

Factors affecting the shift towards a 'primary care-led' NHS: a qualitative study

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SUMMARY

Background: Local Health Care Cooperatives (LHCCs) and Primary Care Groups (PCGs) reflect the continuing importance of a shift towards a 'primary care-led NHS' as a health policy goal in England and Scotland. Yet many commentators have concluded that, to date, the extent of the shift has been limited. To assess the ways in which LHCCs and PCGs might develop in the future, it is necessary to understand the progress made in moving towards a primary care-led NHS and the factors that have either encouraged or hindered its development.

Aim: To investigate the nature of, the barriers to, and the incentives encouraging the shift towards a primary care-led NHS.

Design of study: Qualitative study using semi-structured interviews.

Setting: Purposive sample of key stakeholders in health authorities, trusts, and primary care in four urban health authorities (two in Scotland and two in England).

Method: The interviews discussed the commissioning types, the nature and scale of shifts that had occurred, the barriers to and the factors promoting the shift, the mechanisms for discussing and monitoring the shifts that were taking place and the likely impact of LHCCs and PCGs, in relation to three common conditions: inguinal hernia, stroke, and asthma.

Results: Shifts in activity from secondary to primary care were regarded as small, non-strategic, piecemeal, and not directly underpinned by resource shifts. Barriers identified by responders include the immobility of existing resources, concerns in the primary and secondary care sectors about the appropriateness of the shift, weak incentives supporting the shift, the perspectives of general practitioners involved in commissioning, and the absence of co-operation between key stakeholders.

Conclusion: The development of a primary care-led NHS needs to resolve a fundamental tension at the heart of the policy: those to whom power was devolved were neither equipped nor minded to engineer the strategic resource shifts necessary to underpin a more primary care-based NHS.

Keywords: primary care; local health care cooperatives; primary care groups; National Health Service.

Introduction

The 'primary care-led NHS', central to health policy in England and Scotland since the early 1990s,¹⁻⁴ has had three components. First, it has devolved commissioning power towards primary care through general practitioner (GP) fundholding and, more recently, Local Health Care Cooperatives (LHCCs) in Scotland³ and Primary Care Groups (PCGs) in England.⁴ Secondly, it has encouraged changes in the location in which health care is provided. Thirdly, the shift has been predicated on resource transfers from secondary to primary care.

Some suggest that a shift to primary care has occurred, citing innovative services provided in a primary care setting⁵ and changes in GPs' attitudes and relationships with health authorities and trusts.⁶ Others argue that the overall impact of policy has been modest.⁷⁻¹³ Yet many components of the primary care-led NHS remain. For example, PCGs becoming trusts will acquire budgetary control, to manage a wide range of community services and to commission hospital services for their patients.¹⁴

Therefore, to understand how LHCCs and PCGs may develop, it is necessary to understand the progress made in moving towards a primary care-led NHS. We report here the results of a qualitative study exploring the factors that have either hindered or promoted this shift and the nature and extent of the devolution of commissioning power.

Method

Four urban health authorities were selected, two in Scotland, two in England. Each had ethnically and socioeconomically heterogeneous populations and each had teaching hospitals within their boundaries. In-depth, semi-structured interviews were undertaken with purposive samples of senior health authority and trust staff, and with GPs from large, small, and single-handed practices from all the devolved commissioning types that existed in each health authority area. Where there was more than one GP in a particular type and size category, responders were selected at random from the practices in that category. Two authorities included standard fundholders, primary care purchasing initiative (PCPI) practices, and GP commissioning groups only. One authority included all fundholding types. The fourth included all types except a GP multifund. Where responders were unavailable or did not agree to an interview, other responders were identified in the same or similar positions, although this was not always possible. Eighty-six interviews were carried out (Table 1).

The interview schedule was piloted in a neighbouring health authority. The interviews discussed the commissioning types in each area, the nature and scale of shifts that had

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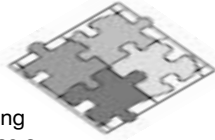
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HOW THIS FITS IN

What do we know?

Local Health Care Cooperatives and Primary Care Groups reflect the continuing importance of a 'primary care-led NHS' as a health policy goal in England and Scotland. Studies to date suggest that the shifts in activity from secondary to primary care have been small, non-strategic, piecemeal, and not directly underpinned by resource shifts. Less is known about the barriers to a shift to primary care, or about the potential for forms of devolved commissioning to overcome these barriers.



What does this paper add?

This study suggests that there is a tension between the need for strategic resource shifts necessary to underpin a more primary care-based NHS and the fragmentation of financial and referral power resulting from the devolution of commissioning.

occurred, the barriers to and the factors promoting the shift, the mechanisms for discussing and monitoring the shifts that were taking place, and the likely impact of LHCCs and PCGs. Responders were asked to consider these issues in relation to three common conditions: inguinal hernia, a condition for which rates of day surgery are increasing; stroke, a medical condition for which lengths of stay are falling; and asthma, a common condition for which an increasing variety of management options is available, including shared care between specialists and GPs and hospital outreach.

Data collection took place between December 1998 and September 1999. The interviews were tape recorded and transcribed in full. Fifteen transcripts, selected at random, were read by each investigator and coded using the framework in the interview schedule and by identifying additional themes that emerged from the data. A coding strategy was agreed between the investigators, before one of the investigators (SM) coded the remainder of the transcripts. From these coded data, a set of themes was derived relating to the shift to a primary care-led NHS. Themed data were also grouped by type of responder, to explore differences in professional perspectives.¹⁵ Data were managed using Ethnograph software.¹⁶

Results

The nature of change

A variety of changes were described, including practice-based physiotherapy, counselling, asthma, diabetes, chi-

ropody, and complementary medicine clinics. However, in general, shifts in activity from secondary to primary care were considered to be small, non-strategic, piecemeal, and not directly underpinned by resource shifts:

'... over the years ... all sorts of specialties where the hospital has suddenly decided we are not interested, we are dumping ... back door shifts ... not because primary care want it but because secondary care don't and normally they don't want to do it because of a costing issue.' [Director of Commissioning, health authority.]

In each of the three disease areas, primary care-led commissioning was not seen as the main driver of change. For hernia repair, increased day-case surgery was attributed to technological advances and pressures on acute trusts. There was little mention of the impact of day surgery on primary care or the potential for day surgery to release resources for reinvestment in primary care. Instead, day surgery was seen as a means of coping with the pressure on the secondary sector with limited implications for primary care, because modern surgical techniques enable the patient to return home with little follow-up required.

The shift in asthma management to primary care was attributed to extra funding for chronic disease management in the 1990 GP Contract and the low priority attached to it by the secondary sector:

'The hospital services ... don't really have a major asthma specialty so that forced you ... whether you had the interest or not ... to take a proactive role. GPs have got to look after their patients themselves.' [GP fundholder.]

It was suggested that this shift predated the policy emphasis on a primary care-led NHS:

'The shift started in the late eighties/early nineties and that was the change in the GP Contract and the development of asthma clinics in general practice.' [Respiratory consultant.]

None of the stroke specialists suggested that shortening stays, which had decreased dramatically in Scotland over the 1990s, were having a significant impact on primary care. Changes in stroke management were attributed to the views of the secondary sector about the most appropriate way to manage a particular condition. Trust responders expressed

Table 1. Personnel interviewed in the study.

Four Health Authorities	Secondary care (two principal Trusts in each Health Authority)	Primary care	Community Trust
Director of Finance Director of Public Health (or proxy) Director of Commissioning Senior Primary Care Manager (Total = 18)	Director of Finance Director of Nursing 3 Consultants (one for each index condition) (Total = 38)	Random sample: all fundholding forms and some non-fundholders (Total = 26)	2 Senior Managers 1 Director 1 Assistant Director (Total = 4)

concerns regarding the skills or inclination of primary care to manage strokes in the community.

'GPs want rid of strokes.' [Finance, trust.]

'GPs are uncertain how to admit strokes.' [Stroke Consultant.]

Reflecting these views, stroke management remained secondary care-led in each of the study areas.

A consistent view was that although the shifts were limited in scale and were often *ad hoc* responses to longer-term pressures, fundholding did 'sharpen up' the secondary sector and was effective in achieving change in the process of care and developing services at the practice level.

Barriers and incentives

There was considerable overlap between the views expressed by responders in authorities and trusts. Barriers and incentives are therefore discussed from a combined trust and health authority perspective. Five main themes were identified.

Resources. The most frequently mentioned barrier was resources. It was suggested that there was an imbalance of resources between the acute and primary sectors, with:

'... too many trusts.' [Finance, health authority.]

Responders suggested that this imbalance distorted patterns of demand between hospital and primary care:

'... supply creates demand ... there are more vascular surgeons on call at night than GPs.' [Commissioning Manager, health authority.]

They also argued that the inflexibility of resources tied up in the secondary sector with a high proportion of fixed costs hinders the development of primary care. The threat to GPs if money does not follow patients, and the threat to trusts if patients do not follow the money, were recurring themes:

'Expertise from secondary care is not moving out to primary care, people are protective of their own service, they do not want to lose resources till they are sure activity will move.' [Nurse Manager, trust.]

When authorities were asked whether resources had been transferred from secondary to primary care, a fuzzy picture emerged of gradual change occurring at a strategic level, as and when conditions, such as ward or hospital closures, allowed. Few mentioned specific savings in secondary care being used to support initiatives or increased activity in primary care. It was argued that the augmented services have been additional to, rather than substitutes for, services previously provided in secondary care.

'Generally work has moved but there has been no shift in resources ... new work always replaces the devolved stuff in secondary care.' [Primary Care Manager, health authority.]

The trust-based responders painted a picture of severe financial pressures undermining the scope to release resources to transfer into primary care. They suggested that trusts use any savings generated by more day cases or shorter stays, to absorb activity growth, to fund staff pay increases, and to achieve financial targets without cutting into patient services.

Most GPs argued that, apart from the resources provided via fundholding, there had been no added allocation to match activity increases. The perception was one of increased workload being dumped on primary care without sufficient resources being shifted to support the additional activity:

'Warfarin ... we were always very comfortable with that being done at hospital, we really didn't want ownership of that, then it was "would you be willing to do a little bit of monitoring?" and then all of a sudden, bang! there it is...' [GP, PCPI.]

The lack of social service support and long-stay facilities in the community were considered to be major barriers. Responders in both authorities and trusts suggested that it undermines GP confidence to manage patients in primary care.

Absence of incentives. For trusts, the main incentives to shift activity to primary care were finance and activity-driven pressure to reduce bed numbers, shorten stays, and treat more patients. Some suggested a strong incentive would be the demonstration that the shift is an effective way of coping with the increasing activity:

'Demonstrate to clinicians the need for early discharge and reduced lengths of stay in order to manage emergency pressures.' [Finance, trust.]

An incentive for trusts mentioned by some responders was the possibility that shifting routine activity into primary care would enable the secondary sector to focus on more specialised work, although this would not free resources for primary care if the volume of specialist work in the secondary setting increased.

Access to monies from a wider arena; for example, social services, and freedom to determine how those resources were used, were cited by responders in health authorities as possible incentives to make the shift happen. Unified budgets within the NHS and with non-NHS agencies, in particular social services, were seen as crucial to this. Moves away from block contracts to service level agreements with money attached to specific aspects of service delivery were also mentioned.

Government policy was seen as a driver of change, in the form, for example, of numerical targets, such as waiting list targets, trust responders said that financial incentives would be necessary to encourage GPs to take on the 'offloaded' activity. This would require a change in GP contracts, towards a salaried service. An incentive for GPs would be visible benefits arising from the shift in terms of quality of patient care and patient autonomy, although it was also

suggested that the strength of such an incentive would vary according to the type of GP.

Secondary care attitudes towards primary care. Many responders in both authorities and trusts referred to the persistence of the traditional roles and attitudes of clinicians as a barrier to the shift.

'The NHS is steeped in tradition ... Entrenched views of senior elderly clinicians.' [Finance, health authority.]

Some health authority responders also suggested that perceived threats to consultant power and to the financial position and power of the trust reduced providers' willingness to engage in the policy:

'Consultants fear losing power and status if there are too many shifts.' [Primary care manager, health authority.]

A number of consultants said they were reluctant to discharge to GPs or that they felt secondary care was often more appropriate:

'The shift ought to be into secondary care, there are too few referrals, patients are not being diagnosed or managed well [in primary care].' [Asthma Consultant, emphasis added.]

There were a number of doubts expressed by both primary and secondary care about the levels of skills and adequacy of physical and human resources in primary care, a concern shared by responders from all four health authorities:

'The main barriers are skills, expertise, knowledge.' [Public health, health authority.]

'Over half the practices don't meet ... what we call minimum standards.' [Director of Commissioning, health authority.]

Primary care culture and attitudes. Poor facilities in many practices, especially in the London authorities, and the constraints and workloads faced by GPs, were seen as constraints on their ability and inclination to embark on a shift of focus to primary care.

It was suggested that the uncertainty faced by GPs in managing certain types of patients in primary care meant that many GPs were not keen either to take on an increased range of services in primary care or to use the power some of them held in the various forms of devolved commissioning, to promote such changes in the locations in which care is provided:

'I don't think we are fit or able to manage a lot of the things that the Trust manage.' [GP fundholder.]

'My concern is that hospitals are now asking the generalists to become specialists. It is not appropriate... I mean what is the point of this shift? Does it have a point? Why move it from the hospital?' [GP, PCPI.]

'Some GPs were more politically active in purchasing but not at promoting a shift.' [Stroke Consultant.]

This was in contrast to the comments made by a number of trust responders about the health authorities' role in promoting a shift towards primary and community care. An unexpected finding was a degree of consensus that the health authorities had actually been more active in promoting a more primary and community care-oriented NHS.

'Only the health board instigated shifts.' [Finance, trust.]

'The health board were most effective. All other commissioning models were very bureaucratic.' [Finance, trust.]

'The health authority is trying to shift but there is a lack of commitment from primary care because it would mean they'd have to do more work.' [Stroke Consultant.]

Cross-organisation co-operation. According to authorities and trusts, overcoming long-term resource transfer issues was hampered by a lack of communication and co-ordination between and within responders' organisations. It was suggested that there were too many competing trusts, which prevented the collaboration necessary to achieve the changes in care delivery required to fund and manage the shift. As a result, health authority strategy was not integrated across sectors:

'There are too many professional barriers in the community — no multiskilling and too much overlap. There is a lack of a relationship between primary and secondary care.' [Stroke Consultant.]

This picture of a lack of cooperation was highlighted by responses to questions on the mechanisms for agreeing and monitoring shifts between stakeholders. Mechanisms existed but they appeared to be patchy in geographical coverage and *ad hoc* in terms of issues covered and who was involved. In one authority, there was an implication that fundholding had made such cooperation more difficult, that the shift to decentralise commissioning and providing decisions pre-dated the internal market but had been hindered by the politics and fragmentation of fundholding.

Both trusts and authorities referred to 'cultural barriers' stemming from a lack of understanding of the perspective of the different sectors:

'Managers in health boards tend to come from hospital services, they don't tend to come from general practice. Health board managers and planners are isolated from what is actually happening on the ground.' [GP fundholder.]

'Hospital managers and health board people don't understand what general practice do, aren't willing to fund general practice and are not in agreement with the long-term ethos of general practice.' [GP fundholder.]

The shifts that did occur were often thought to have been

achieved by working with the secondary sector and non-fundholding GPs in, for example, GP commissioning groups and locality purchasing mechanisms.

Discussion

Because the primary care-led NHS was a policy with diffuse objectives,¹⁷ some of which concerned organisational processes rather than specific outcomes,¹⁸ we used semi-structured interviews to explore stakeholders' perceptions¹⁹ of the policy's impact. Two methodological issues need to be considered in interpreting the results. First, while we have largely left the participants' responses to speak for themselves, the responders are not neutral observers presenting 'pure' descriptions of the world in which they work. We cannot, for example, say what their motives were when they were responding to our questions. Secondly, the processes of identifying key themes and of teasing out the implications of our results involve selection and interpretation. This has been termed 'progressive focusing'²⁰ — the gradual shift from describing social processes to the development of explanations for them. However, our interpretation of the data does not represent an attempt to build a general theory explaining the nature of and the barriers to the primary care-led NHS. Rather, it represents an attempt to identify our responders' perceptions, attitudes, and concerns because they are likely to be important in understanding change and potential resistance to change.

Our findings are consistent with another recent study looking at the barriers to shifting services into primary care, which concluded that 'the issue of disinvestment was at the heart of the failure of the schemes described ... the postures adopted by the different stakeholders are better understood in terms of the competing and frequently contradictory interests the current structure of the NHS engenders'.²¹ Although both studies are based on data from the later stages of the fundholding era, current forms of primary care organisation still bear many hallmarks of fundholding and its variants. The views revealed in this study may therefore have profound implications for the development of PCGs and LHCCs. Indeed, resource constraints, GP attitudes, and relationships between the organisations involved were key issues in a recent study of the development of PCGs.¹⁴

The main barriers to the shift suggested by the responses given in this study were:

- insufficient and inflexible resources;
- the absence of clear incentives encouraging the shift;
- the secondary sector's doubts about the capability of the primary sector to take on additional workload and responsibilities;
- the attitudes of GPs towards the shift; and
- the absence of trust across organisational boundaries.

This study suggests that, to overcome these problems, a number of issues need to be addressed. The first is the workload pressure felt by responders. Although the workload implications of the shift are ambiguous,²² workload concerns are central to the uncertainty and scepticism we found. They suggest that either additional resources must

be found or that the shift must begin to take place to release resources from their existing uses.

Secondly, to crack this resource and activity 'chicken and egg' dilemma it would appear that more cooperation and trust are needed between those responsible for strategic resource decisions and care providers. Thirdly, it seems that, to develop such cooperation, most of the key stakeholders need to see more in the shift for them than they did towards the end of the fundholding era. Incentives are crucial to the breakdown of the barriers identified.

Fourthly, the data suggest that the effectiveness demonstrated by some fundholders in challenging the way in which services were delivered, needs to be harnessed to the strategic perspective adopted by health authorities. Although the devolution of commissioning power, in particular to fundholders, was seen as a way of creating the incentives to shift activity and resources and improve the quality of care, its impact was not that radical.²³

In conclusion, one of the most important potential barriers to the creation of a primary care-led NHS appeared to be that those to whom power was devolved were neither equipped nor minded to engineer the shifts or take the strategic perspective envisaged by the architects of the policy. It is a finding consistent with other studies.²⁴⁻²⁶ It remains to be seen whether PCGs and LHCCs resolve these contradictions.^{27,28}

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