Fundholding in the South Thames Region

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SUMMARY

Background. *The general practice fundholding scheme is now at the forefront of the National Health Service (NHS) reforms and should lead to the more efficient use of services by making general practitioners more aware of the financial consequences of their clinical decisions. However, there is a concern that adverse effects may also occur.*

Aim. *To monitor the changes occurring in a sample of fundholding and non-fundholding practices between 1992 and 1995, including providing care nearer to patients, the mixed economy of care, the efficiency and costs of fundholding, and the commitment of fundholders.*

Method. *Fifteen first-wave practices, four second-wave practices, and four non-fundholding practices in the former South East Thames Region took part in the study. Information was collected using interviews, questionnaires, prescribing data, and annual fundholders' income and expenditure accounts.*

Results. *Consultant clinics were set up in 10 different practices in 15 different specialties, and paramedical clinics in 12 different practices. Physiotherapy and mental health clinics constituted over 90% of the paramedical hours. Fundholders had private arrangements with an individual consultant or practitioner for approximately half of the contracted hours in both types of clinics. Fundholders had lower overall prescribing costs than non-fundholders, but the overall costs for prescribing for all groups had risen by about one third over three years.*

Conclusion. *While outreach clinics may help to provide for the needs of patients with common conditions, they may lead to the fragmentation of services. The provision of primary care by those who are not NHS employees needs careful consideration. Recent policies for general practice have emphasized its role in disease prevention and in co-ordination of care for chronic illness. Fundholding also promotes two additional roles, the purchasing of care and the development of in-house facilities. Combining these different functions presents a considerable challenge.*

Keywords: fundholding; cost effectiveness; South East Thames RHA; consultants.

Introduction

IT has been argued that, by making general practitioners (GPs) more aware of the financial consequences of clinical decisions, fundholding would lead to the more efficient use of hospital services and community care.[1] However, as well as these benefits, adverse effects may also occur. For example, it was predicted that fundholding might lead to 'cream skimming' (GPs removing costly patients from their lists), 'cost shifting' (shifting to those elements of care that were not covered by the budget), and a 'two-tier' service.[2] Some predicted that the last item would disadvantage the patients of fundholders since fundholders would undertreat and under-refer,[3] and others argued that the converse might occur in that the patients of non-fundholders would be disadvantaged.[4,5]

The research findings have been equivocal. Fundholding is thought to have brought about a shift in the balance of power between fundholders and hospital consultants.[6] Some fundholders have been found to be more successful in constraining prescribing costs,[7,8] and the patients of fundholders appear not to have been adversely affected.[7] However, the Audit Commission[1] suggested that fundholders had failed to develop the scheme to its full potential. Few had developed sophisticated purchasing strategies and few had made major changes to the way in which care is provided. Furthermore, there have been concerns that the inequalities in the budget-setting process, both between different fundholders,[9] and between fundholders and non-fundholders,[10] carried the implication that the patients of many fundholders will receive preferential access to resources. This paper builds on a previously published study[11] to report further developments in fundholding in the former South East Thames Region.

Method

In December 1991, four second-wave and four non-fundholding practices in the former South East Thames Region were selected to take part in the study. The four fundholding practices were selected out of 13, so that a range of geographical areas was covered including urban, suburban, and rural practices. Second-wave practices were chosen so that interviews could be undertaken before the practices became fundholders. The non-fundholders were matched for size of practice and type of practice population. In addition, questionnaires were sent to all the 15 first-wave practices in the region, and practice information was collected.

A number of data sources were used. Two sets of interviews took place with GPs and practice managers from the second wave and the non-fundholding practices in early 1992 and in 1994. Questionnaires were sent to the first-wave fundholders in January 1992 and to all practices in August 1995.

The practices were also asked to send their annual reports. The annual fundholders' income and expenditure accounts were obtained from the family health services authorities (FHSAs) as well as the level 1 prescribing data.

Results

All of the second-wave fundholders and the non-fundholders took part in the interviews and filled in questionnaires. During the three-year period, none of the non-fundholders became fundholders. However, one practice joined a consortium of local practices. In 1995, only 12 of the 15 first-wave practices were still in the same form as before. One practice had disbanded, another had withdrawn from the scheme, and a third had split, with some partners remaining as fundholders and others withdrawing from the scheme. Ten of the remaining 12 returned questionnaires in 1995.

Considerable difficulty was found in obtaining access to annual reports, and those obtained varied considerably in length, material included, and quality. Considerable inconsistencies were found, making it impossible to monitor changes over time, such as referral rates or the number of staff employed.

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Providing care closer to patients

The main way that fundholding has developed services closer to patients is through the development of 'outreach' clinics. Of the 14 practices that responded in 1995, nine had set up both consultant and paramedical or diagnostic clinics, three had set up paramedical or diagnostic clinics only, and one had set up consultant clinics only. One practice had set up none.

Consultant 'outreach' clinics. Sixty-three clinics had been set up since 1991–92 in 15 different specialties. The most popular specialties were general surgery; dermatology; ear, nose and throat (ENT was set up in eight practices); gynaecology and orthopaedics (set up in seven practices); and urology (set up in six practices). Clinics were also set up in rheumatology (four), general medicine (four), psychiatry (three), ophthalmology (two), diabetology (two), chest medicine (one), paediatrics (one), vasectomy (one), and cardiology (one). Eight practices gave details of the number of hours contracted. On average, the hours of these clinics were 30 hours a month per practice or 2.33 hours per 1000 patients per month. There was a considerable range between practices of 0.2–3.7 per 1000 patients per month. The specialties of gynaecology, general surgery, orthopaedics, and ENT together constituted 59% of the contractual hours for the clinics (Table 1).

Four practices did not set up consultant clinics. Two reported that it was because of lack of space, a third was situated on a hospital site and saw few advantages, and the fourth reported difficulties in finding suitable consultants.

The majority of fundholders considered the advantages of such clinics to be the convenience to patients, the improvement in communication with consultants, and the transfer of specialist skills to GPs. However, outreach clinics placed extra demands on the practice in terms of space, finances, administration, and organization. There were also increased demands on the fundholding budget in terms of increased pathology requests, radiology, equipment, and prescriptions.

Paramedical and diagnostic clinics. Twelve respondents had set up 38 paramedical or diagnostic clinics since 1991–92, including counselling (10), physiotherapy (nine), audiology (five), psychotherapy (three), dietetics (two), osteopathy (two), and ultrasound (two). One clinic was also set up in each of the following areas: clinical psychology, community psychiatric nursing, optometry, acupuncture, and phlebotomy. These figures do not include clinics and the attachment of workers set up before fundholding.

Ten practices gave the number of hours contracted. These averaged 88 hours per practice per month, or 5.7 hours per 1000 patients per month. The range between practices was from 1.4 to 12 hours per 1000 patients per month. The majority of these hours were either contracted to mental health practitioners or physiotherapists.

Facilities for investigation. Improvements in practice facilities for investigations were reported by half the fundholding practices. Many of these new investigations were introduced to support the 'outreach' clinics, but others could be used by practice members. The following had been made available in the practice since fundholding: ultrasound, sigmoidoscopy, proctoscopy, Doppler, audiology, 24-hour electrocardiographs (ECGs), full ECG monitoring, lung function, glaucoma screening, urine flow measurement, biopsies, including endometrial biopsy, phlebotomy, and additional blood tests.

Non-fundholders. None of the non-fundholders had developed consultant outreach clinics, although one had unsuccessfully asked the health authority to commission such clinics. However, there had been some developments in providing services closer to patients. Tomlinson money had brought improved access to physiotherapy and counselling for one practice, another had employed an additional nurse, a third had been awarded a contract to undertake minor surgery for the patients from non-fundholders in the locality, and the fourth had instituted sessions for the checking of cholesterol and had a chiropodist attached. Other than these services, no additional facilities for investigations were mentioned by the non-fundholders in 1995.

The development of a mixed economy of care

The accounts given at interview suggest that, in contracting care, GPs are attempting to balance three potentially conflicting objectives — cost containment, improved services to patients, particularly in terms of shorter waiting times, and the need to maintain or develop a local infrastructure for care. In general, many GPs tended to restrict their use of private services or non-local providers, recognizing the need to support their local provider. However, the contractual arrangements made for outreach clinics differed in that private and non-local providers were frequently used (Tables 1 and 2).

Fundholding costs and efficiency

Overall budget. In 1992–93, 1993–94, and 1994–95, the average

Table 1. Total number of hours by specialty and provider (n = 8; first wave = 6, second wave = 2).

Specialty	Total number of hours	Private arrangement (in hours)	Local NHS provider (in hours)	Other NHS provider (in hours)
General surgery	54	23	3	28
Gynaecology	43	31	5	7
Orthopaedics	34	12	12	10
ENT	31	3	7	21
Dermatology	26	17	9	–
Urology	19	10	9	–
Ophthalmology	11	11	–	–
Psychiatry	14	5	9	–
General medicine	15	15	–	–
Rheumatology	10	4	4	2
Diabetology	8	–	8	–
Cardiology	6	–	6	–
Paediatrics	2	2	–	–
Vasectomy	2	2	–	–
Total hours	275 (100%)	135 (49%)	72 (26%)	68 (25%)

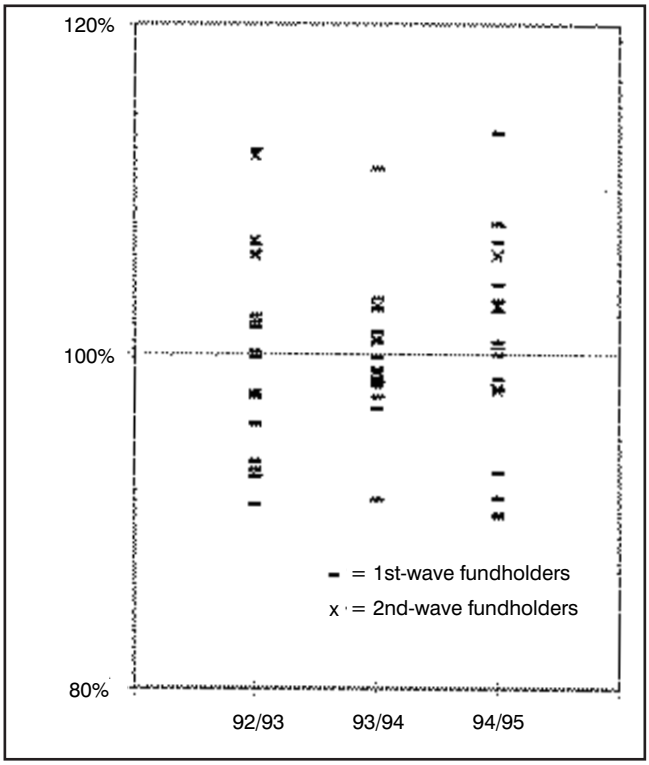

Figure 1. Total expenditure compared with budget.

allocation per head for hospital services, prescribing, and staff was £110, £122, and £133 respectively. There was a wide variation between practices, with the lowest funded practice receiving 60% of the budget of the highest funded practices. Figure 1 shows the performance of practices against their budgets for three years. Figures over 100% indicate an overspend, and figures under 100% indicate savings. No practice underspent by more than 10%, while, in each year, one or two practices overspent by more than 10%. In addition, staff in half of the practices indicated that they had experienced major difficulties in managing their budgets.

Prescribing costs. Taken as a whole, the first-wave practices and the non-fundholders underspent and the second-wave practices overspent their budgets. However, this overall picture masks significant variations. Some practices overspent in all four years, including five out of the 13 first-wave practices, one second-wave practice, and one non-fundholding practice.

When costs per prescribing unit were considered, the costs of first-wave fundholders were lower than those of non-fundholders by approximately 8%. This differential remained unchanged over the four years since both groups had approximately the same increase in costs (36%). This similar increase in costs for all groups suggested that fundholding had little or no effect on cost constraint. However, the results need to be treated with caution, given the large range in costs per prescribing unit and the small sample of non-fundholders.

Equity

Seven of the 13 fundholders and three of the four non-fundhold-

Table 2. Number of hours for paramedical and diagnostic clinics (n = 10; first wave = 7, second wave = 3).

	Total number of hours*	Private arrangement (in hours)	Local NHS provider (in hours)	Other NHS provider (in hours)
Mental health				
Counselling	314	118	160	36
Psychotherapy	26	2	24	–
Clinical psychology	45	45	–	–
Community psychiatric nurse	8	–	8	–
Physiotherapy	368	154	94	120
Phlebotomy	48	48	–	–
Ultrasound	12	12	–	–
Dietetics	12	4	8	–
Audiology	10	8	2	–
Optometry	2	–	2	–
Total	845 (100%)	391 (46%)	298 (35%)	156 (18%)

*Hours for osteopathy and acupuncture were not known.

Table 3. Cost per prescribing unit (£).

Year	First wave (n = 13)	Second wave (n = 4)	Non-fundholders (n = 4)	Figures for England
1991–92	34.6	35.6	37.2	37.5
1992–93	38.5 (+11%)	39.5 (+11%)	40.9 (+10%)	42.6 (+14%)
1993–94	42.9 (+11%)	42.8 (+8%)	46.2 (+13%)	47.1 (+11%)
1994–95	47.5 (+11%)	48.9 (+14%)	50.2 (+9%)	50.9 (+9%)
Increase 1991–92/1994–95	+37%	+37%	+35%	+36%

Figures in brackets represent percentage increase year on year.

ers perceived that a two-tier service was in operation, with patients of non-fundholders being disadvantaged. The degree of inequity seemed to vary in proportion to the concentration of fundholders in the vicinity. The non-fundholder in the area with few fundholders did not consider that the secondary care service had deteriorated, whereas non-fundholders in areas with high concentrations of fundholders considered that their patients were disadvantaged.

The commitment of fundholders

Although the fundholders felt that the scheme had benefited their patients, many had doubts about the overall advantages. Of the nine fundholders who responded to the question, 'On the whole do the advantages of fundholding outweigh the disadvantages?', three responded with a definite 'yes', one with a definite 'no', and the remainder with a qualified positive response. One quote was: 'Yes, historically. But most of the major improvements have now been achieved, so there is little scope left. This has been of benefit to patients and the NHS generally. However, budget cuts will reduce this option further until the cons outweigh the pros, and a health authority is better placed to take over and continue the purchasing.'

Conclusion

Details were only collected from a sample of the first- and second-wave fundholders in the former South East Thames Region and from four non-fundholding practices. Thus, the findings do need to be treated with caution.

The results suggest that most fundholders had developed 'outreach' clinics and increased the range of diagnostic services in their surgeries. There are many advantages in these services for both patients and practice staff. With the development of clinics for counselling or physiotherapy, fundholders have been able to respond to previously unmet needs in their patients, although it is debatable whether the clinical effectiveness of these has been fully evaluated in the general practice setting.[12] In addition, the clinics can be used to develop the infrastructure of general practice in terms of both additional skills and services available in this setting.

Despite these advantages, there are also disadvantages associated with 'outreach' clinics. First, such clinics may fracture the links of practitioners with hospital services, jeopardizing the provision of a 'seamless service' between sectors. Secondly, fundholders may be able to gain most control over the activities in 'outreach' clinics when private contracts are negotiated with individual practitioners, but such practitioners may lack supervision, support, organizational backup, or resources. Individual practitioners may therefore look to the practice for support, adding to the work required to sustain fundholding. The implications of providing primary care services using non-NHS employees needs careful consideration.

There are also concerns regarding the quality of annual reports and the information infrastructure within general practice. At present, few routine data are available with which to monitor the balance of referrals between 'outreach' clinics, NHS trust outpatients, and private hospitals. As well as providing activity data, referral data also provide a crude measure of need. However, when referrals are made to the private sector, it is often not possible to capture what diagnoses have been made, or the procedure or operations undertaken. If such referrals continue or increase, then there will be a lack of data on which to plan the funding of future services.

In general, the fundholders had balanced their budgets, but there were significant variations between practices. Fundholders had lower overall prescribing costs than non-fundholders. However, as the overall costs for prescribing had risen for all groups by a similar amount, it is questionable whether fundholding had an effect on cost constraint during the period of time covered. Other studies have found that the effect of fundholding on prescribing may be only short term.[13]

Finally, fundholding should not be seen in isolation from the other aspects of primary care. In the past, policies for primary care have emphasized the role of general practice in delivering population disease prevention programmes and in coordinating long-term community care. Fundholding has the potential to promote two other aspects of general practice: practice purchasing for secondary care and community services, and expanding the range and complexity of facilities within the surgery. Integrating and developing these disparate aspects of general practice will require GPs not only to be responsive to the needs of individual patients but also to build and maintain a management infrastructure to deliver and purchase these different types of service. This may require the development of a new role for some GPs, combining the function of clinical director with that of community or public health physician. Given the present structure of general practice and the unsophisticated nature of many of the information and management systems, these changes will present a considerable challenge.

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