General practice fundholding in the United Kingdom
Do not copy

S.E.D. Shortt, MD, PHD, FCFP

Primary care reform is an important component of the restructuring rhetoric applied to Canadian health care over the past decade. What the term means, however, is less clear. Most conceptions assume that fee-for-service will be replaced with capitated payment and commonly include plans for 24-hour coverage of registered patients and the use of ancillary health professionals. Some researchers have suggested the possibility of borrowing fundholding principles from United Kingdom primary care to use in Canada.[1,2]

Under this innovation, groups of family physicians were given funds from which to purchase various services for their patients. It was assumed that family physicians have a well developed sense of their patients' needs and, by being allowed to retain funds for practice development, would have more incentive to provide efficient care. But is the evidence that general practice fundholding (GPFH) leads to better care at an equal or lower price adequate to recommend it as a component of Canadian primary care reform?

Origins of general practice fundholding

Fundholding was a key element in Britain's market-oriented National Health Service reforms implemented in 1991. General practices received funds annually to purchase designated services on behalf of a specified population. Initially, it was some hospital services and drugs, but community services were added in 1993, and the following year some total service budgets were introduced. Practices were allowed to retain surpluses for practice augmentation, creating an incentive to seek low-cost suppliers. Because suppliers competed for clients, it was believed that practices would be able to demand better-quality service. By 1995, fundholding practices accounted for 10 000 physicians in 2500 practices and provided care to 41% of the UK population.[3,4]

Prescribing costs

By creating financial incentives to reduce unnecessary or highly discretionary prescriptions, it was thought GPFH would better control drug costs. A study of prescribing in all general practices in England for the first 6 years of fundholding found costs increased 56% to 59% for fundholders and 66% for non-participating practices. The maximum savings, gained by reduced cost per prescription rather than fewer prescriptions, was achieved by fundholders in year 1; by year 4 the rate of cost increase was equal to non-fundholders. The relative reduction between fundholders and non-fundholders was small compared with the absolute increase in drug costs for both groups.[5]

There might be local variation. Early results from Lincolnshire suggested fundholders were more successful than non-participating practices in reducing costs by issuing fewer prescriptions per patient.[6] A subsequent study, however, found that the economies achieved in the initial year quickly reached a plateau.[7] In a study of the Oxford region, despite early reports of fundholder cost reductions,[8] at the end of 3 years the highest costs were found among non-dispensing fundholding practices.[9] A study of 10 health authorities in the Trent region in central England found cost reduction was confined to the first year of fundholding status.[10]

A somewhat similar pattern to that described for England was found in a study of all practices in Northern Ireland. Fundholder drug costs fell in year 1 due to increased use of generic prescriptions, which led to substantially lower costs than for non-fundholders. The rate of increase in drug costs by year 3, however, was similar in both types of practice.[11]

It appears that GPFH had an initial effect on drug costs due largely to increased use of generic preparations. However, because "only prescribing costs were measured, it has not been possible to evaluate whether lower prescribing in fundholding practices is rational prescribing, or whether prescribing cost control has affected patient welfare."[12]

Patterns of referral and specialist care

A study comparing referral rates in the Oxford region before and after implementation of fundholding found a similar increase in referrals for both fundholders and non-fundholders.[13] A subsequent study of the same region over 3 years, however, found the rate of increase in referrals among fundholding practices was markedly less than among non-fundholders.[14] Results from Scotland are limited and mixed. A study of six Edinburgh practices found a downward trend in referrals and a stable rate in use of diagnostic investigations.[15] A hospital-based study of referrals, however, reported similar rates of referral among fundholders and non-fundholders.[16]

Patients from fundholding practices in West Sussex have been reported to experience notably shorter waits for elective surgery than patients from

non-fundholding groups.[17] In southwest England, patients from fundholding practices enjoy a similar advantage in shorter waits for outpatient orthopedic appointments.[18] Evidence shows that, in fundholding practices that have instituted specialist outreach clinics, waiting times are shorter than at hospital outpatient clinics for the same services.[19] Such findings clearly raise issues of system equity. These results, however, are from very few regions, and their generalizability is unknown.

Quality of primary care

Six Scottish practices provide almost the only evidence on the important issue of quality of care. In the initial year, researchers noted a stable rate of diagnostic investigations and referrals, stable length of contact during patient visits, and a declining rate of patient satisfaction.[20] Care for a subset of patients with joint pain was compared over 2 years. Time spent with patients and rate of prescribing was constant, but rates for referrals and investigations declined.[21] When the investigators extended their study over the initial 2 years of fundholding, it was again noted that, while length of patient visits was stable, patient satisfaction declined, and patients with certain medical conditions appeared to fare better than others.[22] The decline in patient satisfaction is worrisome; however, the generalizability of these findings is unknown.

Administrative and organizational issues

Estimates of the administrative cost of fundholding for 1993 to 1994 were 3.5% of the total budget, an amount far in excess of original projections.[23] Subsequent evidence suggests that between 1989 and 1990 and 1994 and 1995, the cost of administering primary care in England doubled, due at least in part to the reforms introduced in 1990.[24] An additional untallied cost is the increased administrative workload for physicians.[20] Despite these financial and labour costs, there is little evidence that the contractual arrangements of fundholding have been translated into enhanced clinical effectiveness.[25] The post-1997 introduction of Total Purchasers in Primary Care appears also to have been encumbered with high management costs[26] and to have been no more successful than earlier versions of fundholding in reducing hospital admissions or length of stays.[27]

Assessing the effect of fundholding

Fundholding poses an almost insurmountable challenge to assess definitively: its objectives were not always clear; some reforms disappeared before assessments were completed; effects differed by time and location; data access was variable; and, finally, the effect of the changes was difficult to separate from contemporaneous alterations in British society.[28] Yet there is a consensus that fundholding failed to achieve increased efficiency or quality in provision of primary care. Two broad reasons are offered for this finding.[29-31]

First, the incentives misread the motivations of providers: competition was simply not seen by general practitioners as the most effective means of providing patient care. Second, recognizing they would be held accountable for spending taxpayers' money, politicians and civil servants were unwilling to devolve control of the health system to a point at which strong competition could exist. As a consequence of this disappointing performance, after 1997 GPFH was replaced by some 500 primary care groups, which are intended to purchase care for populations of 100 000 patients, based on collaboration and partnerships rather than competition.[29]

Conclusion

While prescribing costs and referral waiting times might have declined marginally in some settings, there is scant evidence that fundholding in the United Kingdom met its overall objective of reduced expenditure and more appropriate care. Would such a policy be expected to fare better in Canada?

Several features of the Canadian health care system suggest it would be incompatible with fundholding. First, family physicians would have to have rostered patients, a format currently available only where payment is on a capitation basis. Second, it is difficult to envision fundholding practices in rural or remote areas being able to choose between competing vendors. Even in urban areas, given shortages of specialists and diagnostic equipment, there is unlikely to be competition among suppliers. Third, hospitals and home care agencies in many provinces operate with deficits and have no price flexibility with which to compete. These organizations have no incentive to encourage additional use of their services that would simply heighten budget shortfalls. Fourth, fundholding clearly puts administrative demands on physicians, diminishing time for clinical service and exacerbating the shortage of family practitioners. Finally, better ways to accomplish some of fundholding's goals might already be in place in Canada. For example, British Columbia's reference-based drug pricing appears to have been effective in encouraging use of lowest-priced products in a manner similar to fundholding's effect on prescribing generic drugs in the United Kingdom.[32]

Not only does fundholding appear to have accomplished little in Britain, but it would also fit

poorly with the structure of health care delivery in Canada.

Dr Shortt *is a Professor in the Department of Family Medicine and the Department of Community Health and Epidemiology at Queen's University in Kingston, Ont. He is also Director of the Centre for Health Services and Policy Research.*

Correspondence to: *Dr S.E.D. Shortt, Centre for Health Services and Policy Research, Queen's University, Kingston, ON K7L 3N6; telephone (613) 533-6387; fax (613) 533-6353; e-mail* **seds@post.queensu.ca**

The opinions expressed in editorials are the opinions of the authors and do not imply endorsement by the College of Family Physicians of Canada.

References

1. Donaldson C, Currie G, Mitton C. *Integrating Canada's dis-integrating health care system.* Toronto, Ont: C.D. Howe Institute; 2001.
2. Marriott J, Mable A. Integrated models: international trends and implications for Canada. In: *National forum on health. Striking a balance, health care systems in Canada and elsewhere.* Sainte-Foy, Que: Editions MultiMondes; 1998. p. 547-75.
3. Wilton P, Smith RD. Primary care reform: a three country comparison of 'budget holding.' *Health Policy* 1998;44:149-66.
4. Ham C. Managed markets in health care: the UK experiment. *Health Policy* 1996;35:279-92.
5. Harris CM, Scrivener G. Fundholders' prescribing costs: the first five years. *BMJ* 1996;313:1531-4.
6. Whynes DK, Baines DL, Tolley KH. GP fundholding and the costs of prescribing. *J Public Health Med* 1995;17:18-22.
7. Whynes DK, Baines DL, Tolley KH. GP fundholding and the costs of prescribing: further results. *J Public Health Med* 1997;19:18-22.
8. Bradlow J, Coulter A. Effect of fundholding and indicative prescribing schemes on general practitioner prescribing costs. *BMJ* 1993;307:1186-9.
9. Stewart-Brown S, Surender R, Bradlow J, Coulter A, Doll H. The effects of fundholding in general practice on prescribing habits three years after introduction of the scheme. *BMJ* 1995;311:1543-7.
10. Whynes DK, Heron T, Avery AJ. Prescribing cost savings by GP fundholders: long-term or short-term? *Health Econ* 1997;6:209-11.
11. Rafferty T, Wilson-Davis K, MacGavock H. How has fundholding in Northern Ireland affected prescribing patterns? A longitudinal study. *BMJ* 1997;315:166-70.
12. Baines DL, Brigham P, Phillips DR, Tolley KH, Whynes DK. GP fundholding and prescribing in UK general practice: evidence from two rural, English Family Health Services Authorities. *Public Health* 1997;111:321-5.
13. Coulter A, Bradlow J. Effects of NHS reforms on general practitioners' referral patterns. *BMJ* 1993;306:433-7.
14. Surender R, Bradlow J, Coulter A, Doll H, Brown SS. Prospective study of trends in referral patterns in fundholding and non-fundholding practices in the Oxford region, 1990-4. *BMJ* 1995;311:1205-8.
15. Heaney DJ, Howie JGR, Maxwell M. The referral component of fundholding: can both quantity and quality be assessed on routine data? *Health Bull* (Edinb) 1994;52:285-96.
16. Duffield JS, Craig K, Plant WD. Patterns in acute referral to hospital. *Scott Med J* 1997;42:105-7.
17. Dowling B. Effect of fundholding on waiting times: database study. *BMJ* 1997;315: 290-2.
18. Kammerling RM, Kinnear A. The extent of the two tier service for fundholders. *BMJ* 1996;312:1399-401.
19. Bailey JJ, Black ME, Wilkin D. Specialist outreach clinics in general practice. *BMJ* 1994;308:1083-6.
20. Howie JG, Heaney DJ, Maxwell M. The chief scientist reports…evaluation of the Scottish shadow fund-holding project: first results. *Health Bull* (Edinb) 1993;51: 94-105.
21. Howie JG, Heaney DJ, Maxwell M. Evaluating care of patients reporting pain in fundholding practices. *BMJ* 1994;309:705-10.
22. Howie JG, Heaney DJ, Maxwell M. Care of patients with selected health problems in fundholding practices in Scotland in 1990 and 1992: needs, process and outcome. *Br J Gen Pract* 1995;45:121-6.
23. Petchey R. General practitioner fundholding: weighing the evidence. *Lancet* 1995;346:1139-42.
24. Giuffrida A, Gravelle H, Sutton M. Efficiency and administrative costs in primary care. *J Health Econ* 2000;19:983-1006.
25. Douglas HR, Humphrey C, Lloyd M, Prescott K, Haines A, Rosenthal J, et al. Promoting clinically effective practice. Attitudes of fundholding general practitioners to the role of commissioning. *J Manage Med* 1997;11:26-34.
26. Goodwin N, Mays N, McLeod H, Malbon G, Raftery J. Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. *BMJ* 1998;317:256-9.
27. Abbott S, Harrison S, Walsh N. Total purchasing in primary care: three case studies. *J Manage Med* 1999;13:365-72.
28. De Wildt G, Bhopal R, Lavender M. Research into purchasing health care: time to face the challenge. *J Epidemiol Community Health* 1996;50:611-2.
29. Klein R. Why Britain is reorganizing its national health service—yet again. *Health Aff* (Millwood) 1998;17:111-25.
30. LeGrand J. Competition, cooperation, or control? Tales from the British National Health Service. *Health Aff* (Millwood) 1999;18:27-39.
31. Mays N, Mulligan J, Goodwin N. The British quasi-market in health care: a balance sheet of the evidence. *J Health Serv Res Policy* 2000;5:49-58.
32. Grootendorst P, Dolovich L, O'Brien B, Holbrook A, Levy A. Impact of reference-based pricing of nitrates on the use and costs of anti-anginal drugs. *Can Med Assoc J* 2001;165:1011-9.