Experiences of first wave general practice fundholders in South East Thames Regional Health Authority

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SUMMARY

Background. *The purchasing power given to general practitioner fundholders has important longterm implications.*

Aim. *A study was undertaken to investigate the experiences of a group of fundholders.*

Method. *All 15 first wave fundholders in South East Thames Regional Health Authority were sent a questionnaire asking about their experiences towards the end of the first year of fundholding.*

Results. *The practices varied considerably in the degree of changes made. Nine had developed consultant outreach clinics in the surgery and four had made major changes in their use of providers. Advantages mentioned by respondents were the outreach consultant clinics, increased practice facilities, increased provider responsiveness, greater direct access and facilities for investigations, reduced waiting times for outpatient appointments, increased computerization and a new awareness of practice and provider activity. A number of difficulties were also mentioned, including provider resistance and time spent on administration.*

Conclusion. *It is important to view these changes in the context of other National Health Service and general practice reforms: practice based innovations are not unique to fundholding and other initiatives could have brought about these changes. In addition, developments such as outreach consultant clinics which may benefit the practice still need to be evaluated in terms of cost effectiveness and health outcomes, as well as their impact on services elsewhere.*

Keywords: GP budget holder; health service reforms; practice finance; referral rates; GP clinics; GP–hospital relationship.

Introduction

AMONG the many changes that have occurred recently in the National Health Service, the introduction of fundholding has perhaps the most important implications, with general practitioners taking over as the main purchasers of health care.[1-3] Although it will be a long time before fundholding can be evaluated in terms of its impact on patient care and health outcomes,[2,3] investigating the first years of fundholding will provide information on the types of changes occurring when general practitioners have budgetary control.[1]

A study was therefore undertaken to investigate the experiences of practices in South East Thames Regional Health Authority who became fundholders in 1991, the first year of operation of the scheme.

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Method

Practices which applied to South East Thames Regional Health Authority to be first wave fundholders were assessed according to list size, administrative capability and degree of computerization. All 15 fundholders were contacted by telephone in February 1992 and asked if they would take part in the study. A postal questionnaire, containing open and closed questions, was then sent. The questionnaire was addressed to the general practitioner most involved in fundholding and the practice/fundholding manager and they were asked to complete it either jointly or separately.

Results

Replies were received from all 15 fundholders between February and May 1992; nine of these had been completed jointly and the other six by the general practitioner.

Specialist clinics

Nine practices had developed outreach consultant clinics as a result of fundholding (Table 1). One practice had three outreach consultant clinics but these were not as a result of fundholding. Five practices had also set up physiotherapy clinics (another four already had these) and two practices had set up audiology clinics. Other clinics were planned in all these specialties and in ophthalmology.

Two practices indicated no interest in setting up outreach clinics; one of these was based close to the local provider. Three other practices had planned to set them up but were unable to because of consultant/provider opposition. Seven practices with clinics had also found resistance from their main provider and six had used consultants from outside the area who either came privately or through a contract arranged with the provider unit. Some consultants were accompanied by a nurse or secretary to assist them in the clinics while in other instances, the practice provided nursing and secretarial support.

Respondents who had set up clinics considered that outreach clinics were advantageous. The advantages mentioned were: that patients preferred being seen in familiar surroundings and that they spent less time and money on travelling; that waiting list times were reduced; that fewer patients failed to keep appointments; that the patient saw a consultant rather than a junior doctor; that general practitioners and other team members could use the clinics to discuss cases with consultants, leading to more appropriate referrals and fewer follow ups; and that the general practitioner had more control over reviews, follow-up appointments and how quickly patients could be seen.

However, a number of problems were also mentioned: initial difficulties and antagonism were encountered from consultants and from managers of provider units; there was a need for additional accommodation and facilities in the practice; extra staff were needed to make appointments, organize clinics, type letters and liaise with hospitals, and practice nurses could be asked to assist with clinics; there were increased costs related to extra prescribing, equipment or items normally issued by hospitals; and there were difficulties regarding where notes should be kept.

Table 1. Consultant outreach clinics developed by nine practices as a result of fundholding.[a]

	Number of practices
Number of specialties	
1	2
2 or 3	4
4	0
5+	3
Specialty	
Gynaecology	6
Dermatology	4
General surgery	4
General medicine	3
Orthopaedics	3
Rheumatology	3
Urology	3
Chest medicine	2
ENT	2
Psychotherapy	1

[a]Clinics developed prior to or not as a result of fundholding are not included. ENT = ear, nose and throat.

One practice with outreach consultant clinics in seven specialties sent 90% of referrals to these clinics. The local provider had been unwilling to provide consultants and had therefore lost this work and the inpatient work which followed the consultants.

General contracts with provider units

All the practices undertook their own contracting arrangements with provider units and had negotiated a variety of contracts. Two practices had negotiated a block contract with their local provider covering all specialties, two had negotiated cost and volume contracts, three had negotiated cost per case contracts and the remaining eight practices had arranged a mixture of contracts. For hospitals outside the district, 12 practices had arranged contracts on a cost per case basis but three practices had also arranged block contracts for certain specialties.

Referrals

Excluding referrals to outreach clinics, 11 practices had not made major changes in their hospital referral patterns. The reasons given were that practices did not wish to disrupt local services and were initially opting for a steady state; that they were reasonably satisfied with local services; that contracts offered by the local hospital were favourable; and that practices had little choice because of their locality.

Four practices reported a substantial decrease in referrals to their local provider. Three of these practices had developed outreach clinics, accounting for part of this decrease. The other had used a private hospital to clear waiting lists for surgery. Two of the four practices had arranged block contracts in certain specialties with other hospitals. These two also made use of the private sector, one having moved 90% of its gynaecology referrals and 95% of its physiotherapy referrals to this sector.

Two practices sent the majority of patients for investigations to private facilities in Wales. However, they also made use of local private services for some investigations because of accessibility.

Most respondents felt that there had been no major changes in the overall number of referrals to consultants (including both referrals to outreach clinics and external referrals).

Two practices had developed systems to reduce outpatient appointments. One practice had established internal standards of history taking, examination and investigations before making any referral to hospital. Potential referrals were all checked internally by general practitioners with a special interest or extra training in an area before contact with provider units was made. Another practice was 'clawing back' follow-up appointments — regular attenders at hospital were identified and, if appropriate, offered an alternative appointment in a practice clinic run by general practitioners.

Improvement in access for fundholders to the following services was mentioned by respondents: physiotherapy, occupational therapy, endoscopy, audiology, non-obstetric ultrasounds, mammography, electrocardiograms, ultrasounds, radiological procedures and computerized tomography scans. One practice had arranged direct access to dilatation and curettage operations.

In general, private facilities were used rarely except in the cases already mentioned. One practice used a private hospital for overnight cataract operations after finding them cheaper than NHS provision. Private physiotherapists were employed by some practices and two practices referred patients to private physiotherapy clinics. Other private direct access facilities included ultrasound, nuclear magnetic resonance imaging, endoscopy and speech therapy. The changes to private facilities were all considered to have brought about improvements in access, waiting times and in quality of facilities.

Relationship with authorities

Respondents considered that providers were generally unprepared for fundholding and many were unwilling to negotiate on quality issues. Twelve practices had noticed a shift in attitudes over the year, with provider units becoming more responsive. The practices varied in their views on the helpfulness and support received from the family health services authority. As with provider units, most practices indicated that relationships with the district health authority had gradually improved. Two practices had found that details of their budget had been given to providers, making negotiations difficult.

Changes within the practice

The arrangements made for the administration of fundholding varied. Five practices had employed a separate fundholding manager (as distinct from the practice manager). The most common arrangement for the administration of fundholding (mentioned by seven practices) was a lead general practitioner working with either the practice manager or fundholding manager. Few practices used outside consultants, such as management consultants and accountants regularly. An increase in clerical and computer staff was usually necessary, involving either an increase in the number of staff or the hours they worked.

A number of extra staff had been employed by the practices since they had become fundholders, including five physiotherapists, two dietitians, two chiropodists, two audiologists, one counsellor and one clinical psychologist. Many practices had also taken on extra practice nurses or increased their hours. More staff were planned, particularly counsellors, dietitians and clinical psychologists.

Two practices had set up a practice formulary since they had become fundholders and another three mentioned that generic prescribing had increased. There was some evidence of the increased use of treatment protocols, as mentioned by two practices.

There had generally been an increase in facilities for investigations and treatment within practices since they had become fundholders. Eleven practices indicated that between one and three extra surgery facilities had been set up, including facilities and equipment for audiology, sigmoidoscopy, cholesterol level investigations, pregnancy tests and erythrocyte sedimentation rate measurements. A number of practices were planning to buy additional equipment from any savings made.

All practices undertook minor surgery and in some this had been increased. One practice undertook more surgery as an outreach clinic in general surgery had been used to train the general practitioners.

Eleven practices cited examples of improvement in patient care, such as the reduced waiting times. Nine of these practices also felt that they had improved patient care in the district as a whole by making providers raise their standards. In one area three fundholding practices had regular meetings together with one provider unit and they felt that this had improved waiting times and other quality measures in general.

One practice considered that the provider's perceived need to compete had brought about an upgrade in pathology services. Another pathology service had started to collect and deliver specimens and results, leading one practice which had been using private facilities to plan to revert back to the local service in the second year of fundholding.

Eleven practices had informed patients about their change in status, using leaflets, posters, video presentations, press and radio. Respondents indicated that no negative feedback from patients had been reported and that many of the patients who had experienced reduced waiting times were enthusiastic.

Perceived advantages and disadvantages

Twelve respondents were positive about their experiences in the first year of fundholding and most of the advantages envisaged had materialized. However, one respondent felt cynical regarding budgets and the lack of choice over providers and another considered that enthusiasm had been dampened by provider resistance. Apart from the advantages previously mentioned, three fundholders also indicated that fundholding provided the opportunity to monitor clinical activity closely. There was an increased awareness of referral patterns for the practice as a whole and a new cost awareness.

Fourteen practices indicated problems with hospital accounts which were often inaccurate, inappropriate and considerably delayed. Fourteen also said that information on waiting lists was often lacking. The time taken over administration was mentioned by 13 of the practices. Four general practitioners reported hostility from non-fundholding general practitioners.

There was some evidence of stress among staff. General practitioner partners not directly involved in fundholding sometimes felt left out of the decision making and resented any increase in their clinical workload and some respondents stressed the need for staff meetings to keep all staff informed and to ask their opinions. One general practice had split up during the first year and it is likely that fundholding had added to previous difficulties. The partners had had mixed views about fundholding originally. One partner took on the main responsibility for fundholding which led to complaints from the other partners of loss of control and increased clinical workload.

Budget setting

Budget setting produced different views: some practices were satisfied while others felt that there was not sufficient flexibility. Three considered that they were being penalized for their previous low referral and prescribing rates. In addition, practices with smaller numbers of ancillary staff (often because of lack of space) were given fewer funds than those practices which had often better premises and high numbers of ancillary staff. The lack of clarity about the basis of budget setting in 1992–93 was also a source of anxiety, practices being concerned that savings incurred in the first year may reduce their future allocation. Practice staff were also unsure about how they could spend the savings accrued.

Discussion

The 15 practices who were the first wave fundholders in South East Thames Regional Health Authority varied considerably in the degree of changes made, many indicating that more would be made in the following year. As has been found in a previous study, fundholding had brought about a power shift so that managers of provider units and consultants now have to take notice of general practitioners' requirements.

While there is no doubt that outreach consultant clinics bring about considerable advantages to the patients and practices involved,[1,4] their cost effectiveness and efficiency, especially in terms of the optimal use of consultants, needs to be carefully examined. Moving consultants away from their hospital bases without staff and technological backup may not be efficient in the long term: it may also result in poorer services for those practices without these clinics and there are also implications for the training of junior doctors.

Holding a budget meant that different treatment alternatives could now be considered based on detailed information on costs and quality issues, thus aiding general practitioners' decision making. While greater availability of direct access for investigations and treatment as well as increased facilities within the practice have the advantage of reducing waiting times, there may an increase in the risk of misdiagnosis. Whether patients receive better clinical care will depend on the clinical/diagnostic skills of the general practitioner and on the use of skilled staff and accurate equipment in the surgery.

Reducing waiting lists is a major priority for general practitioners. However, apart from the outreach consultant clinics, only a minority reported substantial changes in this respect. The private sector was used comparatively rarely but this may change in future if private hospitals start to undercut the prices of NHS hospitals.

While respondents felt there had been no change in the overall number of referrals to consultants, there may have been a slight reduction owing to the increased use of investigations, direct access and minor surgery within the practice and reduced referrals to rheumatology and orthopaedic departments owing to the greater availability of physiotherapy.

Despite the advantages cited by the fundholders, problems were also encountered, for example provider resistance and poor information. However, while hostility was common initially, the responses suggested that there there had been some improvement over the year. There is no doubt that the increased administration as a result of fundholding was considerable. In terms of cost effectiveness, the additional costs spent in administration need to be set against the costs of gains which patients receive.

Are the advantages gained at the expense of the other non-fundholding practices or does fundholding raise the standards for all? Fundholders have received contradictory messages from the government – on the one hand they should provide a competitive edge to raise standards but on the other hand, this should not result in a two tier service. In the first year, the increase in outreach consultant clinics implies that waiting times were reduced for many patients of fundholders but the effect of these clinics on outpatient hospital waiting lists is not known. On the other hand, the upgrade in the service for investigations implies that some overall benefits were also occurring. It is still early days to make overall judgements, and circumstances will change as more practices become fundholders or join into consortia.

A frequent criticism of fundholding is that it makes planning of local services more difficult.[1] The district health authorities have the responsibility of determining population needs, setting priorities and making contracts to meet these needs. In addition, the fundholding scheme covers only a proportion of the total hospital and community services costs.[2] Developing an integrated

strategic purchasing programme requires collaboration between district health authorities, family health services authorities and general practitioner fundholders.[5] In this survey, practices varied in how closely they collaborated with other commissioning agencies and the importance they placed on developing these contacts.

General practitioners in fundholding practices lose some of their independence, as an individual overspend will have an effect on the other general practitioners. Further organizational problems may occur when community nursing services are included and budgets are decided on a capitation basis.

As this survey was undertaken towards the end of only the first year of fundholding, it may have been inappropriate to expect large changes to have been made. However, it is possible that the way budgets were set accounts for the lack of radical change in many of the practices. The lack of clear guidelines on what will happen if fundholders underspend or how they can spend their savings yields no incentives to cut costs dramatically. As Day and Klein have pointed out, there are no clear rules and therefore no clear incentives.[3]

In general, the results of this survey present a positive picture of fundholding. Questionnaires were completed by the lead fundholding general practitioner and the practice/fundholding manager and it is likely that if questionnaires had been sent to all general practitioners in these practices plus a group of non-fundholding practices, a less positive picture may have emerged. Many of the changes described here have also taken place in non-fundholding practices, such as generic prescribing policies, computerized information systems and specialist clinics. Other initiatives to reduce waiting lists have led to increased surgery facilities and greater direct access[6] and outreach clinics are common in some low technology specialties such as psychiatry.[7]

Many would argue that these changes could also have been brought about by the use of consortia[8] without the additional administrative costs involved. The use of consortia where smaller practices can also play a part have been considered to have many more advantages, avoiding the development of two tier services and cash limiting.[5,8] It is therefore vital that changes in services are monitored carefully, taking into account health outcomes and that the value of other approaches and developments are also considered in detail so that fair comparisons can be made.

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