

# Can primary care groups learn how to manage demand from fundholders? A study of fundholders in Nottingham

M D TOBIN

C J PACKHAM

## SUMMARY

**Background.** Primary care groups (PCGs) will commission care for their patients and may be increasingly required to manage clearly defined resources. Existing general practice fundholders already operate in this environment, but can PCGs learn from the experience of fundholders in managing demand?

**Aim.** To explore how general practice fundholders manage demand for hospital and community health services, and for prescribing.

**Method.** A general practitioner (GP), and a fundholding manager from each of 26 practices were invited to take part. Questionnaires were developed, with structured and semi-structured components, and piloted in three practices. Interviews were conducted between October 1996 and February 1997 by the same interviewer (MDT).

**Results.** All practices stated that they were monitoring their waiting lists and giving priority to patients whose problems had become worse, but eight of the 23 GPs felt that they were unable to manage demand. Eight of the 15 fundholders who had developed in-house services actively managed the waiting list for these clinics. All fundholders had identified areas of unmet demand. Widely differing methods for increasing supply to meet demand were identified, and are described. Formularies were used by 12 out of the 23 fundholders. Guidelines were only considered useful by eight of the 23 practices; fundholders from later waves were less likely to find guidelines useful than fundholders from earlier waves (odds ratio [OR] = 0.11; 95% confidence interval [CI] = 0 to 0.96). Private specialist surgery was less likely to be accessed by later wave fundholders using the fund than by early wave fundholders (OR = 0.10; 95% CI = 0.09 to 0.97).

**Conclusion.** Fundholders in Nottingham had not developed consistent approaches to managing demand within limited resources. Given the apparent diversity of attitudes and practices, the larger PCGs will require strong support to develop the intended commissioning function.

**Keywords:** primary care groups; fundholding practices; practice management.

## Introduction

FUNDHOLDING was abolished on 31 March 1999. The Government wishes to keep what has worked from fundhold-

ing and abolish what has not worked. The White Paper, *The New NHS*, outlines how primary care groups (PCGs), comprising general practitioners (GPs) and community nurses, will commission care.<sup>1</sup> Each PCG may serve an average population of 100 000. PCGs may become increasingly involved in managing clearly defined resources. How will they fare?

Views on appropriate ways of managing demand depend on what people believe about rationing in the NHS. Those who dispute that rationing should be necessary argue that demands can be met.<sup>2-4</sup> Of those who believe that rationing is inevitable, approaches to managing demand vary from those of cost-control, priority setting, and efficiency savings,<sup>5</sup> through to managed care.<sup>6</sup> How fundholders manage demand has been largely un-researched; yet all those who will commission care can learn from careful evaluation of their experience.<sup>7</sup>

This study was set up to explore how fundholders in Nottingham managed demand for hospital and community services, and for prescribing.

## Method

There were 26 fundholding practices in Nottingham (out of 118 practices) when the study began in October 1996. All 26 were invited to take part.

Separate questionnaires were developed for interviews with GPs and with fundholding managers. The questionnaires had structured and semi-structured components. They were successfully piloted in three practices, and no changes to the original questionnaire were made following the pilot. Interviews were carried out separately with a GP and a fundholding manager from each practice by the administration of the questionnaire by the same interviewer (MDT) between October 1996 and February 1997.

Interviewees were asked about demands on services and about how their practice managed demand. In this study, demand was defined as the demand for services by GPs acting as agents for their patients, and unmet demand was defined as the gap between such a demand and what was currently supplied.<sup>8</sup>

Practice deprivation indices were calculated from enumeration district level data from the 1991 Census. The Townsend score was used as a measure of deprivation and the Jarman score was used as a measure of GPs' workload.<sup>9,10</sup> Affluent practices were described as those with a Townsend score of less than or equal to zero, and deprived practices were defined as those with a Townsend of score greater than zero. All practices with a Townsend score greater than zero also had a Jarman score greater than zero. Results are presented for practice Townsend score only.

Statistical analysis was performed using SPSS for Windows, version 8.0. Logistic regression was used to adjust for time of entry to fundholding and for deprivation on subgroup analysis.

## Results

Twenty-three of the 26 (88%) fundholding practices took part in the study. Characteristics of participants and non-participants are shown in Table 1.

M D Tobin, ChB, MRCP, MRCP, lecturer in public health medicine, Department of Epidemiology and Public Health, Faculty of Medicine, University of Leicester. C J Packham, MMedSci, MRCP, MRCP, MFPHM, senior lecturer in public health medicine, Division of Public Health Medicine and Epidemiology, School of Community Health Sciences, University of Nottingham.

Submitted: 5 February 1998; final acceptance: 16 December 1998.

© British Journal of General Practice, 1999, 49, 291-294.

### Managing demand and prioritization

In all 23 practices, either the GP or the fundholding manager stated that the practice monitored waiting lists at intervals, with patients already on the waiting list whose problems had become worse being given priority. All practices had looked at increasing supply in areas of unmet demand and four practices commented that limiting supply was an effective way of controlling demand. Eight practices felt that they were unable to manage demand for secondary care services.

Waiting lists for in-house services were held by eight of the 15 practices that had developed such services. One practice had piloted managing a specialty waiting list for their patients admitted to one local hospital, but this had been discontinued. The hospital administrative system was seen as 'unwieldy' and incompatible with that of the practice.

### Use of guidelines in purchasing and prescribing (Table 2)

In response to a question on whether they found management and prescribing guidelines<sup>11</sup> useful in general (whether locally or nationally produced), only eight out of the 23 practices considered guidelines useful. Fundholders in later waves were less likely to have considered guidelines useful than fundholders in early waves (adjusted odds ratio [OR] for finding guidelines useful = 0.11; 95% confidence interval [CI] = 0.01 to 0.96). Deprived practices (Townsend score >0) were not shown to consider guidelines more or less useful than affluent practices (adjusted OR for finding guidelines useful = 0.48; 95% CI = 0.06 to 4.21), but the power of the study is too low to draw firm conclusions.

### Unmet demand

All practices identified orthopaedics, ophthalmology, ear, nose and throat (ENT), and dermatology as areas with significant unmet demand. Of the 21 practices that were able to do so (excluding community fundholders), 14 stated that they had

increased provision of orthopaedics. Methods to achieve this included shifting provider for the bulk of services (10 practices), negotiating with the local provider (eight practices), shifting provider for a small number of patients 'let down by the current system' (three practices), and changing types of referrals away from orthopaedics to physiotherapy (five practices).

Twelve practices added that they had also increased provision of ophthalmology, and seven practices had increased provision of ENT.

Fifteen practices had developed in-house services, including physiotherapy (15), counselling (nine), and specialist appointments (eight). Development of in-house services was constrained in practices with a small list size and lack of space.

Fifteen of the 23 practices expressed a wish to support their local provider (five of the nine fundholders from waves one to three, and 10 of the 14 fundholders from waves four to six). These practices were more reluctant to shift from local providers, particularly outside of the National Health Service (NHS). Two fundholders stated that, although there had been early major shifts in provider, they were now returning to local providers in the interest of patient convenience and improved quality of care and waiting time.

### Access to private care (Table 3)

Nine of the 21 practices that were able to do so (excluding community fundholders) arranged for new referrals to some specialties to be seen by a specialist working in the private sector to shorten waiting time. Fundholders from later waves were less likely to have referred patients for private care under the fundholding scheme than those in earlier waves (OR = 0.10; 95% CI = 0.09 to 0.97). Deprived practices were not shown to be more or less likely than affluent practices to refer privately (OR = 0.22; 95% CI = 0.20 to 2.35). Specialties for which private referrals were arranged included orthopaedics, ophthalmology, ENT, general surgery, and gynaecology. In seven of the above nine practices, some new referrals were subsequently admitted to an NHS waiting list if procedures were necessary.

### Information constraints

All practices commented that information from providers was unacceptably slow, constraining the ability to influence waiting times. Five practices stated that they required more information on the health status of their populations from the health authority. Four fundholders felt that lack of a suitable forum for the sharing of ideas hampered innovation and led to duplication of effort.

### Financial constraints

Six of the 23 practices felt that innovation required increased short-term investment, and that their budget did not allow for this.

### Other considerations

All practices stated that they had become more aware of the costs of treatment since becoming fundholders. Two practices commented that their referral rate had decreased as a result of becoming fundholders, and nine practices were limiting unnecessary follow-up.

Of the seven practices that had overspent in the financial year 1996–1997, one of these practices was affluent (out of nine affluent), and six were deprived (out of 14 deprived). Of the overspent practices, one was planning to defer procedures until the next financial year to limit expenditure, two practices stated that they would not defer procedures, and two stated that they would

**Table 1.** Comparison of participating and non-participating fundholding practices.

Practice characteristic	Participants n = 23	Non-participants n = 3
Type of fundholder		
Standard	7	2
Consortium member	13	0
Community	2	1
Total purchasing pilot	1	0
Wave of fundholding entered		
Waves 1–3	9	1
Waves 4–6	14	2
Practice population		
Less than 3000	9	1
3000 to 9000	8	1
More than 9000	6	1
Number of partners		
Single-handed	10	1
Two to four partners	9	1
Five partners or more	4	1
Practice Townsend Score		
More than 0 (relatively deprived)	14	0
Less than 0 (relatively affluent)	9	3
Training practice		
Yes	6	2
No	17	1

**Table 2.** Odds ratios for GPs finding management and prescribing guidelines generally useful, according to time of entry into fundholding wave and practice Townsend score.

Practice characteristic	Number of practices with characteristic	Odds ratio (95% CI) for GP finding guidelines useful	
		Unadjusted	Adjusted for other variable in table
Time of entry to fundholding			
Wave 1–3	9	1.00	1.00
Wave 4–6	14	0.08 (0.01–0.64)	0.11 (0.01–0.96)
P-value		0.017	0.046
Townsend score			
Less than or equal to 0 ('affluent')	9	1.00	1.00
More than 0 ('deprived')	14	0.22 (0.03–1.36)	0.48 (0.06–4.21)
P-value		0.104	0.509

**Table 3.** Odds ratios for practices referring any patients to consultants working in the private sector under the fundholding scheme for hip and knee replacement, carpal tunnel release, hernia repair, varicose veins, hysterectomy, coronary artery bypass surgery, or angioplasty, according to time of entry to fundholding and Townsend score of the practice.

Practice characteristic	Number of practices with characteristic	Odds ratio (95% CI) for referring any patients to consultants working in the private sector	
		Unadjusted	Adjusted for other variable in table
Time of entry to fundholding			
Wave 1–3	9	1.00	1.00
Wave 4–5 <sup>a</sup>	12	0.06 (0.01–0.51)	0.10 (0.09–0.97)
P-value		0.010	0.047
Townsend score			
Less than or equal to 0 ('affluent')	8	1.00	1.00
More than 0 ('deprived')	13	0.10 (0.01–0.78)	0.22 (0.20–2.35)
P-value		0.028	0.209

<sup>a</sup>Wave six (community) fundholders were excluded as they could not purchase such services under the scheme.

try to increase their influence over what happened to the patient after referral.

### Prescribing

Fundholders were asked about their prescribing for three examples of high-cost prescribing items, and about their prescribing for 'secondary care-led' expensive items. Twelve fundholders had developed practice formularies. Around one-third of practices had systematically used guidelines or audit to manage demand for lipid-lowering drugs or proton pump inhibitors.

Lipid-lowering drugs were frequently prescribed in two practices; in 18 practices their use was infrequent, but increasing. Five fundholders used guidelines from the British Hyperlipidaemia Society, and four practices had performed their own audit. Two GPs stated that they would not prescribe statins to smokers.

Proton pump inhibitors were the most expensive item of drug expenditure for 22 out of 23 practices. Three practices commented that most prescribing was secondary care-led. Measures taken to limit expenditure included use of an H<sub>2</sub> receptor antagonist as first line treatment (10 practices), establishment of a definitive diagnosis before starting treatment using endoscopy (four practices) or testing for *Helicobacter pylori* infection (11 practices), and using a low maintenance dose or gradual weaning of dose (eight practices). Two fundholders used guidelines and five had performed their own audit.

Bisphosphonates were infrequently prescribed for osteoporosis in 19 of the 23 practices. Six GPs stated that they were usually secondary care-led. One fundholder used guidelines and one had

performed its own audit.

Expensive 'secondary care-led' items did not generally cause great concern, as the health authority made allowances if treatment was particularly expensive for an individual patient.

### Expensive fertility treatments

The approach to the prescription of expensive fertility treatments, such as Gonadorelin, varied widely. Five practices were aware of recent local guidelines. Fourteen fundholders stated that they would not prescribe expensive fertility treatments. Reasons stated for not prescribing such treatments included cost (six practices), the requirement for specialist supervision (six practices), or both (two practices).

### Chronic disease management

One fundholder had allocated resources to chronic disease management in primary care using the fund.

### Discussion

Although small, and based on subjective opinions of fundholding general practices themselves, this study gives a useful insight into the mechanisms used by doctors who have a defined budget within which to purchase defined services. The study highlights the difficult position of GPs when placed in conflicting roles of providing for individual patients' needs and 'purchasing' services. In this study, the role of fundholders as advocates for their patients appeared to take precedence over that of managing their budget. 'Managing demand' for most GPs meant increasing sup-

ply of services to meet unmet demand for their own patients. Limiting the supply for services based on an assessment of need rather than demand was not raised by the GPs or the fund managers. It may be that this assessment was implicit as part of the clinical decision-making process.

It was not clear whether a limited supply affected the individual doctor's assessment of need for services — producing, in effect, 'rationing'. However, in the fundholding situation that applied at the time (where overspending was met by the health authority), the limitation on 'supply' may not have been perceived as a powerful enough influence to effect a change in the clinical identification of need. The larger PCGs may have no such 'safety valve', and limitation of supply may be much more acutely felt. How the GP-led commissioning groups will respond is not clear. Increases in supply lead to opportunity costs (services which must be foregone) for patients registered with other practices or primary care groups.<sup>12</sup> This issue was not raised by any of the fundholders in this study. It has been suggested that fundholding could increase individual patient and practice perspective,<sup>13</sup> but low levels of coordination between devolved purchasers reduces the ability to view purchasing from a population perspective and leads to inequities in service provision.<sup>12</sup>

Although some of the methods described here are good practice, such as active management of waiting lists and practice formularies, they are not unique to fundholding.

The majority of GPs in this study did not consider guidelines useful. Although guidelines are being published at a greater rate than ever before, they often fail to improve practice. Changes in clinical practice are more likely to occur where there is ownership in guideline development and implementation.<sup>14,15</sup>

The subgroup analyses in this study need to be interpreted with caution owing to the small sample size. However, they do suggest that the approach taken to managing demand by late wave fundholders differed markedly from that of early wave fundholders.

Nottingham has had a low proportion of fundholding practices and a 'non-fundholding' commissioning culture. This could have inhibited communication between fundholding practices and resulted in less consistent approach to managing demand than in other districts. Communication and cooperation between practices will be essential if the primary care groups are to be successful in achieving consistent management of demand. PCGs will need to develop high quality management to achieve this goal.<sup>16</sup> Adequate development funds will also be required to support such clinical and organizational innovation.<sup>12</sup>

In summary, it is not clear that the experience of fundholding has led to consistent or reproducible approaches to managing demand with limited resources within individual practice settings. The challenge for the much larger PCGs is to refine and develop these approaches; however, they will require strong and consistent support to achieve this goal.

## References

1. Secretary of State for England. *The New NHS*. London: HMSO, 1997.
2. Harrison A, Dixon J, New B, Judge K. Can the NHS cope in future? *BMJ* 1997; **314**: 139-142.
3. Roberts C, Crosby D. Anti-rationing group also wants to contribute to the debate. [Letter.] *BMJ* 1996; **313**: 557.
4. Mackay K. Britain could still have a comprehensive NHS without rationing. [Letter.] *BMJ* 1996; **313**: 557.
5. New B (on behalf of the Rationing Agenda Group). The rationing agenda in the NHS. *BMJ* 1996; **312**: 1593-1601.
6. Enthoven A. *Theory and practice of managed competition in health care finance*. Amsterdam: North-Holland, 1988.

7. Godsen T, Torgerson D, Maynard A. What is to be done about fundholding? *BMJ* 1997; **315**: 170-171.
8. Stevens A, Raftery J. *Health care needs assessment: the epidemiologically based needs assessment reviews*. Volume 1. Oxford: Radcliffe Medical Press, 1994: 17.
9. Townsend P, Phillimore P, Beattie A. *Health and deprivation: inequality in the north*. London: Croom Helm, 1988.
10. Jarman, B. Underprivileged areas: validation and distribution of scores. *BMJ* 1984; **289**: 1587-1592.
11. Field MJ, Lohr KN (eds). *Guidelines for clinical practice: from development to use*. Institute of Medicine. Washington DC: National Academic Press, 1992.
12. Light DW. Is NHS purchasing serious? An American perspective. *BMJ* 1998; **316**: 217-220.
13. Cornell J. Has general practice fundholding been good for patients? *Pub Health* 1996; **110**: 5-6.
14. Conroy M, Shannon W. Clinical guidelines: their implementation in general practice. *Br J Gen Pract* 1995; **45**: 371-375.
15. Lomas J, Sisk JE, Stocking B. From evidence to practice in the United States, the United Kingdom, and Canada. *Millbank-Q* 1993; **71**: 405-410.
16. Butler T, Roland M. How will primary care groups work? *BMJ* 1998; **316**: 214.

## Acknowledgements

We should like to thank Dr Sarah Wilson, Director of Public Health, Nottingham Health Authority. The study was a modification of her original idea. We should also like to thank Dr Jim Pearson, Division of Public Health Medicine and Epidemiology, University of Nottingham for advice on statistical analysis. We are particularly grateful to all participating general practitioners and fundholding managers. Finally, we thank Dr Clive Richards, Nottingham Health Authority, for his constructive criticism of early drafts of this paper.

## Address for correspondence

Dr Martin D Tobin, Lecturer in Public Health Medicine, Department of Epidemiology and Public Health, Faculty of Medicine, University of Leicester, 22-28 Princess Road West, Leicester LE1 6TP.