Primary care budget holding in the United Kingdom National Health Service: learning from a decade of health service reform

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ABSTRACT

- The United Kingdom National Health Service (NHS) has experienced 10 years of primary care budget holding in a variety of forms.
- Half of all general practitioners had joined the GP fundholding scheme by 1997, and many others had joined broader GP commissioning groups, but fundholders controlled only about 20% of the budget for hospital and community health services.
- Research on fundholding and commissioning groups suggests that delegation of budgets produced some gains in the range and effectiveness of services, but also had significant management costs and inequities.
- From 1999, all primary care professionals joined Primary Care Groups, which are now becoming Primary Care Trusts (PCTs). PCTs will control three-quarters of the healthcare budget and provide all primary and community services as well as commissioning hospital care.
- Control of a unified healthcare budget presents opportunities to improve quality, increase integration of services, reduce inequities and improve health. However, PCTs are threatened by a growing gap between capacity and expectations, and by continuing tension between devolution of power and increasingly prescriptive management by central government.

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THE REFORMS INTRODUCED into the United Kingdom National Health Service (NHS) in 1991–92 were the most radical changes to its funding and organisation since its inception in 1948. Separation of purchaser and provider functions and creation of the "internal market" replaced the old structures in which Health Authorities were responsible for planning, managing budgets and providing hospital and community health services. Health Authorities and fundholding practices became purchasers or "commissioners" of services, while providers of hospital and community services became NHS Trusts contracting to provide the services. Perhaps the most innovative element of the reforms was the general practitioner fundholding scheme, in which volunteer practices were responsible for managing their own prescribing budgets and purchasing a limited range of community health services and elective hospital procedures on behalf of their patients. Fundholders were able to make savings from their budgets, and invest these savings in additional services or improving facilities in their practices.

The decade since the introduction of the internal market has seen continuing evolution of the reforms, culminating in the changes introduced by the "New Labour" government during its first term (1997–2001). New Labour was elected with a commitment to abolish the GP fundholding scheme. Nevertheless, Labour's White Paper, "The New NHS", (Secretary of State for Health, 2000) retained the separation of purchaser and provider and the commitment to devolving budgets to primary care.

The pace of change over the past decade has been breathtaking. No sooner had we begun to implement one set of reforms than another followed. Comprehensive and systematic evaluation has been difficult; nevertheless, we have learned a great deal through research and our experiences.

GP fundholding

During the 1990s, successive waves of fundholding practices were recruited, so that by 1997 about half of all GPs were in fundholding practices.[1] Fundholders had greater freedom than Health Authorities to innovate and shift resources between providers. However, Health Authorities retained responsibility for about four-fifths of the budget for hospital and community services for patients of fundholding practices and the entire budget for non-fundholding practices. Thus, GP fundholders were marginal players in the internal market and changes to their contracts with NHS Trusts would not greatly destabilise the local health economy. This made it possible for them to shop around for services, often achieving lower prices, shorter waiting times for treatment and more user-friendly services than their Health Authority counterparts. They also tended to have better facilities (premises, equipment and staff) before joining the scheme and to be in more affluent parts of the country than non-fundholding practices.[2,3]

Although the government decided not to formally evaluate GP fundholding, the scheme attracted considerable research and commentary. Much of the research focused on budgets, activity and the process of care rather than changes in quality or outcomes, and few studies compared the performance of GP fundholders and Health Authorities as purchasers of services. A number of published reviews assessed the evidence available.[3-7] One review concluded that:

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> . . . the scheme probably produced at least some of its intended consequences by curbing the rate of increase of prescribing costs and increasing practice-level services. It seems, on balance, that providers were more responsive to fundholders' quality demands than to those of other purchasers. . . . Fundholders were offered lower prices, though possibly at the expense of health authorities. However, the criticism that fundholding led to a 'two tier' service . . . appears to have been borne out. Finally, fundholding created higher administrative workload and higher transaction costs for NHS Trusts than other forms of purchasing, without necessarily being any more responsive to the preferences of individual patients.[7]

Variants on GP fundholding

No sooner had the GP fundholding scheme been established than variants began to appear (Box 1), often promoted by managers and non-fundholding GPs who sought to enhance the influence of primary care while avoiding the costs and divisiveness of the fundholding scheme. The evidence for the effectiveness of these alternative models is even thinner than that for GP fundholding. No systematic evaluation of multi-funds was undertaken.

Total-purchasing pilot schemes were evaluated during their first three years.[8-10] Successful achievement of their objectives was associated with greater responsibility for budgets, more support from Health Authorities, higher spending on management infrastructure and well-developed relationships with local providers. Many of the pilot schemes concentrated on improvements in primary care provision rather than better hospital and specialist services.

Commissioning groups aimed to work with providers to develop the desired pattern of services, without necessarily controlling the budget. They aimed to make Health Authority purchasing more sensitive to local needs and patients' views through the medium of local GPs acting as a group. Studies of individual commissioning groups concluded that gains claimed by fundholding could be achieved at lower cost,[11] but the only direct comparison with GP fundholding suggested that commissioning groups varied widely in their effectiveness.[12] The most successful schemes gave GPs some autonomy and control over their budgets.

Overall, research on the early models of fundholding and commissioning suggests that delegation of budgets produced some gains in the range and effectiveness of services, but at significant cost in terms of management, transaction costs and equity. In a unified healthcare system such as the NHS, more radical change depended less on competition and more on the development of effective communication and good relations between purchasers and providers.

A primary-care-led NHS

Despite the radical nature of the reforms in the early 1990s, they did not affect provision of GP services. Apart from some important changes to the GP contract, general practice remained separately funded and managed. The individual independent contractor status remained, and there were few opportunities or incentives to develop an integrated system of healthcare for local communities. However, many of the GPs who became involved in purchasing and commissioning of hospital and community services did so because they saw opportunities to improve the range and quality of services in their own practices. They were able to use savings to improve premises, provide new services (eg, counselling, complementary therapies) and purchase new equipment. Nevertheless, such developments were patchy and only exacerbated existing inequities between practices.

By 1996, the language of competition was being replaced by the language of collaboration. The term "purchasing" had been replaced by "commissioning", and the Conservative government was building a primary-care-led NHS.[13] There was increasing recognition of the need to integrate budgets and services, reinforced by the results of a comprehensive "listening exercise" in which managers consulted widely with healthcare professionals working in primary care.[14] One important conclusion was that an alternative to the traditional independent contractor status of GPs was needed so practices and other organisations could contract for the provision of primary medical services (PMS) and GPs could be employed on a salaried basis. During its last days, the Conservative government passed the NHS (Primary Care) Act 1997. This allowed Health Authorities to contract with practices or other organisations for the provision of PMS, specifying their own quality standards and payment systems. The Act also allowed PMS-plus schemes, in which the contractor would provide other community-based services in addition to medical care.

1: Schemes for commissioning hospital and community health services (HCHS) in the NHS internal market

Health Authorities
- 100 Health Authorities (each covering about 200 000 population).
- Responsible for commissioning all HCHS on behalf of non-fundholders and 80% of services for fundholders (emergency, unplanned and some elective procedures).

GP fundholders
- 3500 fundholding practices (15 000 GPs).
- Standard fundholding practices responsible for approximately 20% of HCHS budget, commissioning elective procedures and community nursing.
- Community fundholders commissioned only community services.

Multi-funds
- 100 multi-funds (7000 GPs).
- Fundholding practices pooled their budgets, sharing commissioning and management costs.

Total-purchasing pilot sites
- 80 schemes involving 1500 GPs.
- Responsible for commissioning all HCHS for their patients, but in practice many continued to rely on Health Authority commissioning for some services.

Commissioning groups
- Collective non-budgetholding alternatives to fundholding, involving around 7000 GPs.
- Worked with Health Authorities to commission HCHS on behalf of a specific area or population.

"New Labour", New NHS?

The "New Labour" government, elected in 1997, was committed to abolishing the internal market and GP fundholding, principally because of the perceived inequities and the costs of managing the market. However, it retained the separation of purchasers and providers and left NHS Trusts largely intact.[1] The centrepiece of the proposed reforms was replacing the various fundholding and commissioning organisations with Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) (Box 2). These new organisations were to be "in the driving seat in shaping local health services".[15] Unlike GP fundholding, membership of a PCG or PCT was not voluntary. Apart from fulfilling an election commitment to abolish GP fundholding, the creation of PCGs and PCTs reflected various policy priorities. These included promoting closer integration of health and social services provision, reducing inequities, focusing on health improvement, increasing accountability, increasing responsiveness to local needs, and shifting control over resources to frontline healthcare professionals.

Taken together with the NHS (Primary Care) Act 1997, the formation of PCGs and PCTs represented a potentially more radical change than the reforms of the early 1990s. For the first time since 1948, the tripartite structure of hospital, community and family practitioner services had been breached. PCTs hold a unified budget for GP, community health and hospital services, with the opportunity to allocate resources according to local needs and circumstances. At least as important is the establishment of collective responsibility for the range of services provided, access, quality and outcomes. GPs and other healthcare professionals are no longer responsible for quality and service provision in their own practices only — they are collectively responsible for standards across the PCG or PCT, including improving health and reducing inequities. As more GPs and practices move into the PMS scheme, PCTs will also hold contracts for the provision of PMS.

2: Primary care organisations in the "New NHS"

Health Authorities
- 30 Health Authorities (covering 1 000 000 population or more).
- Responsible for strategic planning and performance management.

Primary Care Groups (PCGs)
- 481 PCGs established in 1999 covering all of Britain (approximately 100 000 population and 55 GPs per PCG).
- Sub-committees of Health Authorities, with delegated responsibility for commissioning hospital and community health services, developing primary and community services, quality improvement, partnership working, health improvement, etc.
- PCG Board with majority of GPs plus other healthcare professionals.

Primary Care Trusts (PCTs)
- Formed through mergers of PCGs (about 200 000 population). All PCGs expected to become PCTs by April 2004.
- Hold unified budget for all primary, community and hospital care. Can become providers of community services (eg, nursing, physiotherapy, chiropody) and commission remainder from NHS Trusts and general practices.
- Professional executive committee responsible for policy and implementation, overseen by a board with majority of lay members. Accountable to Health Authority.

Primary medical services (PMS) contracting
- Optional form of GP contract replaces independent contractor status.
- PCTs will contract with practices and other organisations to provide PMS.
- Allows salaried general practice, nurse-led services, service specification, quality incentives, extended range of services, etc.

PCGs and PCTs: the first two years

The first 17 PCTs were established in April 2000, and by April 2001 there were 164. Many PCTs are being formed through mergers of PCGs. The NHS Plan sets a target that all PCGs should become PCTs by April 2004.[16]

The National Tracker Survey of a representative sample of 72 PCGs established in 1999 has been monitoring these organisations through annual surveys.[17,18] In their first year, most were getting to grips with organisational development and working collectively, and dealing with the consequences of the abolition of GP fundholding.[17,19] The latest survey (completed in December 2000) shows they have begun to make improvements in primary care provision, concentrating on improving access to care, targeting poorly served groups, sharing resources between practices, extending professional roles (eg, nurses and pharmacists) and integrating practice and community nursing.[20] They have also made important steps towards improving quality through clinical governance (creating an environment in which excellence in clinical care will flourish), notably through educational interventions and incentives.[21] An important indicator of cultural change is that 50% of PCGs and PCTs are sharing or planning to share identifiable information on quality of care between practices.[21] Progress in commissioning and working in partnership with other agencies (eg, social services, education, housing, community development) is slower,[22] and it is too early to assess any impact on population health.[23] The importance of the unified budget is illustrated by the fact that 59% of PCGs planned to shift funding between categories of expenditure, mostly from hospital to primary care services.[24]

Our surveys also raise some important areas of concern. Lack of management capacity, including GPs and other healthcare professionals responsible for leading change, because of low management budgets (around £3 per head of population) is reported to be a major difficulty.[25] While trying to build a new organisation, more than two-thirds are also planning mergers with neighbouring PCGs, which will increase the average size from 100 000 population to almost 200 000.[25] Although the NHS Plan target is for all PCGs to become PCTs by 2004,[16] 89% of our sample were aiming to become PCTs by 2002.[25] These organisational changes are likely to consume an increasing proportion of the limited managerial capacity, with the danger of diverting attention away from services and health. There is a growing perception of a gap between expectations and capacity.[26,27] National priorities and targets set out in the NHS Plan and National Service Frameworks (for coronary heart disease,

mental health and older people so far, with more to follow) often leave limited scope for local priorities. The fact that 59% of PCGs gave "focusing on local needs/services" as a reason for wanting to become a PCT may reflect their desire to shift the balance from national to local priorities.

Opportunities and threats

Over the past decade, the UK NHS has moved from a system of directly managed services in three sectors (primary, community and hospital) to a system in which a single budget is devolved to organisations dominated by primary care professionals. This delegation of budgets to primary care has been a consistent feature of the changes, and various approaches have been tried. There was widespread support for the creation of PCGs and PCTs to replace the internal market and GP fundholding, and there is some evidence that these organisations can deliver improvements in health and healthcare, but there are also serious threats.

PCTs provide tremendous opportunities for everyone involved in primary care to play a pivotal role in shaping the healthcare system for the 21st century. They combine the potential for local ownership of health policy with collective responsibility for effectiveness and efficiency. The control of a unified healthcare budget presents unprecedented opportunities to improve service integration and direct resources where they are most needed. Unlike GP fundholding, PCTs provide opportunities to address inequities in resource allocation and to improve the range and quality of services for all patients, rather than just patients who are registered with particular practices. For healthcare professionals, PCTs offer opportunities to enhance their roles (eg, GP clinical specialists, nurse practitioners, extended roles for pharmacists) and to work as part of a larger organisation. The most exciting opportunities lie in improving the quality of care and the health of the population. Quality improvement is no longer an individual option but a collective responsibility. PCTs have the potential to deliver health improvements through improvements in quality of care, illness prevention and health promotion, and to demonstrate the improvement through integrated information systems. However, achieving this is still some way off.

There are real threats to the success of these infant organisations. As a State-funded healthcare system, the NHS is vulnerable to political pressures, and healthcare is an increasingly important political issue. PCGs and PCTs need time and resources to realise their potential, but political pressures demand rapid results and reduced spending on management and infrastructure. There is also tension between devolution and central control. New Labour has made much of devolving power and responsibility,[28] but its rhetoric has often been accompanied by an increasingly prescriptive central agenda. The NHS is familiar with a command and control management style and might find it difficult to allow PCTs the freedom to innovate and address local priorities. Add to this the trend towards larger organisations with their inherent tendency towards bureaucratic control and there is a real risk of losing the engagement of professional stakeholders in primary care. Lastly, there is potential for a conflict of interest between purchasing and provision of healthcare. The separation of purchaser and provider has been retained for hospital services, but, as PCTs begin to play an increasing role in commissioning primary care services, the GPs and other healthcare professionals who make up the organisation will become both the commissioners and the contractors providing the services.

Competing interests

None declared.

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