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Practice budgets: lifting the veil of ignorance

LIKE much of the white paper *Working for patients,*[1] the proposals for practice budgets for general medical practitioners are shrouded in mystery. Even if practical details on the calculation of budgets are issued, the precise implications of budgets for resource management and patient welfare will remain uncertain.[2] This is because little is known of the costs and consequences of existing patterns of patient care let alone the patterns which may result from transferring the financial risk of caring for patients to budget holders.

Budgetary control, incentives and efficiency

Practice budgets are one manifestation of a capitation based system of physician payment. As such they are attractive from the perspective of controlling public expenditure on health care. The government can simply adjust budgets and capitation payments to meet financial targets. More importantly, practice budget holders are given incentives to minimize costs. With direct budgetary responsibilities and penalties for overspending, budget holders will choose patterns of care which generate the smallest possible total cost.

The theoretical financial advantages of this approach will only be realized if the attendant practical difficulties are overcome. Budgetary incentives will only lead to a more efficient use of total resources when general practitioners, family practitioner committee managers and others are both able and willing to evaluate the costs and benefits of alternative ways of achieving explicit objectives. Without valid and reliable information on the costs and consequences of different courses of action it is difficult to see how more efficient or cost-effective care can be identified or adopted. Less costly care is not synonymous with cost-effective care. When two or more ways of caring are equally effective, the less costly approach will indeed represent a more cost-effective use of services. However, a more realistic expectation is that both costs and effectiveness will vary between alternatives. More costly, and more effective practice styles could be seriously jeopardized if a preoccupation with minimizing costs is coupled with ubiquitous ignorance of effectiveness.

Pricing hospital services

The introduction of practice budgets requires general practitioners to have detailed knowledge of health care costs and prices. Two sets of prices can be distinguished. The first are the prices of services confronting the budget holder when 'purchasing' hospital care on behalf of patients. Ideally such prices should reflect the actual resource use inherent in the medical care but in practice prices are often absent or distorted by imperfections in the medical marketplace.

Charges for hospital care based on existing financial and activity data should be regarded with scepticism. Centrally set patient pricing schemes such as the diagnosis-related-groups used in the USA for hospital reimbursement may not be easily employed in the National Health Service.[3] Given sufficient investment, more sophisticated information systems integrating clinical and resource data for individual patients could be developed. The resource management initiative projects represent the beginning of what must become a routine feature of the NHS if the

implementation of practice budgets is to proceed beyond the demonstration stage. The emergence of prices which are good proxies for health service resource costs will take time. During the transition period, the process of establishing prices should heighten general practitioners' awareness of the resource implications associated with their own practice style and that of others.[4]

Biased selection or biased subsidy?

The second set of prices are those assigned to patients via capitation payments. In the UK the process of setting risk based capitation payments is at an early stage. Its growth and development is likely to follow that of other countries where capitation payments reflect historical (average) patterns of health service utilization in different strata of the population. Age, sex and geographical area of residence are obvious factors that can be used to determine capitation payments. However, these factors on their own are poor predictors of variation in the use and cost of medical care.

A heavy dependency on capitation payments may encourage a biased selection (and retention) of patients.[5] This bias in favour of 'healthy' or less costly patients is a common criticism of capitation when compared with other payment systems such as fee-for-service. Overcoming this bias is a difficult task in a system which uses pre-determined capitation payments which are independent of actual service use. Biased selection will remain a possibility until a capitation system emerges which is based on an informed understanding of the distribution of health risks and the utilization of health services. Similarly, budget holders inheriting a set of patients with favourable health risks would effectively receive a subsidy from practices with less healthy populations.

Critical acceptance or blind faith?

Although the idealized features of a theoretical market may be irresistible, prospective budget holders like all novices in the marketplace have good reason to tread carefully. In health care, as in other markets, poor information leads to poor decisions. Information is costly but so too are the unintended consequences resulting from ignorance. The introduction of practice budgets should await the evaluation of well designed pilot projects. Despite pleas for experimentation from those responsible for popularizing the notion of primary care budgets in the UK[6-8] much work remains to be done. When the current atmosphere of confrontation is replaced by one of collaboration both the government and the medical profession should seize the opportunity to subject the budget scheme to the same critical appraisal that would naturally take place in a true market setting. Neglecting this requirement could unwittingly induce more costs than gains.

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Classification of psychosocial disturbance in general practice

PSYCHOLOGICAL disorder is one of the commonest reasons for consultation in general practice[1-5] yet at present we lack an effective system of classification of psychological disorder which is understood by all those who encounter patients in primary and secondary care as well as by mental health specialists themselves.

It is inherent to human society that we categorize to make sense of our environment. For classification to be of value, clear objectives need to be defined. First, a classification system should be a tool in the creation of a sensible differential diagnosis, which is the first step towards taking effective clinical action, avoiding non-specific and inappropriate care. A 'multiaxial' system, which takes account of psychological, physical, social and personality factors[6] may sensitize practitioners to diagnostic possibilities they had not previously considered. Secondly, classification should allow us to predict the natural history of a disorder, but this will only be the case after careful epidemiological study of each syndrome or diagnosis. Lack of agreement between researchers and clinicians on the diagnostic criteria of psychosocial disorders has so far impeded this work. Thirdly, classification is needed to achieve clear communication between doctors, patients and their families, not only for clinical purposes but also for education. Thus it is imperative that diagnostic labels are unambiguous. Lack of confidence in present systems of classification may explain why general practitioners remain reluctant to apply diagnostic labels in this field of care. However, labels can have a positive effect, giving patients an understanding that their symptoms are part of a recognized disorder.[7] Patients may function more effectively when they and others understand the psychological component of their problems. Obviously, labels can have negative effects by becoming self-fulfilling, by failing to encompass the complexity of individual human behaviour or by their inappropriate medicalization of social concerns. Thus diagnostic labels should not be considered indelible but should be subjected to regular review. Fourthly, classification not only directs research but must also be the object of carefully designed research in order to refine its own reliability and validity.

Present state of the art

Psychiatric diagnosis remains at the descriptive or syndromal