identify a leader for their fundholding initiative, and to indicate the level of support there was among partners. Submissions had to include a planning framework within the practice and its relationship to national, regional and local FHSA policies. Descriptions of any practice innovations and developments, medical audit procedures and methods of communicating information to patients were also required. In the end several practices dropped out from the sixteen selected, leaving nine at vesting day.

**RHAs and FHSAs: roles in the selection process**

In all the regions there was some complaint, especially from the most enthusiastic practices, that the regional staff, at least initially, had not been sufficiently enthusiastic or evangelistic about fundholding. Several were quite angry about this and had complained about it. On the other hand, managers responsible for a completely new scheme, knowing how little preparation or guidance there was, were understandably cautious about being too encouraging. They wanted a group of practices they could be reasonably sure were capable of carrying the major management tasks that would be involved.

It was evident that the longer established relationships with the FHSAs proved warmer. The FHSAs in areas where many GPs opted for fundholding took on the role of guides, advocates and advisors. FHSA managers to some extent resented the role regions had played seeing their long standing links bypassed. Certainly it led to duplication of effort, or outright hostility in a few cases. By the end of the preparatory year, the regions had retreated and left the detailed oversight of fundholding to the FHSAs whose managers emerged robust from these organisational tussles, with ideas about the way fundholding might bring about a revival in and an expanded role for primary health care.

**Fundholder networks**

The dialogue between some GPs and the regional staff showed the rough edges of the new relationship between GPs and the larger bureaucratic structure of the RHAs. The major worries the doctors had were concerned with the administrative load the scheme would bring, the capacity of their computer systems to cope and the uncertainties of handling the budget.

Once the GPs had the opportunity to discuss problems together, they found a collective voice to articulate their criticisms. There was some discussion of forming a breakaway fundholders' union. The large number of GPs in two FHSAs joined together in a group that gave them substantial political muscle, which they used to gain concessions from their region, for example in the demands for data. This collective response resulted in a loose but more long-term group forming. GPs for the first time, as fundholders, found they had a unified voice, which once raised, could influence policy.

Being drawn into the mainstream of the NHS structure was a new experience for GPs who worked in relative isolation from each other. It was a situation which inevitably created some conflicts. Later, groups met to share experience and knowledge about regional tactics, budget setting, contracts and deals made with particular hospitals.

Groups also emerged in other areas where there were several practices nearby. In the more rural region the fundholders met to give each other mutual support in the first instance. Since then the meetings have become more useful as ways of discussing contracts and providing a forum for meeting the providers and consultants. The meetings on practical administration issues have become less necessary as 'all the practice managers are always on the phone to one another if anything new comes up and faxes flash between them'. In one area, as we shall see, fundholders joined together to employ a contract manager who

handled negotiations with all the providers in the county and beyond.

As Weiner and Ferriss (1990) predicted from American experience, networks are emerging to strengthen the practices' political and market power.

**Differential spread of practices**

The strict criteria for entry to the scheme combined with the geographical pattern of applications meant that there was a very uneven spread of practices entering fundholding in our three regions. The highest concentration of practices lay in the suburban and semi-rural areas just beyond greater London. The consequence was that very few traditional practices in inner city deprived areas entered the scheme. One inner London practice did become a fundholder but it was located in a prosperous/mixed area. Most were too small to apply. Where they were not too small they were overburdened and had none of the entrepreneurial and physical space of the rural and suburban practices. However, we did have three practices with a poor and/or mixed ethnic population in our sample in the outer fringes of London and in the centre of a large town.

Overall, of the 40 district health authorities (DHAs) in our three regions, 17 had no fundholders at all in the first wave. Of the others, 6 DHAs had less than 5 per cent of the population registered with a fundholding practice, in 9 DHAs it was between 5 per cent and 10 per cent, and in 5 DHAs between 10 per cent and 13 per cent. The other 3 districts had a high concentration, with 19 per cent to 22 per cent of the population being registered with a first-wave fundholding practice.

Only the most highly motivated and well organised practices were selected for the first wave. Those under least stress and with most space – physical and entrepreneurial – became fundholders. If the scheme does bring organisational and medical practice gains and if some additional resources flow too, in management allowances, this poses questions of geographical and social equity.

Most innovations tend to benefit the most advantaged first, but if the scheme is not to be discredited this bias will have to be redressed in later waves. It will mean giving more resources to practices in poorer areas or with high rates of morbidity, to enable them to participate. It will mean enabling smaller practices to participate by combining forces. There was already some discussion of this with the first wave practices acting as advisers. In one case a practice saw itself as the focus for other smaller practices who might attach themselves for fundholding purposes.

## Making up the rules of the game

While the regions had been getting on with the job of choosing which practices could go forward into the first phase, the Department of Health was filling out the details of the scheme. The small group of civil servants with responsibility for fundholding met with regional officers once a month or so. They shared news about how work on the financial software was going and the precise definition of the diagnostic categories that should be included in the fund. The statutory instrument laying down the regulations under which the scheme would operate was only published on the 8th March 1990, laid before Parliament on the 11th March and came into force on the 1st April. It was not until August 1990 that a definitive list of inpatient and day case procedures was produced. This is reproduced in the appendix to this report. The definitions and coding had been a matter of some lengthy discussion.

The regional officers brought to the Departmental meetings dilemmas and questions from practices which they could not answer. Often issues would arise that had to have a quick answer. Some took longer to resolve, including, for example, the extent to which GPs could use the management allowance to pay themselves or a locum replacement for the time the management of fundholding was taking. The original question and the answer were then circulated to all the regional officers. This proved a remarkably flexible and effective means of developing the rules of the game, and changing them, as the scheme took shape. Examples of the types of questions brought to the Department meetings are outlined in Box 2.

Regional staff and others who had had direct contact with the DoH spoke well of the way those in the Department had responded and been helpful and supportive. They thought that the monthly meetings, the circulation of letters and responses and the frequent informal links had worked very well. GPs were more critical. They did not necessarily distinguish between the Department and the region. All were frustrated by the delay in the production of the financial software package. It had to be left to the multiplicity of private computer companies whose systems practices used. They had to produce software according to specifications laid down by the Department. The companies claimed there were too few fundholders for it to be worth their while and the saga dragged on with some packages not available until well into 1991. All in all, the Department did well to get the packages produced at all. However, it took a long time for the Department to agree that the costs of the financial package could be reimbursed at 100 per cent as this was to prove very expensive in the

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## QUESTIONS TO BE ANSWERED

- What criteria should be adopted for choosing practices?
- What definitions of procedures to be covered by the scheme should be chosen?
- How should the Management Allowance be decided? Could GPs claim from it for time spent on fund management?
- How were the budgets to be set for the new fundholders?
- On what basis would the prices be calculated?
- What were the precise limits to the treatments that would fall within the budget?
- How was emergency treatment to be defined?
- What was to happen where outpatient treatment followed on from an inpatient episode that was not in the categories covered by the fund?
- How would treatment that took place in the first year of fundholding, but had been initiated in the previous year be handled?

case of some practices. If they had agreed earlier it would have avoided a period of damaging uncertainty for the practices although the companies would have found no limit to the prices they charged.

Another cause of discontent was the reimbursement of the costs of purchasing, leasing or upgrading computer systems to cope with the new data demands of fundholding. There was delay in producing the sliding scale by size of practice for the claims to be assessed. Would equipment bought in advance be included? Practices were irritated at being kept waiting while these rules were worked out.

Frustration was also expressed among fundholders as the Department began to stress the need to maintain the 'steady state'. GPs said that one of the most important reasons for entering fundholding was that they wanted to change the present state of things. 'Why go through all this trouble and stress if we cannot do anything different? If they give us a budget they cannot tell us what to do with it'. One small practice in which the main partner was carrying the load of contracting work nearly gave up at this point. Some practices however had their own reasons for not wanting to make too great a change in year one and they made up their own minds about the contracts they would set.

When we reflect that so little detail was in place at the outset of the scheme, the implementation phase which put the flesh on it, was remarkably well done. Some strategically problematic decisions, such as the way that budgets were set, derived almost inevitably from the time scale required and the lack of detailed previous technical ground work, as we shall see in the next section.

Plainly, the Department had underestimated the costs and the difficulty of introducing the fundholding financial information system. It had also underestimated the information demands which the existence of fundholding would put on providers. They had been led to expect simple block contracts from their districts asking them to do largely what they had been doing previously. The practices' information demands, a bill itemising each patient, was to come as a nasty shock. Moreover, the specifications needed by fundholders were not consistent with providers' software. Districts were slow to appreciate the significance of fundholding, particularly in areas where the number of fundholders was large.

## Patient consultation

A number of the practices we interviewed, including some we knew were not going to join, were concerned about the impact of financial considerations on doctor-patient relations. They feared patients might be put off by the thought that the doctor might refuse treatment because it was expensive. We overheard one patient say jokingly to a doctor in the pub where we were having lunch, 'I 'ear you're getting them plastic Korean hips for us then'.

None of the practices consulted their patients when they first decided to apply for fundholding status. This was something of an examination or job application phase and few felt they wanted to raise the subject with patients at this point. When fundholding status had been agreed the practices did tell their patients in a variety of ways. Most simply left leaflets about in the waiting room or asked partners to hand them out to patients as they saw them. Others put a brief notice up in the waiting room. Some went to greater length. One practice called a village meeting, described the scheme and took questions and a lively discussion followed. Another sent an invitation to one in three of those on its list and asked them to attend meetings in the practice. After a general talk the partners split the meeting into groups to discuss questions and issues more informally. Nevertheless some anger was reported from practice patients in other areas because they had not been consulted in the decision to apply for fundholding status.

However, although practices were initially reluctant to break the news to their patients about assuming fundholding status, in the subsequent phase of actually running the scheme patients seemed to be more closely involved in the crucial

decisions that affected them. For example, a practice faced with a long list of its own patients waiting treatment and serious problems of communication with the local hospital decided to call a meeting of those patients who constituted the most urgent cases. At the meeting the partners presented the options: (a) admission to a private clinic, bills paid by the practice, (b) admission to the NHS Trust of the area, eager to attract more patients, and (c) 'do nothing', wait for a call from the local hospital. As the first two options depended on the specialty to which the patient would be referred, the choice was really between waiting and taking advantage of the doctor's newly earned flexibility. Eighty per cent of the participants in the meeting, especially parents of small children, opted for immediate treatment in the private clinic or the NHS Trust. The rest said they preferred to wait as they were familiar with a particular surgeon who had followed their case. The GPs put no pressure to anyone and acted according to their patients' wishes.

This case (by no means unique but simply characteristic) clearly shows the potential gains in patient welfare as a result of the closer involvement of all interested parties in making choices. One conclusion is that, although there is nothing in theory to prevent non-fundholders from following similar patterns of behaviour, the freedom of fundholders to take decisions and the responsibilities that go with it has encouraged a shift away from paternalistic versions of the doctor-patient relationship.

# 4 Fixing the budgets

A major dilemma that the Department of Health had to solve was whether budgets for each practice should reflect some measure of patients' needs for health care or simply reflect past patterns of service use.

At one extreme the principle might be to allocate budgets according to some standard of need, based on a formula applied to population profiles. This model would mirror the approach developed by the Resource Allocation Working Party (RAWP) for application in the case of hospital and community health services.

At the other extreme it would be possible to calculate the current use of services by each practice and set the budget in such a way as to interfere as little as possible with professional judgement and current arrangements regarding referral patterns. Thus, this alternative would imply using existing patterns of service use as the criterion for allocating funds. Given the wide disparity in referral patterns and hospital cost structures, it has to be borne in mind that any attempt to move to a common formula basis would have caused enormous problems and made implementation of the programme difficult in the timescale set.

## Formula funding or historic patterns?

Setting budgets based on the historic pattern of service use had the advantage that it minimised disruption: it allowed practices to continue referring to the same hospitals if they wished without any financial penalty. They could also switch to less expensive providers and make savings. The introduction of an explicit budget to fund past differences in service utilization would not in itself affect the equity of resource allocation. However, it could well bring the issue into the open, a point to which we return.

Funding on the basis of historic patterns did, however, raise questions of efficiency. It involved accepting high costs and high referral rates, whether justified or not, and penalizing conservative medicine. Moreover, intending practices would face an incentive to increase their referral activity in order to obtain a larger budget when becoming a fundholder.

The advantage of formula funding, on the other hand, is that it would introduce an element of consistency and eliminate possible perverse incentives. However, it was unclear what factors should be included in the formula and how they should be weighted.

Another problem with formula funding concerns the variability in costs and referrals between practices. Research into referral patterns has found it extremely difficult to explain these variations in statistical terms (Coulter *et al.*, 1991). Whatever the formula, there would be many budgets set well below what practices currently 'spent'. They would have to refer far fewer patients if they joined the scheme. As such, they would be unlikely to join. On the other hand, some practices would end up with an enhanced capacity to refer. They might join but would put extra demands on the service and take resources away from the districts.

Furthermore, a formula approach to funding practices could result in even greater controversy than RAWP encountered at the regional level. Target levels for RHA allocations had still not been reached when, after 15 years, use of the formula was discontinued. Given their much smaller populations and relatively limited range of services, convergence towards targets in the case of fundholding practices will require a time span much beyond the planning horizon of politicians. It was these dilemmas that the Department and the regions had to resolve rapidly in 1990.

In the white paper it appeared that the government favoured a capitation approach basing the budget on some assessment of the needs of the patients on the practice list. 'Each practice's share will be based on the number of patients on its list, weighted for the same population characteristics as are proposed for allocations to districts. There are social and other local features which affect the use of hospital services, and these too will be reflected in the budget' (DoH, 1989a, p.51).

In the more detailed working paper that followed (DoH, 1989b) it became clear that this approach was for the future.

> *It is the Government's intention to move towards a weighted capitation approach to setting budgets in line with that proposed for RHAs and DHAs. Initially, however, budget setting will need to have regard to the different expenditure components contributing to the total budget. The hospital services component of the practice budget will be determined by comparison of the costs of the relevant services provided as a result of the practice's referral pattern in the previous year with the average for the district(s)*

*taking into account the number, age, sex and health of the practice's patients. The actual budget will be set at a point between the two, taking account of local and social factors. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause. (DoH, 1989b, pp.10-11).*

These last caveats were to prove difficult to enforce.

The government was rightly concerned that one of the consequences of funding existing referral patterns would be to set budgets on a basis that was not only arbitrary but also rewarded inefficiency. If practices with high referral rates to high-cost hospitals were awarded larger budgets than more responsible and cost-aware practices, the former would be able either to continue to make inefficient use of NHS resources or to 'profit' from a sudden reduction and/or switch of referral patterns to more efficient providers. Either way the result would be exactly the opposite of the one originally intended.

Moreover, first-year budget allocations might damage the prospect of moving to weighted capitation in the medium term. As the RAWP experience has underlined, convergence towards targets involves a large redistribution of funds. Establishing a wide variation in budgets in the first year could increase the frictions of later redistribution.

These reservations seemed to fade as preparation for the changes advanced. The Department's description of the scheme for the practices warned them that they would be required to give regions data on past referrals.

*The RHA will consider whether levels of referrals are justified given the average levels of referrals and the particular circumstances of each practice. [...] Hospital treatment patterns will need to be identified from your practice data since they are not readily available at hospital level. [...] This will determine the type of hospital treatments you normally use and the level of activity generated by your patient list for each of the hospital procedures covered by the budget. The RHA will consider whether levels of referrals are justified given the average levels of referrals and the particular circumstances of each practice (such as the number of elderly patients). (DoH, 1989c, section 6).*

In practice this procedure would have put an impossible burden of judgement and negotiation on regions. They were concerned with the prospect of agreeing prospective treatment patterns rather than ascertaining and funding the current level and patterns of treatment. In the end the DoH agreed to a middle course: using the current levels and location of hospital services as a basis and then discussing any reasonable changes that practices wanted to make.

It was also apparent that the government had become averse to changes in service provision that might disrupt the functioning of the new system. Instead, it favoured a 'steady state' approach. Regions encouraged prospective fundholders not to change their usage of hospitals dramatically in the first year. In order not to put off intending fundholders, however, regions were encouraged to agree increases in budgets where there were significant increases in list sizes, or significant increases in the number of patients on high cost treatments, particularly drugs. Similarly, the opening of a new local establishment, such as a home for the elderly, or a sudden upsurge of demand, caused by, for example, a severe flu epidemic, would also be a cause for budget adjustments.

## Identifying historic patterns

It was against this background that budgets were set by the regional health authorities. The RHAs had to establish past levels of referral activity for each type of hospital services: in-patients, day cases, out-patients and diagnostic tests. The sources of information were three: regional databases, hospital records and practice reports.

Regional databases presented various problems. The systems only covered in-patient admissions and day cases. The identification of the referring GP was often impossible, as coding systems were incomplete. In the case of one region about a quarter of referrals could not be traced back to a practice, and uncoded cases were allocated to fundholders on a *pro rata* basis. In another region a backlog coding exercise was undertaken in order to improve the database.

Data on out-patients and tests were collected by hospitals. However, most records did not classify patients by referring GP and were therefore unhelpful for the purpose of setting fundholding budgets.

In view of the above defficiencies, the main source of information was the accounts of referral patterns provided by the practices themselves. The use of self-reported information involved a number of problems.

- **Retrospective information.** In some cases practices were asked to collect retrospective information. Practices tried to put together information from different sources (eg medical record notes, discharge letters) thereby increasing the possibility of errors.
- **Summer period.** The period covered was often as short as three months, included the summer months when activity was lower because partners and consultants were on leave, hospital wards closed etc. It was felt that adjustments should be made to take account of these factors

as simply to extrapolate these data to the whole year would be unfair to practices.

- **Regional data forms.** The forms regions sent to practices for referral data collection created frictions. Case classification was often at odds with the way the practice recorded information for their own purposes, and that increased the amount of paperwork.
- **Data manipulation.** The method of establishing activity through past referral rates made GPs more aware of the potential for data manipulation by providing them with an obvious incentive to refer in anticipation of larger budgets. Whether this actually happened or not is something about which one can only speculate. However, the method certainly sent the wrong kind of signals as far as efficiency is concerned. It is likely that this will be more of a problem with the second-wave of practices in the scheme.

The next step for regions was to negotiate agreed activity figures with the practices. Regions felt little confidence in the accuracy of the data they collected, and lacked the means (and in some cases the willingness) to cross-check the data provided by practices. This situation provided all the ingredients for a sequence of meetings in which initial offers, objections, appeals and counter-offers were put forward. Those who seemed to come out best were the minority of practices where computerisation and referral data collection had started early (in some cases a year or more before fundholding). These better-organised practices found themselves in a strong position, able to contest the regional figures and to make a persuasive case for their own estimates.

## Costing services

Regions were also faced with the task of making sure that hospital cost estimates were collected in time for the calculation of budgets. At the time hospitals were rather more concerned with the transition to directly managed status or with applications for NHS-Trust status than with fundholding. This was perceived as a 'nuisance' – something that represented an insignificant proportion of the hospital's business and yet required time-consuming costing of individual procedures.

Detailed costing by item of service was an example of this: while DHA contracts could be broad enough to include whole specialties, fundholding contracts had to be procedure-specific. Services for the practices had to be priced at a level equal to producer cost. Neither profit making or cross-subsidisation was permitted, at least in theory. The estimation of the cost of each individual procedure was fairly crude. It involved taking average costs for the specialty to which the procedure belonged (eg gynaecology for hysterectomy), and weighting by average length of stay for the procedure. Length of stay was used as an approximation of the resource implications of each case. Overheads were apportioned on a *pro rata* basis. No other weighting factors were used.

This method produced rather unstable results. Some costings were looked upon with incredulity by hospital consultants and general practitioners alike. In many cases they bore no relation either to common sense or to cost estimates from the resource management initiative or other *ad hoc* studies. The reason for this is likely to be that the number of cases for any particular procedure treated over a year was too small to allow for reliable estimates, since length of stay within procedures can vary widely between patients. It is also possible that other factors should have been taken into account for estimating the intensity of the resource use of each treatment.

Despite the known problems, these cost figures had to be used to set the budgets. Hospitals, when it came to fixing the prices they actually charged practices, were not obliged to keep to the figures that regions had used to set the budgets.

In Region A this created considerable anxiety among fundholders and necessitated last minute negotiations between the region and hospitals. Budgets had to be reviewed to take account of actual hospital prices. In some cases confusion led to long delays (extending to May or June) before budgets were finally agreed. However, in Region B the budgets were first indicated before Christmas or soon after and mostly agreed in January. Region C was not far behind. This was a considerable achievement.

## The outcome

Overall in our three regions the budgets turned out to be the equivalent of about £109 per patient. Large practices (list size over 16,000) were awarded hospital budgets per patient 10 per cent above the average figure for all practices, as can be seen in Table 3.

*Table 3* List size and budget per patient

| List Size | Hospital Budget | Total Budget |
|---|---|---|
| < 10,000 | 61.70 | 111.99 |
| 10,000–11,999 | 59.65 | 103.01 |
| 12,000–13,999 | 60.63 | 107.57 |
| 14,000–15,999 | 56.21 | 104.88 |
| > 16,000 | 67.49 | 115.29 |

As Table 4 illustrates, regional averages do not differ much but individual fundholding budgets vary quite significantly on a per patient

*Table 4* Fundholding budgets per patient in the three regions

| Region/ Practice | Inpatients (1) | Outpatients (2) | Tests (3) | (1+2+3) | Drugs budget (4) | Staff budget (5) | Total (1+2+3+4+5) |
|---|---|---|---|---|---|---|---|
| A.1 | 15.89 | 33.56 | 9.11 | 58.53 | 44.44 | 9.44 | 112.42 |
| A.2 | 24.12 | 27.14 | 4.79 | 56.05 | 36.81 | 9.58 | 102.44 |
| A.3 | 33.91 | 28.33 | 3.91 | 66.16 | 32.79 | 8.62 | 107.57 |
| A.4 | 25.26 | 19.10 | 3.27 | 47.65 | 43.24 | 6.99 | 97.88 |
| A.5 | 29.36 | 18.79 | 3.21 | 51.34 | 35.71 | 8.36 | 95.41 |
| A.6 | 33.08 | 25.96 | 1.47 | 60.51 | 35.45 | 6.41 | 102.37 |
| A.7 | 31.03 | 22.47 | 3.20 | 56.72 | 33.92 | 10.73 | 101.37 |
| A.8 | 19.58 | 34.48 | 3.23 | 57.31 | 23.65 | 8.33 | 89.29 |
| A.9 | 31.55 | 44.66 | 9.42 | 85.66 | 11.35 | 10.19 | 107.20 |
| A.10 | 16.13 | 29.68 | 5.75 | 51.57 | 28.09 | 14.28 | 93.94 |
| A.11 | 16.67 | 28.52 | 4.81 | 50.03 | 25.26 | 11.56 | 86.85 |
| A.12 | 26.97 | 17.36 | 3.35 | 47.70 | 36.73 | 8.95 | 93.37 |
| A.13 | 22.67 | 26.79 | 2.75 | 52.17 | 35.48 | 10.76 | 98.42 |
| RHA A | | | | | | | |
| Average | 25.78 | 26.62 | 4.21 | 56.61 | 33.08 | 9.33 | 99.02 |
| Std. Dev. | 6.54 | 7.44 | 2.37 | 10.12 | 8.77 | 2.05 | 7.43 |
| B.1 | 47.95 | 29.07 | 9.84 | 86.86 | 44.94 | 5.57 | 137.37 |
| B.2 | 37.45 | 21.75 | 5.83 | 65.03 | 34.91 | 5.15 | 105.09 |
| B.3 | 33.99 | 20.80 | 4.54 | 59.33 | 42.14 | 7.14 | 108.61 |
| B.4 | 34.09 | 41.26 | 5.59 | 80.94 | 38.01 | 7.45 | 126.40 |
| B.5 | 34.67 | 40.68 | 8.62 | 83.97 | 41.13 | 7.86 | 132.96 |
| B.6 | 31.10 | 35.77 | 4.03 | 70.90 | 35.99 | 5.76 | 112.65 |
| B.7 | 34.43 | 34.94 | 6.25 | 75.62 | 43.65 | 8.18 | 127.45 |
| B.8 | 39.05 | 15.86 | 11.04 | 65.95 | 32.13 | 6.90 | 104.98 |
| B.9 | 37.54 | 17.88 | 10.16 | 65.58 | 38.79 | 9.57 | 113.94 |
| B.10 | 33.12 | 24.61 | 3.17 | 60.90 | 39.84 | 7.11 | 107.85 |
| B.11 | 33.87 | 21.23 | 5.77 | 60.87 | 41.06 | 4.54 | 106.47 |
| B.12 | 27.23 | 29.09 | 4.28 | 60.60 | 36.13 | 7.16 | 103.89 |
| B.13 | 30.57 | 18.59 | 5.43 | 54.59 | 47.80 | 11.27 | 113.66 |
| B.14 | 19.12 | 27.53 | 5.23 | 51.88 | 40.28 | 10.55 | 102.71 |
| B.15 | 28.32 | 18.91 | 2.02 | 49.25 | 37.87 | 6.53 | 93.65 |
| B.16 | 17.39 | 34.82 | 4.03 | 56.24 | 40.22 | 14.13 | 110.59 |
| B.17 | 20.64 | 21.66 | 5.35 | 47.65 | 27.99 | 9.09 | 84.73 |
| B.18 | 36.22 | 19.34 | 5.20 | 60.76 | 37.46 | 8.83 | 107.05 |
| B.19 | 25.57 | 44.58 | 3.87 | 74.02 | 41.53 | 6.27 | 121.82 |
| B.20 | 10.53 | 48.44 | 9.88 | 68.85 | 25.73 | 9.58 | 104.16 |
| B.21 | 18.59 | 23.30 | 4.93 | 46.82 | 33.54 | 10.63 | 90.99 |
| B.22 | 43.14 | 20.47 | 4.36 | 67.97 | 44.97 | 12.86 | 125.80 |
| RHA B | | | | | | | |
| Average | 30.76 | 28.00 | 5.92 | 64.67 | 38.44 | 8.08 | 111.19 |
| Std. Dev. | 9.06 | 9.63 | 2.45 | 11.29 | 5.37 | 2.49 | 13.31 |
| C.1 | 31.50 | 31.01 | 7.09 | 69.60 | 55.75 | 12.19 | 137.75 |
| C.2 | 32.38 | 23.22 | 3.41 | 59.01 | 57.65 | 11.73 | 129.64 |
| C.3 | 33.04 | 20.93 | 5.36 | 59.34 | 48.48 | 12.93 | 120.74 |
| C.4 | 34.80 | 18.99 | 7.35 | 61.14 | 56.77 | 9.81 | 127.71 |
| C.5 | 43.53 | 23.30 | 6.49 | 73.32 | 39.69 | 8.28 | 122.30 |
| C.6 | 30.69 | 14.50 | 4.63 | 49.82 | 42.12 | 8.60 | 101.48 |
| C.7 | 28.35 | 16.89 | 7.90 | 53.15 | 46.59 | 6.92 | 106.72 |
| C.8 | 28.52 | 26.44 | 5.69 | 60.66 | 42.85 | 10.49 | 114.00 |
| C.9 | 26.27 | 16.34 | 4.67 | 47.28 | 37.42 | 5.80 | 90.49 |
| RHA C | | | | | | | |
| Average | 32.75 | 20.96 | 6.09 | 59.79 | 46.93 | 9.37 | 116.46 |
| Std. Dev. | 5.03 | 5.29 | 1.48 | 8.52 | 7.68 | 2.44 | 15.02 |
| A+B+C | | | | | | | |
| Average | 29.67 | 26.09 | 5.44 | 61.20 | 38.61 | 8.73 | 108.61 |
| Std. Dev. | 8.04 | 8.53 | 2.31 | 10.73 | 8.61 | 2.40 | 13.71 |

3

## HOSPITAL PRICES FACED BY A LONDON FUNDHOLDING PRACTICE

**In-Patients (cost per procedure)**

| *Procedure* | *Average Price* | *Highest Price* | *Lowest Price* | *No of Units* |
|---|---|---|---|---|
| Cataract | £1,392 | £3,622 | £ 250 | 5 |
| Hysterectomy | £1,704 | £2,300 | £ 969 | 5 |
| Tonsillectomy | £ 572 | £ 680 | £ 446 | 5 |
| Hip Replacement | £2,619 | £3,830 | £1,525 | 8 |
| Varicose Veins | £ 471 | £ 715 | £ 161 | 7 |

**Out-Patients (average speciality cost)**

| *Speciality* | *Average Price* | *Highest Price* | *Lowest Price* | *No of Units* |
|---|---|---|---|---|
| Ophthalmology | £217 | £486 | £ 88 | 20 |
| ENT | £136 | £247 | £ 44 | 20 |
| General Surgery | £182 | £514 | £112 | 21 |
| Gynaecology | £145 | £362 | £ 52 | 21 |
| Orthopaedics | £192 | £507 | £ 87 | 21 |

**Diagnostic Tests (cost per test)**

| *Test* | *Average Price* | *Highest Price* | *Lowest Price* | *No of Units* |
|---|---|---|---|---|
| Cervical Smear | £15 | £36 | £ 3 | 3 |
| Blood Count | £ 8 | £13 | £ 3 | 4 |
| Cholesterol | £ 6 | £12 | £ 2 | 3 |
| X-ray (spine) | £35 | £64 | £12 | 3 |

basis among all of the practices in our three regions. The largest total budget per patient in the three regions was more than 1.5 times as high as the smallest, whereas the highest hospital budget per patient in these regions was almost twice as high as the lowest. In the whole of England, budgets ranged from a low of £52 to a high of £176 per patient (Day and Klein, 1991).

It is noticeable that region A, which had sought greater consistency in the way hospitals costed procedures and the eventual settling of referral figures with practices, did achieve a narrower spread (lower standard deviation) in budgets per patient.

Budget variations reflect the influence of two factors: estimates of provider costs and differences in referral patterns. They also reflect, to a lesser extent, variations in the information practices had about their referral patterns and their bargaining power.

In fact, variations in the prices actually charged by different hospitals suggest substantial variations in costs. As Box 3 shows the price variation for standard procedures such as hip replacement or tonsilectomy is considerable. However, it is possible that although some of this variation reflects real cost differentials between hospitals, it also results from the difficulty which hospitals face in calculating prices which accurately reflect real costs: too few observations for each procedure and poor accounting methods.

The upper part of the table refers to prices for in-patient procedures in hospitals situated within a radius of at most 10 miles from Oxford Circus. These are the hospitals which a real fundholding practice taken from our sample can (and often does) use. In the first year of the scheme hospitals were able to get away with these variations as no fundholding practice in our sample acted on these prices massively to switch its referrals in order to gain advantage. However, the knowledge that in the future purchasers could (and should) respond to market signals must provide an incentive to hospitals to improve their information and accounting systems.

Variations in referral rates are also difficult to explain. Such variations have been known for a long time and are much discussed in the medical journals. (See for example, Coulter *et al.* (1990 and

1991), Roland *et al.* (1990), Baker and Klein (1991)). It is very difficult to identify the extent to which these variations can be attributed to the different needs of the registered population or to the decision-making within the practice.

It must be stressed, however, that fundholding has *revealed* rather than *created* these variations. Moreover, it can be reasonably assumed that fundholding may provide the chance for a wider debate on the causes of such large differences within the NHS by making the cash consequences more explicit. The possibility of reducing inequities in primary care resource allocation as a result of fundholding may at first sight seem a paradox. However, it is compatible with our experience of practices' own reactions to such variability. As Day and Klein (1991) remarked:

> *given the sums involved and the likely increase in the transfer of resources to GPs if fundholding spreads, there will be an inevitable demand for equity in the allocation of money according to need, rather than to accident or history, which is what happened in the hospital sector.*

In the hospital sector, such demands for equity led to the introduction of the RAWP formula.

## Efficiency

The adverse effects of the way budgets were decided for the first year of the scheme are not limited to the current year. The lack of clarity about the basis of budget setting in 1992-93 was a source of anxiety among fundholders in our recent interviews. They found themselves in the strange position of being unable to respond fully to the incentives of fundholding feeling that an efficient running of their budget which resulted in savings, for example, would reduce their allocation next time round.

In other words, the rules of the game were unclear, and there are few things that can harm the smooth operation of a market (internal or otherwise) as much as uncertainty. It is therefore necessary that, as soon as possible, the calculation of future allocations are agreed and made independent of current spending. The most obvious way to do this is by introducing a formula. Despite the difficulties involved in designing a formula we believe that it would be wrong to wait until the 'perfect formula' has been devised before taking steps to ensure that the current perverse incentives are neutralised.

# 5 Contracting with providers

So far we have seen that the implementation of the scheme had worked remarkably smoothly. Setting the contracts was to prove the most difficult phase. The Department had kept seeking to impress on all the actors that they wanted a 'steady state'. That meant that purchasers were to make arrangements as last year but do them in the 'contract mode' wherever possible. The response of general practitioners was, 'Why should we? That is not why we went into the scheme, and in any case who are they to tell us what to do?'

What few had foreseen was just how difficult it would be for the provider units to respond. First, there were practical and political difficulties that fundholders experienced in actually agreeing contracts with individual providers. Second, on a much deeper level, the contracting process brought out into the open some of the inherent ethical issues the scheme raised. Once set, some of the contracts become national political issues that sparked a party political and a professional row which had to be settled by negotiations between the NHS Management Executive and the Joint Consultants' Committee. We return to the deeper issues in the next section. Here we are concerned with the practical difficulties the GPs encountered in making contracts and the strategies they employed in order to deal with them.

## The contracts

The practices negotiated a wide variety of contracts, as can be seen from the summary of them in Box 4. The form of contracts falls into three categories:

- *block*, when the purchaser agrees to pay a lump sum for the right of access to a particular hospital service irrespective of number of patients;
- *cost and volume*, when the number of cases to be treated is specified, as well as a charge for each additional case;
- *cost per case*, when the purchaser is charged a fixed price for each separate item of service.

In practice the line between cost and volume and block contracts was often blurred, as some 'block' contracts were subject to fee renegotiation if the actual number of cases fell below or above the specified upper and lower boundaries of expected number of cases.

Not only was the form of contracts varied and often with a number of different providers, the quality specifications also varied. Most contracts specified times within which an appointment should be made; that dates of appointment should be sent to the practice by fax; that patients should be seen within specified time limits and that they should be seen by a consultant on the first visit unless exceptional circumstances prevailed. Tertiary referrals should not be made without the practice's approval except in an emergency. These were just some of the specifications.

### Single and group contracting

All our practices except one undertook their own contracting arrangements. This was done either by one of the partners, in the case of the smallest practice, or by the practice manager with close support from a partner or by a part-time adviser. However, in one area several practices employed a manager from the FHSA to act on their behalf. He was able to negotiate with hospitals throughout the area. He had an unrivalled knowledge of what each hospital could offer in terms of price and waiting times. Flexible short-term contracts enabled him to take advantage of slack capacity in some hospitals. He was also able to offer a large bulk purchase contract for rare and expensive operations to a specialist hospital outside the district. The quality specifications this group of doctors drew up were copied by other practices. The contracts were cost and volume with no floor or ceiling to the volume so that the practices could review how well the hospital was meeting their specifications as the year went on. If the hospital was not performing well, the custom could be switched elsewhere. Continual monitoring of the contracts was possible through the year.

## Response from providers

### Providers unprepared

Most provider units in our sample areas found the whole process of drawing up a contract and setting prices for the practices difficult. The units were simply not prepared for the fact that practices might want to specify different conditions from the standard district contract. Wide variations in prices for the same procedures suggested different accounting practices were being used or were barely understood. Many units were unable to produce prices until shortly before the scheme began. Two has not done so by the end of June 1991.

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# CONTRACTS SET BY TEN FUNDHOLDING PRACTICES, JUNE 1991

| Practice | Form of contract | Breakdown by specialty | Quality specification | Contract review |
|---|---|---|---|---|
| 1 | No contracts agreed by June 1991.<br>Practice using DGH services as before, on a month by month basis | No | Accepting DHA specifications "for the time being" | More negotiations due in July |
| 2 | 2 main providers:<br>cost and volume on a month by month basis<br>Multiple specialist cost per case contracts | Yes | As defined by the FHSA purchasing consortium | Monthly |
| 3 | To be finally negotiated end of June<br>7 contracts with DGH<br>In-patient and day: cost and volume<br>Out-patient and path tests: block<br>Two other local hospitals: cost per case<br>Psychiatry and community: cost and volume<br>Two private contracts: cost per case | Yes | Detailed specification by practice | 6 monthly |
| 4 | One main provider cost and volume contracts | Yes | Detailed | Quarterly |
| 5 | 7 contracts<br>Two local hospitals: in-patient and out-patient cost and volume<br>Psychotherapy and community: cost per case<br>Radiology: block<br>3rd local hospital: cost and volume<br>2 other hospitals: cost per case | Yes | Detailed | Yearly with main providers, monthly with rest |
| 6 | Two main providers:<br>In-patient and out-patient: cost per case<br>Out-patient physio and radiology : cost and volume | Yes | As specified by consortium | Monthly |
| 7 | 6 contracts<br>In-patient and out-patient: cost and volume<br>Path lab: block<br>Occupational therapy etc: block<br>Psychiatry: cost and volume<br>Other: cost per case | No | As DHA, but an agreement in contract to discuss quality with Consultants at regular meetings | Quarterly |
| 8 | Two contracts: one hospital, one community services | No | As above | Quarterly |
| 9 | 8 contracts<br>Main provider: in-patient and out-patient block<br>2nd hospital: out-patients cost per case<br>Psychiatry: block<br>Radiology: cost per case<br>Dietetics and physio: block | No | Detailed specifications | Yearly |
| 10 | One main provider: cost and volume<br>Another hospital: path lab cost and volume | No | Own limited specifications as in referral letter. Special deal on [redacted] lab | Yearly |

**Monopolist mentality**
Providers expected GPs to ask for block contracts which specified the same volume of service that they had taken the year before for the same range of services. None of our practices were prepared to do that. They all wanted some flexibility, especially if it turned out they were under-using a facility compared to the rather uncertain statistics on which their budgets had been set. There seemed no purpose in having a budget if they had to give it all back to the hospital with nothing gained. In almost every case they were not satisfied with the services they were receiving from at least part of the hospital and wanted some change in their referral pattern. The units' response was in some cases very hostile. One district general hospital official phoned up the practice manager to demand what the practice thought it was doing holding back some of its budget. 'It is our money you have taken. You have no right to take it elsewhere. You could cause the closure of this hospital and deny services to local people.' When practices said they wanted to put certain quality standards in the contract – for example, the receipt of discharge letters within a certain time – they mainly received a fairly negative response, at least initially.

**Confusion of roles**
Several practices complained that districts had taken the side of provider units. In one case the district had told the provider unit the sum that had been included in the practice's budget for particular services which increased their prices accordingly.

## Consultant versus GP power

One practice we interviewed in June 1991 still had to negotiate a contract with its main provider. The differences were over the wording of the quality specifications. The original draft had been with the hospital in good time, but in April, after the scheme was meant to have begun, consultants saw it and raised 19 objections to the contract which the practice had agreed with management. The practice had wanted an 8-week maximum waiting time for outpatients appointments as an objective. The managers had agreed. The consultants responded that nothing under 24 weeks was reasonable. They objected to statements in the contract that 'it would be ideal to work towards ...'. There had been a recent meeting at which management and consultants had met with the local GP fundholders who hold about a quarter of the specialties' money. The meeting had ended in disarray as the consultants blamed the managers for agreeing the contracts. The fundholders had watched amused. Their feelings had been summed up by one who said 'It's all about your power. You can't bear the thought that you are not top dogs any more. That's what it's all about'.

5

## SOME DO'S AND DON'TS OF CONTRACTING

### Keep on good terms with your main provider

**Almost all our practices were very keen to keep on good terms with their traditional provider hospitals. 'Our interests and theirs are the same. We can't afford for them to close.' 'Our doctors and the consultants know one another, they play golf. We can't lose that link or build up others quickly.'**

### Use diplomacy

**In discussions with the local hospital one practice made it clear that they wanted to refer virtually all their patients as before. However, they wanted a contract which committed only 75 per cent of their budget formally so that if there was a shortfall they could either carry it forward to the next year or use it for other things. The hospital appreciated their position. On the understanding that if need was as high next year as this year, they would refer as before, the deal was struck at 80 per cent of the past activity level.**

### Compromise

**In another instance a local hospital insisted that the practice contract 100 per cent of last years referrals. The practice held out, wanting to keep some back. The region finally entered into the discussions and a deal was agreed at 90 per cent. The GPs were also aware that to press for the various quality standards they wanted would be difficult in the short run. The contract merely said that the management and the consultants from the hospital would discuss ways of improving standards with the GPs at regular intervals. In June after a couple of reminders, this discussion took place. One of the practices present said, 'I realised that this was an historical event. For the first time ever we had managed to get to talk to the consultants about the standard of care they were giving our patients.'**

### Do not make unnecessary enemies

**Most practices were also very sensitive to the charge that they might be getting something for their patients that would disadvantage patients of non-fundholders in the same area. Most made a rule that any quality criteria they negotiated should apply to other patients. If they got a consultant to come to their premises to do an outpatient clinic, this should either come out of non-NHS time or not disadvantage NHS patients in any way. They were very anxious not to get fundholding a bad name, as they feared they might if it were felt they were taking resources away from the rest of the service.**

**In one area, two practices combined to pay £100,000 into the district funds if they agreed to open a ward that had been closed for some time. They said that if the district agreed the beds would be available to anyone in the town. Another practice in our sample did the same.**

Nevertheless most practices were well aware of other interdependent links with the local hospital and negotiated accordingly. Box 5 illustrates some of the prerequisites for successful contracting.

## Service improvements

**Exercising exit**

One practice had for years received complaints about one of the services for its women patients but had had no success in improving it or been able to change its referrals more than marginally. Fundholding enabled it to transfer referrals to a hospital that was more popular, if some distance away. The first reactions from patients had been very positive.

Another practice has shifted its gynaecology from its local hospital; it was good but had a two year waiting list. The practice also shifted its orthopaedic and ophthalmology referrals. The alternative was 20 miles away but the waiting times were much shorter and the patients were pleased. The local district hospital used to get 85 per cent of this practice's referrals now it would get between 65 and 70 per cent.

In another case the local dermatology department has a long waiting list. People with skin complaints could wait for nine months. Serious and less serious cases both took a long time. For less serious cases there seemed no point in the referral. The partners knew a local specialist who now practised privately. A year's contract was agreed so that the specialist would take at least a minimum number of cases and be paid monthly depending on the actual number referred. A special rate was negotiated. The patients were seen within ten days of referral and were seen in the specialist's carpeted private premises. Again the consumer satisfaction has been very high!

Other practices were beginning to look at private clinics that were eager for work, having been hit by the recession and were prepared to offer cut price deals that would clear some of the practices' waiting lists. In the main, however, practices were not keen to use the private sector. They were eager to make the NHS work better, partly by using their leverage and partly by transferring their custom to good consultant teams when they felt they were getting a poor deal from the existing one. They were prepared to go further to seek shorter waiting times.

**A more convenient service**

One common strategy had been to persuade consultants to come and give their outpatient sessions in the GP's own surgery. Again most practices had been careful to see that these were either extra NHS sessions or, in some cases, a private arrangement.

In one case a GP knew that some patients would never be able to get an operation or would not be helped by one, but they found it difficult to accept this decision from a GP. This type of case accounted for a sizeable part of the waiting list. The GP discussed this problem with a hospital consultant and they agreed that it would help them, and be more convenient for the patients, if the consultant came to the practice to see these patients. As a result, a consultant came to visit the practice regularly. In cases where the consultant thought hospital treatment might be appropriate, another appointment was arranged at the hospital. The consultant would be paid at well below the hospital average cost for outpatients.

One practice was building a suite of rooms for consultants to come to their out-patient clinics.

Another practice is hoping to be able to organise a testing service on the premises by getting the cooperation of a hospital to licence this as part of its service, using equipment lent by the hospital.

**Efficiency in the use of resources**

In the past there has been no financial reason for a GP to worry about what happened inside a hospital. Now the frequency with which consultants recall patients after an operation or continue with out-patient treatment is a matter for financial concern to GPs because it adds to their practice costs. GPs have been thinking quite hard about these matters. GPs complain of the senior house officer syndrome: a junior doctor sees a patient in outpatients and fairly automatically says come back in six months or some lengthy period by which time he will be in another post. This avoids any criticism that he should not have discharged the patient and seems the safe option. A number of GPs were insisting that the consultant check with them before continuing such repeat appointments beyond the first one or two.

In the same way they wanted the consultant to discuss the drug regime in certain cases where the GP was unconvinced that a particular brand name drug was really necessary for a common condition. The discussions in this case had been amicable. Both agreed it would be in the interests of the hospital and the patient to think more carefully about these decisions. It had merely been in no one's interest to do so before.

**Competitive pressures**

There are many examples, more frequent in the London districts, where practices have been able to get better deals by switching or threatening to switch between NHS providers and/or use the private sector. This has been most evident in the field of laboratory testing. One practice used a private service for its private patients and received individualised test results on the same day,

returned by courier. The local NHS laboratory returned test results weekly. Moreover poor documentation meant that it took the practice some time to distinguish which result related to which patient. The practice asked its local NHS supplier if there could be a faster turn round and a courier service. The answer was no, nothing could be done. The senior partner then approached the private supplier who was prepared to cover all the practice's work. However, the fee was higher. With this knowledge the partner let his old supplier know that he was prepared to switch all his custom. The laboratory responded by saying that it had been reconsidering its service and thought it could now do a daily courier service which it would offer to all the practices in the area. The partner asked if he installed a Fax could urgent test results be Faxed through? That too seemed possible.

Another practice had exactly the same story to tell. In the more remote rural areas too, local hospitals had realised that either their equidistant competitor or a private company were in the market place. They preempted this challenge by offering twice weekly or three times a week returns of test results and a daily collection service which the practices accepted.

In an inner London area where a practice had been obligated to remain with its local provider for political and practical reasons in the first year, the laboratory responded with faster results and a special delivery service because it knew the practice would transfer its custom eventually if they did not do so. Each one of our practices that were dissatisfied with their pathology laboratory services managed to improve them.

In some cases local providers failed to respond to GP pressure for improved quality of service and, reluctantly in most instances, GPs went to private laboratories. Usually they received a far better service, but it was more expensive. As one partner said, 'We are delighted to pay for a better service.'

It is significant that laboratory services was the only field in which a true market could be said to exist almost universally. It provides an example of a 'contestable market'; not only the existence, but the mere *threat* of competition can induce efficient behaviour in incumbent providers. In contrast, only those practices that were able to form a group and to bargain together – and were faced by hospitals that were in a weak financial position – were able to bargain for major changes in waiting times that would advantage their patients. Only one of our sample was in that position. Most were dependent on one supplier with whom their patients were familiar. In situations where they were unhappy with this position, practices were taking steps to diversify between suppliers.

**Practices providing services**

The provision by practices of services previously supplied (more expensively) at hospitals was seen as a legitimate claim on their budgets by fundholders. They felt that practices should not be penalised for taking advantage of the new freedom fundholding allowed them. In this connection, the DoH gave fundholders the right to set up private companies to enable them to charge their funds for such services.

This provision immediately raised questions. First, the mere notion of a private company can give rise to fears of privatisation. Many fundholders, who appreciate this better than anyone else, refused to proceed with the establishment of a private company on the grounds that it would create unnecessary anxiety and give ammunition to those who opposed the scheme.

Second, many such services were already provided by practices, whether fundholding or not, and formed part of the services patients came to expect from their GP, eg minor operations. To recover the cost of these services from the budget would seem unethical and unfair to other GPs. Region B dealt with this particular problem by allowing fundholders to charge the fund only for services over and above the number prescribed in the GP contract.

Third, the introduction of fundholding was meant to be a version of the new purchaser/provider split. If the current trend to provide in-house services became the norm and 'the way forward for primary care' as some fundholders seemed to believe, the purchaser/provider split would be undermined to some degree. The conflict of interest between the roles of patients' advocate, on one hand, and provider of services, on the other, would repeat itself in primary health care. The assumption of the provider role by fundholders will require closer regulation of quality and appropriateness of services. One of our regions spent a considerable amount of time and effort thinking through what form this should take.

In short, though it was very early days and most practices has been actively operating in the market place for only two or three months, there was evidence of the market working in small but significant ways.

Everywhere there was optimism that, if the government was prepared to let the market work, steady improvements were possible and not a few really dramatic ones.

# Unresolved issues

# 6

Given the early stage of the development of fundholding, it is not surprising that several issues remain unresolved and potentially problematic. In this section, we consider some of these issues. These include the question of whether districts or GPs are the best purchasers, the trade-offs between equity and efficiency that are posed by the fundholding scheme, how 'cream-skimming' in the selection of patients could become a problem and how it could be addressed by creating a formula for budget setting.

## Districts or GPs as purchasers?

This was, of course the central question the white paper left unresolved once it was decided that some form of contracting between purchaser and provider was the right answer. Does economic theory or the outcome of the first year give us any more clue as to the answer?

American economists have done a lot of work on competitive contracting with hospitals as health providers. Its possible relevance to the new UK situation is reviewed by Culyer and Posnett (1990) and Bartlett (1991). Neither addresses fundholding directly, stressing instead the general problems that arise in seeking to set contracts in a situation where the information about quality is very poor, where comparable price information is negligible, and where transaction costs are high.

Since the US literature is based on a very different form of contracting and purchaser/provider system, the help these theories and experience can give is limited. It is, however, a beginning and it is worth trying to formalise some theories which bear upon this question.

Bartlett (1991) argues that the potential gains from competition between health suppliers may be offset by the administrative costs of negotiating contracts that take account of all the potential contingencies that may arise. Alternatively contractors may negotiate rather vague block contracts that are simple and shift all the costs of uncertainty onto the provider. The result will be to give hospitals freedom to adapt their behaviour in opportunistic ways, as US hospitals have, to do less work for the same income or act in inefficient ways that benefit the employees. Alternatively, hospitals may increase prices in the long run to cover the increased risks they are facing. The more competitive the environment, the less this will be possible but, in practice, extensive competition is difficult in specialist health fields. These were precisely the reasons why hierarchical forms of health delivery emerged in the first place.

Culyer and Posnett (1990) suggest that because the DHA is not the sole purchaser, it will be placed at a disadvantage and costs will be raised. They also stress that if efficiency gains are to be reaped from the reforms the competitive level must be as high as possible. By this they mean that there must be true competitive bidding, good monitoring of standards and a logical structure within which to compare bids.

From these propositions and the experience of this project certain questions are suggested. We begin with the cost side of the equation.

**Transaction costs**

Opponents of fundholding have always claimed that its existence would merely multiply the extent of contracting, putting additional time costs on both providers, who had to make contracts with several purchasers, and on the practices. We have seen that the costs of contracting were significant in this first year for the practices. It was also clear that practices were evolving strategies to minimise the costs. They might combine to buy the services of an expert contract manager, or make use of the district block contract terms if it was acceptable and modify small parts of it. They might use examples from other districts or practices in a group. Where they did go their own way it was because they felt the district's contract did not meet their own particular circumstances or was insufficiently rigorous. They judged that the input of time needed to negotiate a different contract with another or the same hospital was worth the effort in terms of patient care or benefits to the practice. In the same way the provider units had to spend more time dealing with separate GP practices and that raised their administrative costs. However, they had the option of refusing to deal and many did, at least initially. If the hospital did trade, it presumably meant the business was worth it.

In short, it is not enough to draw attention to the costs of fundholding. If the contracts are different to those set by districts, that is because the participants think it worthwhile to trade to their mutual advantage. Where a district contract is acceptable, practices can 'free ride' on the negotiating costs. We are not persuaded that transaction costs are a decisive argument against fundholding if general contracting is to be the norm. They have to be set against the benefits.

**Administrative costs**
Every sizeable practice has taken on a clerical assistant to handle the input of individualised data required by the funding process. In addition, a half- time equivalent of a manager's time is needed to deal with the higher level accounting and contract negotiating elements. GPs themselves are using time administrating the scheme. In the early days this time was given usually by the partner who was most enthusiastic about the scheme and most often got a kick out of the new experience. In the large well-run practices most of the administration has been off-loaded onto the manager but a fairly continuous flow of professional decisions or advice is still needed. It is too soon to say exactly how that time will level out. One practice manager in a very large and well run practice said, 'Now it is up and running I am not sure the partners even know it is happening.'

The total cost of the extra management allowances in 1990-91 was £6 million, while the estimated total cost of the new NHS measures was £306 million (Cm 1513, 1991). The gains which patients are reaping from more convenient or improved services must be set against these costs. Just how that balance will work out is difficult to say. However, if twenty patients a fortnight are saved an all day journey to the county hospital, the gains from this alone may be considerable.

**Consistency and rationality in planning**
Another frequent criticism of fundholding from those in health authorities, for example, is that it makes the planning task more difficult. The new DHAs have the task of determining the health needs of their residents and then making contracts with hospitals and units best placed to meet those needs. If 30 per cent of their population lie outside their immediate responsibility as patients of fundholders, how are they to plan?

It is worth noting that only a fifth of the NHS budget would come under fundholding provisions if the present procedures remained unchanged and if budgets were extended to every patient in the country. However, it is true that it does change the nature of planning for the range of services where districts and fundholders are both involved. Districts will need to take into account GP's preferences in their contracts. This could be viewed not as a difficulty but as additional information. If it were the case that planners had access to a clear crystal ball that measured medical need and set priorities, the case might be stronger.

What fundholders have often done is to introduce ideas from their own practice situations and build them into a contract. They may, over time, come to shift the priorities they attach to one kind of treatment compared to another. These may be different from the district pattern. A good planner would see this as a bonus, alerting him or her to GPs' and patients' revealed preferences. As Maynard (1986) originally argued, a multitude of rationing decisions made close to the consumer are more likely to reflect consumer information and preferences than some overall average view arrived at in a district planner's office. Broad priorities in budget setting between major priority groups and areas of medicine will still be possible because the total budgets available to fundholders are relatively small. Even if they became much larger it would be possible to introduce incentives to encourage GPs' to meet particular health objectives if that was felt necessary – money for infant welfare clinics in deprived areas, for example.

Once more the planning case does not seem to us a decisive one against fundholding.

**Incentives**
Bartlett (1991) suggests that block contracts are reached because of the high transaction costs of cost per case or cost and volume contracts, but that they give hospitals few incentives for efficient work. In contrast, our practices agreed more cost per case and cost and volume contracts and also set short term contracts which gave them maximum capacity to bring pressure to bear or switch contracts if need be. The incentives for fundholders to get the best out of their contracts were high. They saw the immediate impact on their day to day work.

The incentives which districts are facing are different. District managers are in an indirect way responsible to the NHS Management Executive. They also face political constraints. It was instructive how districts responded to the request to maintain a steady state, while GPs acted as independent professionals might be expected to respond. The constraints districts face are not just party-political. They are responsible for most local facilities, which are directly managed units (DMUs). Districts try to play the double role of contractor and final manager. The result is that they are very cautious about change for the provider units. Ultimately they have to manage the unpopularity of a hospital closing.

The practices also took the future of their local hospital seriously. They usually wanted it to survive but if they thought it or a department was no good it was not their problem if it closed. This is, in fact, much nearer the arms-length relationship needed for a market to work than that which currently prevails between a district and its local hospital. The relationship is too incestuous. The incentives for bureaucratic and political inertia are greater.

**Is the evidence from the first year misleading?**
It has been argued by a number of district managers and commentators elsewhere (Hugh and

Dingwall, 1991) that the first years' experience of contracting is no guide to the future. Fundholders have only gained better contracts because districts had their hands tied and the practices could pick up easy gains. They were unusually good and well managed and those that follow will not be. No conclusions can be drawn from their experience.

There is some truth in this. Certainly, like any experiment, early volunteers were enthusiastic and well organised. Districts in the next phase will be able to be more flexible. Providers will have less room for manoeuvre as fundholding becomes less marginal. GPs may be drawn into joint contracts.

On the other hand, most observers last year underestimated the ability of GPs to cope. It was fundholders who adapted quickly to the new climate. The pessimists may well be underestimating the capacity of the next wave of fundholders.

As fundholding grows in scale and as informal groups and joint contracting spreads, fundholders will be far more powerful than they were in a disorganised first year. In a tight funding situation their demand for service could be particularly important to many providers. Moreover, many of the constraints on district actions we have outlined remain. GPs' capacity for independence seems to us robust. The future will tell.

There is little doubt that the substantial presence of fundholders enhances the competitive environment. How far fundholders themselves were faced with competition is another question. Because of their size and remoteness, some were not. Yet they did have to fear new entrants to the market in a way that a large hospital will never do.

In summary, it seems to us that there is no convincing overall case for saying that districts must be better purchasers than GPs. For some large scale specialist services this may be true but the social and contextual richness of information which GPs have may put them in a superior position for a range of purchases. Nor does it appear that dual purchasing is necessarily costly given the possible benefits. All in all, the case is still open and the experiment worth continuing.

## Equity and efficiency trade-offs

It was clear from the outset that the issue of equity between fundholding and non-fundholding practice patients was going to be critically sensitive. This came into the open on vesting day as the press took up examples of differential contracts entered into by hospitals with fundholding and non- fundholding practices.

The arguments are to a large extent confused. Above all the critics have tended to adopt a static view of the consequences of competition. They ignore that what we may be seeing are first-round effects in a move from a forced static equilibrium to a new long term outcome in which the equity consequences are difficult to predict. They also ignore the overall efficiency gains from which all patients may gain. Some critics sound as if they are arguing that we should never have introduced television in the 1950s because only a few people were able to enjoy it. On the other hand there may be instances where there is a zero-sum game and the fundholders are capturing better services at the expense of others. It is crucial to have some idea which of these things is happening.

It may be helpful to clarify the issues by examining the efficiency and equity implications of certain theoretical situations that could arise as a result of fundholding.

**Theoretical scenarios: inequity?**

***Case 1*** *Budgets are set for fundholding practices on a more generous basis than their past referral patterns deserve. This gives fundholders more of the NHS cake than before. Nothing else changes.*

Whether Case 1 existed in reality is difficult to say. The system of setting the budgets was open to criticism, and we made our reservations clear in earlier sections. It is possible that in identifying past referral patterns practices were given the benefit of doubt. It is unlikely that the sums involved were very significant. In the longer term, regions will be better briefed and in less of a rush to agree budgets. When the scheme becomes more universal this case will largely disappear.

***Case 2*** *Fundholding practices use their collective power to win preference for their patients on waiting lists as against non-fundholding GPs. There are no efficiency gains.*

We found no examples of Case 2. Despite the fact that national press coverage concentrated on what was presented as a 'Case 2' situation, it was our experience that no case we met corresponded to it in a pure form, ie an unambiguous equity loss with no efficiency gain. Some practices did use the weak position of one hospital to drive a potentially hard and favourable bargain for their patients, but this produced a counter challenge from other GPs. In the second round – or longer term – such competition is likely to drive out local inequities.

Such pressures for inequity as existed came from the reality of funding not the form of finance that fundholding represents. It is, if anything, a case of making the system universal – as we discuss in the last section of this report.

**Theoretical scenarios: more efficiency?**

*Case 3* *The system of routine referral for repeat outpatient attendances, some of which are unnecessary, comes under review. Consultation time becomes available for patients in real need.*

*Case 4* *Hospitals introduce, under pressure from fundholders, a new service for fast delivery and collection of laboratory specimen and test results. The service may become available to all GPs in the area, irrespective of status.*

*Case 5* *Fundholding practices pool together funds to re-open a closed ward at the local hospital. Hospital capacity increases. The extra beds may become available to patients of other GPs, fundholders or not.*

In Cases 3, 4 and 5 improvements in the supply side take place. Hospitals are not operating at peak efficiency because they have never been forced to or had their administrative or professional procedures effectively challenged. Practices use their power as purchasers to force hospitals to use their resources more efficiently. The scheme is used as a lever for the realization of practical ideas held for a long time by GPs. Fundholding redresses the balance between primary and secondary care by 'correcting' the NHS bias which presently exists in favour of hospitals.

*Case 6* *Previous outpatient treatment in the hospital is transferred to the practice, as fundholders contract with individual consultants. The consultants may do practice work as part of their NHS time or in their private time. The 'hidden costs' of the NHS to individual patients (transport, own time) are 'internalised'. Patient welfare increases.*

*Case 7* *The fundholding practice uses its budget to offer less elaborate but appropriate care at a lower price, e.g. counselling before a serious mental condition develops, physiotherapy instead of anti-inflammatory drugs.*

Cases 6 and 7 show a more efficient outcome that derives from the fundholders flexibility to implement ideas that non-fundholding GPs would like to put into practice but have no means of doing so.

Case 6 also illustrates the difference between private and NHS contracts. These need not be confined to contracts with consultants who spend at least part of their time working for the NHS, but may (and often do) include contracts with private clinics, laboratories etc. The efficiency implications are quite clearly positive. If every taxpayer's pound can buy more and better quality services in the private sector than in the NHS (which is presumably why such contracts exist in the first place), then there should be no objection to it on efficiency grounds. It may be unfair to NHS hospitals to lose contracts because of sloppy pricing, but this will certainly give accountants an incentive to work out cost structures that make NHS producer units less vulnerable to predatory pricing. In any case, it seems that fundholders do understand the difficulties of the first year: we saw that many of them consciously ignored attractive 'business propositions' from the private sector for the benefit of a longer term relationship, based upon trust, with the local hospital.

The equity implications are less clear-cut. The mere fact that other GPs cannot have access to private services puts them at a certain disadvantage, but the implication of this must be that this advantage should be extended.

**Static versus dynamic equilibrium**

In the short run efficiency gains may be largely captured by the patients of the fundholders who force a change in provider practice. No one is worse off, but some may be better off than others as a result of the changes and innovations.

However, in the longer run these efficiency gains may spread. Districts may force the same changes on all hospitals. Equally, the non-fundholding practices may group together to insist on the same waiting time and quality specifications as the fundholders. We found one example of a situation where fundholders' combined pressure had provoked a competitive response from non-fundholders.

## Adverse selection, cream-skimming and budget setting

Patient selection has always been a troubling aspect of the fundholding idea. The preliminary year could throw no light on this. Nonetheless, some reflections on the problem and on its link with budget setting may be made.

**Definitions**

The term adverse selection derives from the literature on health insurance (Arrow, 1963; Akerlof, 1970; Atkinson, 1989). The problem arises in cases where risk premiums tend to be equalised in the insurance market and individuals have more information on their expected health status than the insurer. In this case high-risk individuals pay subsidised premiums while low-risk individuals

face too high premiums. Some low-risk individuals will opt to join a lower premium company with the result that premiums rise for everyone next time around. That leads to more desertions, even higher premiums and so on. Ultimately the scheme will be impossible to sustain as the insurer ends up with high risks only. This is a familiar outcome of the financial arrangements in health insurance in the USA.

A variant of this situation arises when insurance is compulsory and insurers or health providers receive a direct subsidy from the government for each patient, according to the expected level of expenditure they are likely to incur. If insurers are in a position to predict the level of expenditure on each extra patient more accurately than the government they will be able to select those individuals whose levels of expenditure are expected to fall short of the grant and refuse registration to all others. This is sometimes called 'cream-skimming'.

**Implications for fundholding**

The relevance of cream-skimming to fundholding is similar to the variant presented above. Let us examine the issues involved.

It has to be said that for the moment there is no evidence that patients are being refused registration as a result of fundholding. This is hardly surprising. In the first year of the scheme budgets were set on the basis of past referral patterns so that the incentive to refuse registration was simply not there. Therefore fundholders have nothing to gain and extra funds to lose by dropping or deterring high-cost patients, unless they make sure they do so after they have received the funding.

One administrative response to quell a long term problem would be to give patients right of access to fundholding practices with the fundholder and patient having an equal right of appeal to the FSHA, either to exclude in special circumstances or gain a place on the list.

The other mechanism is to use the formula approach to budget setting in a way that neutralises the perverse incentives.

**Formula funding**

If cream-skimming is to be avoided, a formula has to be devised which is sufficiently sophisticated to counteract any fear that a patient will be an unusual burden on the practice. This may be difficult because, apart from the problems of small risk pools, limited range of services covered, etc, there is recent evidence that shows that the prediction of the cost of each extra patient to the fundholding practice is very difficult.

This evidence derives from work undertaken in the Netherlands. The Dutch government has announced its intention of introducing budgets on the basis of a formula that includes age, sex and region of residence. This motivated research into the possibilities for cream-skimming. The work of van Vliet and van de Ven (1990) in particular has produced interesting results. They tested whether the global formula the government intended to use predicted costs accurately. They found that age, sex and region explained only a very small amount of the total variation in costs leaving substantial opportunities for manipulation by insurers. The addition of variables measuring past medical consumption, socio-economic background and health status factors – such as chronic conditions, physical disability and self-assessed health – improved prediction considerably. As a result they recommended that prior costs should be included in the Dutch formula, although this could involve longer term problems.

More generally van de Ven and van Vliet (1990) reviewed the evidence on adverse selection from the Netherlands and the USA. They concluded that factors related to health (such as prior utilisation, prior expenditure and the several measures of health status) are relatively good predictors of future health expenditure, while socio-demographic factors like age, gender, income and education appear to be relatively poor indicators.

How does all this relate to fundholding? As the Dutch study put it

> *The prevention of cream-skimming is not only relevant for a competitive health insurance market but it is also relevant with respect to competing provider groups who receive ex ante determined risk-adjusted capitation payment to provide a defined set of services to a defined population group (eg the GP budget-holding in Great Britain).*

There are of course many differences between a competitive health insurer and a GP. In the environment of the NHS, fundholders lack the information and the administrative capabilities to out-smart the formula, even if they had the motivation to do it. However, if the ethos of general practice in Britain can be used as a safeguard against cream-skimming, it is in the interest of everyone not to undermine this ethos with a crude formula that penalises those GPs who care for a higher than average proportion of the very sick and very old. Incidentally, such a formula would intensify aspects of geographical inequality associated with fundholding by making it even more unattractive to practices in inner cities and other disadvantaged areas.

The 'right' formula can only be derived with great effort and care. However, it seems possible that the wealth of health-status information contained in the medical records which practices possess could be used in order to identify the parameters that predict future expenditure more accurately (perhaps just enough to be a disincentive to cream-skimming).

# 7 The future

## The short term

In the short term a number of changes are required in order to keep the scheme developing, build on its strengths and tackle its weaknesses.

- There needs to be support for practices in poorer areas under stress and with limited space to enable them to join the scheme. Intending practices in such areas need help to reach the managerial and information standards required for running budgets.
- Budgeting methods need to be devised that reduce uncertainty, allow practices to be flexible, and provide them with efficiency incentives. Practices must know they can keep and use efficiency savings. There needs to be preparation for the introduction of a weighted capitation formula as the eventual basis of funding.
- Ways of making smaller practices eligible for fundholding need to be developed. Carefully regulated contingency funds are needed to safeguard such practices against the effects of large, chance year-to-year variations in spending. The transfer of surpluses and deficits from year to year should be permitted.
- Groups of practices should be encouraged to share contracting and managerial skills.
- Providers should be helped to respond to the information and billing needs of fundholders. Hospitals must produce realistic price lists; their share of revenue is at risk if they do not.
- Accountability procedures need to be developed for fundholding, especially in relation to provision of services at the practice. The quality of services needs to be monitored as does the value for money obtained in attached private companies.
- There should be minimal interference in contracting arrangements – market pressures should be allowed work their way through. DHAs should be encouraged to be responsive to the needs of the local population and listen to the advice of non-fundholding GPs. The equity implications will be less worrying when the interests of all residents are equally well represented by their 'agents', whether fundholders or DHAs.

## The long term

Some see the future as an extension of the present. Fundholding is confined to a small group of good practices acting as vanguard contractors and innovators. This has its attractions but raises problems of equity.

Others have a grander vision. Fundholding in its early stages has shown the virtues of demand-led funding of health care. The long-term implications, especially for determining the health needs of an area, remain unresolved. What might a long term future look like if fundholding led on to a general system of 'bottom-up' funding with primary health care at the centre rather than on the periphery? How can health needs be met in such a system?

- The purchaser/provider split should be deepened. The political and managerial responsibilities of running provider units should be kept separate from planning and purchasing services. Greater autonomy should be given to all provider units.
- The boundary between primary and secondary care needs to be redefined. Primary care should include services that GPs can competently purchase, such as short-stay acute care, outpatient services and community health services.
- Primary health care budgets should be amalgamated with a wider range of hospital and community health services funding as in fundholding.
- The remaining combined recurrent grant should be allocated on a formula basis to primary health carers of two kinds:
  - larger practices or combinations of practices who hold their own budgets, and purchase the hospital care and community services they need;
  - all other primary care providers who will contract as a group with the help of contracting staff and a monitoring group – a combined and slimmed down version of the present DHAs and FSHAs.
- A single commissioning authority should be created that will:
  - promote health in the locality;
  - assess the health needs of the population;
  - purchase secondary care;

- allocate funds to primary health care purchasers on a formula basis supplemented by discretionary funds designed to ensure that health care needs that are presently not being met are addressed in the future;
- monitor the quality of care provided system-wide;
- make capital allocations based on the revealed trends in demand from purchasers and the business plans of providers.

In our view, the initial phases of getting fundholding off the ground and agreeing the first contracts has been a success. We will watch and observe how the practices respond to the challenges of operating within the market in their first year. At present we are not in a position to judge whether fundholding should be extended universally, but hope to report after the final phase of our research.

# Appendix

## National Health Service and Community Care Act 1990

**Approved list of goods and services**

The Secretary of State for Health, in exercise of powers conferred by Regulation 17 (2) of the National Health Service (Fund-holding practices) (General) Regulations 1991, (SI 1991/582), hereby approves the goods and services, other than general medical services, specified in this list as being the goods and services which members of a recognised fund-holding practice may purchase for the individuals on the lists of patients of the members of the practice out of an allotted sum.

**1 Definitions**

(1) An 'in-patient' means a patient who has been admitted to hospital, whether or not he spends a night in the hospital.

(2) An 'out-patient' means a patient attending a hospital or clinic other than as an in-patient, or for whom a consultation by a hospital consultant is arranged by the GP in the patient's own home.

(3) An 'emergency' means where the patient is admitted to hospital when admission is unpredictable and at short notice.

(4) A 'GP' means a doctor who is providing general medical services under Part II of the National Health Service Act 1977.

2 (1) Subject to sub-paragraph (4), all goods and services listed in paragraph 3 provided to in-patients except in all cases where the initial route of admission was as an emergency or the patient had self-referred.

(2) For the goods and services listed in paragraph 3, the codes after each procedure are those found in the Office of Population Censuses and Surveys Tabular List of the Classification of Surgical Operations and Procedures (Fourth Revision) published in February 1990.

(3) The allotted sum may not be applied to the provision of any of the goods and services listed in paragraph 3 for a patient who has been admitted to hospital before the date on which his GP becomes a member of a fund-holding practice.

**3 The goods and services referred to in paragraph 2(1) are:**

**OPHTHALMOLOGY**

Operations for squint C31-35
Chalazion operation C12
Pterygium operation C39.1
Operations for ectropion, entropion and ptosis C15.1 C15.2 C18
Operations for glaucoma C59 C60 C61 C62 C66.3 C66.4
Operations for obstruction of the nasolacrimal duct C25 C27
Extraction of cataract with or without intra ocular implant C71 C72 C74 C75
Corneal graft C46
Laser treatment for vascular retinopathies C82.1

**ENT**

Myringotomy D15.3
Insertion of grommet D15
Mastoidectomies D10 except D10.5
Stapedectomy D17.1 D17.2
Tympanoplasty D14
Labyrinthectomy D26.2 D26.3
Septoplasty E03.4–E03.6
Sub-mucous resection of septum E03.1
Polypectomy E08.1
Ethmoidectomies E14.1–E14.4
Turbinectomy E04.2–E04.1
Cautery of lesion of nasal mucosa E05.1
Puncture of maxillary antrum with wash-out E13.6
Drainage of maxillary sinus E12.2–E13.1
Exploration of frontal sinus E14.8
Tonsillectomy F34
Adenoidectomy E20.1
Pharyngoscopy E24 E25
Laryngoscopy E34 E35 E36
Laryngectomy E29
Block dissection T85.1

**THORACIC**

Bronchoscopy with or without biopsy E50 E51 E49 E48
Biopsy/Excision of lesions of lung or bronchus E46.2–E46.9 E47.1 E55 E59.1–E59.3
Lobectomy E54
Pneumonectomy E54

**THE CARDIOVASCULAR SYSTEM**

Operations for valvular or ischaemic disease of the heart K25–K35 K40–K51 (Excluding neonatal and infant surgery)

## GENERAL SURGERY

Partial thyroidectomy B12.1–12.2 B08.2–B08.9
Total thyroidectomy B08.1
Thyroidectomy of aberrant thyroid gland B09.1 B09.2
Operation on salivary gland and ducts F44–F58
Operations on parathyroid glands B14 B16
Oesophagoscopy with or without endoscopic procedures G14–G19
Dilation of oesophagus G15.2 G15.3 G18.2 G18.3
Operation on varices of the oesophagus G10 G14.4 G17.4
Gastrectomy partial or total G27 G28
Vagotomy with or without other operative procedures A27 +/- G33.1 G40.1 G40.3
Endoscopy with or without endoscopic procedures G43–G45 G54–G55 G62 G64 G65 G79 G80
Laparoscopy with or without biopsy T42 T43
Excision of lesion of small intestine G50 G53.1 G59 G63.1 G70 G78.1
Partial colectomy H06–H11
Total colectomy H04 H05
Sigmoidoscopy with or without biopsy/polypectomy H23–H28
Colonoscopy with or without biospy/polypectomy H20–H22
Exteriorisation of bowel H14 H15
Repair of prolapsed rectum H35 H36 H42
Operations for anal fissure and fistula H55 H56.4
Excision of rectum H33
Pilonidal sinus H59 H60
Dilation of anal sphincter H54
Haemorrhoidectomy H51–H53
Operations of the gall bladder J18–J26
Operations on the bile ducts J27–J52
Mastectomy B27
Excision/biopsy of breast lesion B28 B32
Repair of inguinal hernia T19–T21
Repair of femoral hernia T22 T23
Repair of incisional hernia T25 T26
Varicose veins stripping/ligation (including injections) L85–L87
Surgical treatment of ingrowing toenail S64 S68 S70.1
Excision/biopsy of skin or subcutaneous tissue S05 S06 S09 S10.2 S11.2 S13–S15
Lymph node excision biopsy T87
Cystoscopy with or without destruction of lesion of bladder M42 M44 M45 M76 M77
Dilation of urethra/urethrotomy M58 M76.4 M81 M79 M76.3 M75.3
Urethroplasty M73
Open repair M73.4
Prostatectomy open or TUR M61 M65
Operation on Hydrocele N11
Orchidopexy N08 N09
Male sterilisation N17
Circumcision N30
Varicocele N19
Removal of ureteric or renal calculus M26–M28 M09 M06.1 M23.1
Lithotripsy M14 M31
Nephrectomy M02 M03

## GYNAECOLOGY

Oophorectomy/Salpingoophorectomy Q22.1 Q22.3 Q23.1 Q23.2 Q23.5 Q23.6 Q24.1 Q24.3
Ovarian cystectomy Q43.2
Wedge resection of ovary Q43.1
Diagnostic Laparoscopy with or without biopsy Q39 Q50
Female sterilization Q27 Q28 Q35 Q36
Patency tests of fallopian tubes Q41 Q39.9
Hysterectomy abdominal/vaginal Q07 Q08
Myomectomy Q09.2
D and C with or without polypectomy Q10.3 EUA Q55.2
Hysteroscopy/Endometrial resection Q17 Q18
Cone biopsy Q03.1–Q03.3
Colposcopy with or without biopsy of cervix P27.3 Q02 Q03.4 Q03.9
Anterior or posterior repair (including vault prolapse, amputation of cervix, perineorrhapy, colposuspension) P22 P23 P24 P13.2 P13.3
Vulvectomy/partial vulvectomy/vulval biopsy P05 P06 P09.1
Marsupialisation of Batholin's cyst/abscess P03.2 P05.3

## ORTHOPAEDICS

Operation on intervertebral discs V29–V35 V52
Therapeutic lumbar epidural injection A52.1
Arthroplasty/revision arthoplasty of hip or knee W37–W42 W46–W48
Removal of implanted substance from bone W35.3
Upper tibial osteotomy W12 + Z77.4
Arthroscopy with or without other intra-articular procedures W82–W88
Intra-articular injections aspiration W90
Meniscectomy W82 W70
Osteotomy for Hallus Valgus/Rigidus W57.1 W15
Correction of Hammer Toe W59.5
Dupuytren's contracture T52.1 T52.2
Carpal Tunnel decompression A65.1
Release of trigger finger (tenovaginitis) T72.3
Excision of ganglion T59 T60
Aspiration/excision of bursa T62.1–T62.5

4 (1) Subject to sub-paragraph (2), all goods and services provided to out-patients where -

(a) these goods and services are listed in paragraph 5 and

(b) an asterisk appears against those goods and services in Column A of paragraph 5.

(2) Notwithstanding sub-paragraph (1), the goods and services listed in paragraph 5 are not goods and services which may be purchased for patients of members of fund-holding practices if -

(a) an asterisk appears against those goods and services in Column B of paragraph 5, or

(b) the goods and services were provided following any case where the initial route of admission was as an emergency or the patient had self-referred.

5 The goods and services referred to in paragraph 4 are:

| | Column A Applicable | Column B Not Applicable |
|---|---|---|
| **a) Out-patient treatment** | | |
| i) in general | I | |
| ii) first out-patient appointment where treatment follows or is a direct result of a procedure listed in paragraph 3. | I | |
| iii) first out-patient appointment where treatment follows or is a direct result of an in-patient stay not listed in paragraph 3. | | I |
| iv) first appointment following an in-patient stay that commenced prior to the practice becoming a fund-holder. | | I |
| v) all appointment thereafter. | I | |
| vi) chemotherapy and radiotherapy provided on a day case or out-patient basis. | | I |
| vii) renal dialysis. | | I |
| viii) all out-patient treatment at a Genito-Urinary Medicine Clinic. | | I |
| **b) Diagnostic tests and investigations provided on an out-patient basis** | | |
| i) in general | I | |
| ii) breast screening carried out under the national call and recall programme and consequential tests or investigations. (The national call and recall programme is a national programme whereby every woman aged between 50 and 64 is invited to attend for screening by mammography and is recalled for screening every 3 years). | | I |
| iii) cervical screening carried out under the national call and recall programme. (The national call and recall programme is a national programme whereby every woman aged between 20 and 64 is invited to attend for cervical cancer screening and is recalled for further screening at least every 5 years). | | I |
| iv) diagnostic follow-up of an abnormal smear from b) iii. | I | |
| v) issue of hearing aids following an audiological test. | | I |
| vi) where any diagnostic test or investigation is carried out by the Public Health Laboratory Service. | | I |
| **c) Services to which a GP may refer directly, or where the referral has been ordered by a hospital consultant following referral by a GP** | | |
| i) physiotherapy, speech therapy and occupational therapy. | | I |
| ii) services in c) i) above where these are supplied by the Social Services Department of the Local Authority or by the Local Education Authority. | | I |
| **d) Maternity services** | | |
| i) in general, including post-natal care. | | I |
| ii) pregnancy tests. | I | |
| iii) antenatal blood tests. | I | |
| iv) services under d) iii) above provided as part of an out-patient appointment. | | I |
| **e) Domiciliary consultations** | | |
| i) consultations by hospital consultants arranged by the GP. | I | |

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