General practice fundholding: progress to date

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SUMMARY

Background. *The cornerstone of the National Health Service (NHS) reforms was the establishment of an internal market, which separated purchasing and providing roles. As purchasers of care, general practice fundholders were seen as a pivotal part of the 'new patient-led NHS', which was intended to lead to improved cost-containment and cost-effectiveness, quality of care, and patient choice and empowerment.*

Aim. *To review published evidence of the extent to which these objectives may have been achieved over the past six years.*

Method. *Keyword search of on-line databases (MEDLINE and Econ-lit) from 1990 to 1996, plus manual search of references within those articles identified.*

Results. *In the absence of any formal evaluation of fundholding, it is difficult to assess the overall success of this reform. However, in terms of cost-containment and cost-effectiveness, there is mixed evidence. In some areas, such as prescribing, the evidence suggests cost-savings, although the evidence is less clear on reductions or changes in referrals. There is also evidence that suggests that improvements in prescribing may have been achieved at substantial additional administration and transaction costs. With respect to quality of care, the evidence suggests that, although quality in the procedural aspects of health provision has improved, there is little evidence about how health outcomes may have been affected. In terms of patient choice and empowerment, the evidence suggests that, whilst general practitioner choice of secondary providers has improved, little progress has been made with regard to increased consumer choice.*

Conclusion. *Evidence concerning the success or otherwise of general practice fundholding over the past six years is incomplete and mixed. The major deficiency concerns any effect on health outcomes that may be the result of fundholding. Until such research is conducted, the jury will have to remain out on whether fundholding has secured improved efficiency in the delivery of health care.*

Keywords: National Health Service; fundholding; internal market; cost-effectiveness; quality of care; patient choice.

Introduction

THE cornerstone of the National Health Service (NHS) reforms[1] was the establishment of an internal market in which the roles of purchasing and providing health services were separated. As purchasers of services on behalf of their populations, district health authorities and general practice fundholders (henceforth referred to as fundholders) were to contract out for these services, with hospital trusts as the main providers.[2,3]

Fundholding, as a pivotal part of the 'new patient-led NHS',[4] was to improve service quality for patients, stimulate providers to be more responsive to general practitioner (GP) requirements, and allow general practices to retain budget surpluses for practice development.[1,5] These cost and quality incentives were to encourage GPs to ensure that their budgets were spent in the most cost-effective way,[6] leading directly to wider NHS efficiencies (as most patient referral for care is determined by the GP).[7] Although formal objectives are brief, and many objectives are not explicitly stated,[1,8] the principle objective of fundholding may arguably be seen as seeking to improve cost-containment and cost-effectiveness, with quality of care and patient choice and empowerment important secondary aims of the reforms.[8]

However, comprehensive evaluation of the effectiveness and efficiency of fundholding is difficult because no formal evaluation structure was established with its introduction, and its impact has been confounded by a series of earlier and concurrent policy changes.[9] Although the scheme's growth has been cited as evidence of its success, more cautious assessment is necessary in the presence of such confounders and the absence of a formal evaluation structure.[10] It is worth noting that, although the government consistently refused to commission an evaluation of 'standard' fundholding (although the King's Fund financed a study that reported on the first three months in 10 practices[11]), the latest initiative of 'total' fundholding (where fundholders purchase *all* secondary care in partnership with their health authority, including emergency admissions) is to be evaluated: King's Fund is to coordinate a three-year programme of the total fundholding pilots (as of 1995, there were 51 total purchasing pilot projects operating in England).[4,8,12]

This lack of formal evaluation means that there is only limited evidence on the overall performance of 'standard' fundholding, making it difficult to decide definitively on the success or otherwise of the reform initiatives. In the absence of such a formal evaluation scheme, one is left to make a judgement from a review of studies that have been conducted in an attempt to make some assessment of the experience of fundholding to date in achieving these objectives.

The purpose of the present paper is to critically review published evidence of the degree to which these objectives have been achieved, particularly where comparative data from fundholders versus non-fundholders is available (either on a case-control or before-and-after basis). Although this review is not definitive because the present authors limit this review to those papers pertinent to the assessment of these objectives for 'standard' fundholding (not 'total purchasing' or 'multifunds'), it nevertheless provides a balanced review of available evidence concerning the progress of fundholding to date.

Method

Papers for review were initially identified using a keyword search of two on-line bibliographic databases, MEDLINE and Econ-lit, from 1990 to 1996 (inclusive). The search terms used were: general-practice, fund-holding, budget-holding, efficiency, quality-of-care, choice, and competition. The abstracts of these papers were then down-loaded and reviewed for appropriateness and relevance to this review.

Papers for review were selected from these abstracts according

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to whether the articles addressed the specific objectives for fundholding as specified. A second stage in the review was undertaken once all papers identified by the on-line database search were obtained. As these papers were reviewed, any additional papers referenced that appeared relevant, but that had not been identified or collected by our on-line search (such as non-peer reviewed papers), were collected and subsequently reviewed. This highlighted a number of non-peer reviewed papers.[1,4,5,8,13-22] There were also several additional references for 1997 that were provided by an anonymous referee for the *British Journal of General Practice*.[23-27]

It should be noted that, as with any literature review, it is likely that a considerable amount of literature may have been overlooked: principally that which is unpublished or not published in peer-reviewed journals. In addition, it is possible that the databases used may not have covered all the relevant literature and, of course, the present review was limited to papers written in English. However, the present authors would suggest that, of these three potential areas for bias, the latter two are of minor concern. Furthermore, it is hoped that the fact that this review is heavily biased toward papers in peer-reviewed journals will reflect some degree of 'quality control' in the assessment of evidence about fundholding. Overall, of course, the present results and conclusions should be viewed in this context and thus seen as indicative rather than definitive.

Results

Cost-containment and cost-effectiveness

The primary objective of the NHS reforms was to curtail rising government health expenditure. Although the secondary and tertiary care sectors are the most costly, the majority of episodes of care begin with GPs who, as gatekeepers to the NHS, have an important influence on overall cost.[8] Fundholding was intended to reduce reliance on expensive inpatient and specialist care. and to curb unnecessary interventions.[13]

Through making GPs more accountable for their health care decisions by introducing financial incentives involved with budgetary control, fundholding aims to achieve cost-containment and cost-effectiveness in two ways. First, by providing fundholders with an incentive to 'shop around' for services that they may wish to purchase, rather than being restricted to a single provider, should encourage providers to be responsive to what is demanded. However, this is dependent on the relative bargaining strengths of market participants, the number of competing providers, the degree of collusion, and the extent of information available upon which decisions can be made. Secondly, providing fundholders with an incentive to provide care that is not only clinically appropriate for their patients, but also financially viable within their budget, should encourage fundholders to search for more effective, and cost-effective, ways of delivering care.

It is difficult to assess whether fundholding has been effective in containing costs because much of the official data is clouded by increasing participation in the scheme. For instance, in 1989, the United Kingdom (UK) Government estimated that implementing fundholding would cost £15.6 million per annum (£14 million on administration expenses and £1.6 million on computing expenses) and that this additional expenditure would be more than recouped in efficiency savings. However, by 1993–1994, these costs had increased to £38 million (£10 million for fundholding preparation and £18.6 for practice computing).[12] The addition of more GPs to the fundholding scheme makes it difficult to assess the precise reason for this increase in cost (in 1991–1992, fundholder budgets totalled £400 million, rising to £2.8 billion by 1994–1995).[4]

However, it has been suggested that, in a decentralized system with many budget holders, it is likely that administrative and transaction costs will be higher than a system with a large centralized budget (i.e. held by district health authorities).[27,28] There is substantial anecdotal evidence to suggest that fundholding entails such additional costs that are not included in official figures; for example, a marked increase in fundholder workloads[8,29-32] and costs to the district health authority in reconciling budgets, auditing expenditure, and monitoring operations.[8,33] However, a possibly misleading impression of high management costs could result from segregation of funds by fundholders not being set against these costs.[8]

Two important areas where efficiencies were predicted to occur as a result of fundholding were through changes in referral rates and patterns, and in the contracting process itself. Fundholding was predicted to reduce, or alter the pattern of, referrals for secondary and tertiary care. Early studies into referral rates did not demonstrate great changes in referral patterns,[29,34,35] although this was most likely because of regional health authority attempts to maintain a 'steady state' in the first year of the reforms. However, although the volume of referrals has changed little, there is (limited) evidence that the pattern of referral has changed, which may indicate improved cost-effectiveness,[14,36] although it is difficult to identify whether these patterns are a direct result of fundholding or a reflection of historical patterns. In addition, the extent to which this is achieved depends upon the number of hospitals with which fundholders may contract and the contracting process itself.[38]

It is also possible that such changes are not necessarily beneficial, such as the increase in emergency admissions, which may reflect the fact that fundholders do not pay for such referrals, and thus, may be substituting these for ones they are financially responsible for.[24,37]

With respect to the contracting process, there is little evidence to suggest that this has improved cost-effectiveness, primarily because of the unavailability of relevant information in the market. Nevertheless, the shift from block to cost and volume contracting might itself increase efficiency by providing an incentive for providers to deliver care that is more cost-effective, and by providing purchasers with greater control over what is produced. Because of initial uncertainty concerning contracting, most first-wave contracts were block contracts, although second- and third-wave contracts have increasingly been on a cost and volume basis.[15,39] However, the informational requirements are extensive, and with current (limited) information on treatment cost-effectiveness, this process is far from ideal.[16,40] In addition, the degree of efficiency improvement is dependent on the relative market power of transacting participants,[16] although evidence to date suggests that fundholders may have the upper hand, particularly through the threat of exit.[17]

On the positive side, it is evident that fundholding has led to considerable savings in NHS drug costs, both through a reduced volume of prescriptions and a switch to generics.[8,41-44] There is also evidence that fundholding has caused GPs to re-evaluate the acceptance of hospital consultant recommendations, particularly when it affects prescribing, which has consequently reduced the degree of cost-shifting between hospitals and primary care.[45] However, although savings suggest that previous prescribing patterns were inefficient, this cannot be stated conclusively, as reducing costs does not *necessarily* increase efficiency (although, in the absence of any accepted standards in prescribing, it is not clear whether quality of prescribing has deteriorated or improved).[24] In addition, recent evidence suggests that such initial savings may not be sustained.[8,26]

There is also evidence to suggest that fundholding has led to innovations and investment in practice services and organization.[23,33,46,47] In 1993–1994, approximately £19 million in savings was spent by fundholders on a wide range of goods and services (about 35% on premises, 25% on practice furnishings, 15% on medical equipment, and 25% on a variety of other things, including hospital and community services).[4] However, innovations are not exclusive to fundholders[29] and there is concern that surpluses could be used to enhance the value of capital stock as an additional fundholder 'retirement' fund.[40]

Finally, although the data suggest that fundholders underspend on budgets (e.g. £64 million in 1993–1994), which may be argued to point to improved efficiency, there is a great deal of variation between fundholders (20% saving £100 000 or more and 3% overspending by that amount[4]) and evidence to suggest that general practices strategically wait to become fundholders until such time that their budget is maximized.[41] Nevertheless, any possible escalation of costs are more appropriately considered against the health and other associated benefits of fundholding.

Quality of care

In addition to cost-containment, improved 'service quality' was also an important objective of fundholding. Through making GPs compete for patient enrolments and by providing patients with greater ability to choose between practices, services, it was argued, should become more patient- (client-) oriented and meet individual needs, both on admission and on transfer back to the community.[18]

There is some evidence of improvements in service quality that could be attributed to fundholding, such as improved communication between fundholders and providers of health care services, shorter waiting times, and improved access to radiology and pathology services.[8,19-21,23,25,31,32,34,47-50] However, analyses that have been undertaken tend to centre on non-clinical aspects and rarely solicit patient views[22] (which is important as there is evidence that there are likely to be wide discrepancies in what fundholders view as a quality experience compared to patients[51,52]). In addition, the Audit Commission[8] have reported that few fundholders are purchasing based on evidence, and that there appears to be a conflict between what patients are seeking, such as complimentary therapies, and those services for which there is evidence of efficacy or effectiveness.

On the positive side, the potential for inequity between patients enrolled with fundholders versus non-fundholders appears to have been controlled through Government responsibility for patients requiring treatment costing more than £5000 in secondary care. Additionally, as the UK moves towards a system of funding through risk-adjusted capitation formulae, the potential for 'cream skimming' may be reduced.[17]

Overall, although evidence suggests that quality in the procedural aspects of health provision has improved from both patient and fundholder perspectives, there needs to more research dedicated to understanding how health outcomes may be affected by fundholding.[53]

Patient choice and empowerment

It has been argued that, prior to the NHS reforms, GPs faced no direct incentive to attract patients and respond to their needs and demands, leading to provider interests dominating health care service provision.[54] Therefore, one of the objectives of fundholding was to redress this balance by ensuring that the 'money followed the patient', by providing incentives for hospitals to be responsive to the referral demands of GPs and incentives for GPs to be responsive to their patients.[8,36,55]

There is anecdotal evidence that fundholding has allowed greater choice by fundholders, who now have an incentive to provide the most cost-effective care.[8] Indeed, it has been argued that one of the reasons for the initial enthusiasm by GPs for fundholding was the increased power to improve the health of patients, particularly through a greater choice of secondary health-care providers.[53] However, this experience has not been replicated across the board.[28]

In addition, although fundholders may have experienced an improvement in choice, there is little evidence that patients are exercising greater freedom of choice,[18] or that fundholders are more likely to take account of patient preferences.[14,33] It has been suggested that availability of patient choice may not be a salient issue for many patients and that many continue to defer that right to the doctor.[14] There is also evidence that patient choice of GP is still determined by geographical rather than quality factors.[56]

It has also been suggested that market behaviour may actually lead to reductions in choice through practices establishing private companies to enable them to sell and buy services from themselves,[40,57] or through the formation of 'multifunds'. Multifunds are created by pooling fundholding practice management allowances, which allow for common management of activities (e.g. day-to-day administration and coordination of contracting), while ensuring funds remain financially independent. These are often a means by which small practices become eligible for fundholding status (i.e. multifunds arise from practices becoming fundholders in the fourth and subsequent waves).[4,8] However, while these arrangements allow smaller funds to collectively enhance their leverage on providers, multifunds may also have the undesirable side-effect of restricting patient choice of GP.[40]

It is difficult to make an accurate assessment of the effect of multifunds on patient choice given the recent nature of their development. However, it is important to note that, at present, these comprise a small proportion of all fundholders. For instance, in 1995, there were only 17 'multifunds' in England and Wales (less than 1% of all fundholders), involving 350 separate practices, in which populations varied from less than 50 000 to around 35 000, but totalling around 2 million.[8] Although the larger multifunds involve 20 to 30 funds and 40 to 60 practices, the majority are smaller groupings of three to four funds and fewer than 10 practices (representing around 50–80 000 patients).[4,8] However, further research is required before any definitive conclusions may be reached.

Discussion

As with other NHS reforms, general practice fundholding was heralded as a means to secure cost containment, improve quality of care, and to empower patients, ultimately leading to improved efficiency in the provision of healthcare. However, the evidence over the past six years is mixed and incomplete. The full picture of standard fundholding is difficult to obtain from a review of the scientific literature, and it is clear that future health service changes would benefit from inbuilt programme and summative evaluation.

However, from the review presented in the present paper, one can draw some tentative conclusions. Although costs have been contained in some areas, such as prescribing, it is not clear if this has been at a *net* saving to the NHS.[8] Nor is it clear that changes in referral, contracting or prescribing have led to improved health outcomes, or that patient involvement in their care has improved. For fundholders themselves, a significant problem in achieving improved outcomes and, therefore, achieving increased cost-effectiveness of care is the paucity of information with respect to both the effectiveness and the cost-effectiveness of alternative

services within the NHS. Until this critical issue is addressed, and more thorough and comprehensive studies of the effect of fundholding on cost and health outcomes is conducted, the jury will have to remain out on whether fundholding has been a success or otherwise.

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