Fund-holding and commissioning general practitioners

Recent government policy and legislation

Tony Kendrick

General practice fund-holders purchase secondary care for their patients directly, encouraging competition between providers. The scheme now includes almost all community mental health services. Practice counsellors may now be funded from secondary care budgets. Fund-holders may use their purchasing power to influence out-patient policies, have consultant sessions in their surgeries, gain direct referral to community psychiatric nurses, resist sectorisation, or change to a different provider altogether. The implications for mental health teams and their patients are discussed. Mental health workers must define their roles very clearly, and get involved in negotiating contracts now, to influence future service provision.

In 1984 Professor Alan Maynard proposed the idea that general practitioners (GPs) should hold funds from which to purchase health services for their patients (Maynard, 1986). He argued that GPs, being close to their patients and therefore aware of their needs, could act as expert proxy consumers on their behalf. This would introduce incentives for hospitals and consultants to improve services in order to attract more referrals and more money.

The fund-holding idea was taken up by the Department of Health during the National Health Service (NHS) review of 1987/88 and incorporated into the White Paper on the purchaser/provider split *Working for Patients* (Department of Health, 1989a).

The fund-holding scheme proved popular with GPs because it offered them a financial lever to improve the secondary care services offered to their patients, the freedom to refer outside of the contracts placed by district health authorities (DHAs), and the flexibility to use savings to increase staff and develop services within their practices (Glennerster *et al*, 1992). By April 1993 around one in four GPs were fund-holders.

The facts

Originally only practices with at least 11 000 patients could apply (Department of Health, 1989b). This fell to 9000 and then to 7000 to allow more practices to join the scheme. Fund-holding by practices is at the discretion of both regional health authorities (RHAs) and family health service authorities (FHSAs). Practices must show that they are committed to the scheme, and have the necessary space, an adequate computer system, and a history of sound financial and practice management. They receive 100% reimbursement of fund-holding computer software costs, 75% of hardware costs, and a £35 000 per annum management allowance.

The fund covers three elements. Savings made in one area may be used for the other two, or for improving premises or equipment.

(a) *Practice employed staff*. The amount is allocated on the same basis as staff budgets for non-fund-holders, by the FHSA.

(b) *Prescribing*. All general practices are given an indicative prescribing budget, and feedback on their prescribing levels. For fund-holders this budget is real money.

(c) *Hospital and community services*. The part of the budget allocated to hospital in-patient treatment covers a list of specific diagnostic categories and treatments (the exclusions are listed below). From its inception in 1991 the fund-holding scheme included out-patient psychiatric referrals and domiciliary visits by consultants. In April 1993 the scheme was extended to include all out-patient and community mental health services, including child psychiatry and services for people with learning difficulties, but excluding in-patient psychiatric care (National Health Service Management Executive, 1992).

The mental health budget covers domiciliary visits or clinic sessions by community psychiatric nurses (CPNs) and community mental handicap nurses as well as other members of the community mental health team (CMHT), except

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for social workers, who are employed by the local authority.

The following are excluded from the scheme:

(a) *self-referrals*, through drop-in centres or drug addiction clinics for example, and referrals to child psychiatry made by school doctors or school psychologists
(b) *voluntary services*, even where these are partly funded by the DHA
(c) *regional or supraregional and highly specialised services*, such as units for eating disorders or puerperal psychosis
(d) *emergency admissions or referrals*
(e) *social services*, provided by local-authority social service departments
(f) *in-patient psychiatric or medical treatment*
(g) *hostel care*
(h) *day care and respite care*.

Fund-holders are encouraged, but not obliged, to place contracts with NHS CMHTs, as these usually have good links with social service departments. They are asked to stipulate that providers operate the care programme approach, and to make a priority the needs of people with severe and long-term mental health problems. They should negotiate local protocols for referral – for example whether referral may be only to the consultant psychiatrist, or to any member of the team.

In addition to community mental health services, mental health counselling has been included in the scheme. Fund-holders are asked to ensure that counsellors are "appropriately qualified and competent" (National Health Service Management Executive, 1992), but no specific qualification is laid down. Counsellors should consider whether patients referred to them might be referred more appropriately to the CMHT, for example for social care of admission. Counsellors are to be encouraged to become integrated with the community mental health services in time.

Implications for psychiatric practice

So far, the main effects of GP fund-holders on secondary care services have been first to reduce waiting-lists for in-patient treatment (either through fast-tracking of fund-holders' patients by their usual provider unit or through a switch to another NHS or private provider), and second to contact consultants to do out-patient sessions within the practice (Glennerster *et al*, 1992; Newton *et al*, 1993; Wisely, 1993).

It is too early to tell what effects the inclusion of community mental health services into the scheme will have on psychiatric services. In many areas there is a lack of information about service activity on which to base contracts, which means that much of the first year has been spent gathering data.

What changes are fund-holding GPs likely to want to make in future? At a meeting of fund-holders at St George's Hospital Medical School a number of probable aims were identified. These are discussed under separate headings below.

To end sectorisation

Most GPs want the freedom to refer patients to different specialists. This has implications for CMHTs who see advantages in having strict catchment areas that are co-terminous with social service patches.

To gain direct access to CPNs

GPs do not like having to refer patients to a consultant psychiatrist in order to obtain CPN help. Many GPs would like the CPN integrated into the primary health care team, and to have a degree of managerial control over the CPN's activities. This has implications for psychiatrists who see themselves as managers of their own teams.

To provide counselling services on site

Many GPs want a person within the practice to whom they may refer patients with anxiety, depression or situational difficulties, for a period of therapeutic listening which the GPs themselves are unable or unwilling to provide. This person could be a practice counsellor, or a clinical psychologist, or a suitably trained CPN.

General practitioners given direct access to CPNs tend to refer increasing numbers of patients with minor psychiatric morbidity and situational crises, increasing the caseloads of CPNs, who may be diverted from the severely mentally ill (Wooff & Goldberg, 1988). However, from the GP's perspective, the 10% to 20% of patients presenting at the surgery with minor morbidity demand much more attention than the handful of patients with long-term mental illness in each practice (Goldberg & Huxley, 1992).

To contract for clinic sessions in the surgery

Fund-holding practices may wish to secure more psychiatric services on-site. A national survey of mental health professionals working on-site within general practices found that larger training practices were more likely to have such services than smaller practices, regardless of sociodemographic indicators of need (Kendrick *et al*, 1993). Small practices can become fund-holders only by banding together (because of the rule about a minimum size of list). Therefore fund-holding may further skew the provision of

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mental health services within general practice towards the larger practices.

To modify out-patient policies

Fund-holders may wish to stipulate that patients should not wait more than a maximum agreed time for an assessment, that new referrals see the consultant rather than a registrar, and that follow-up appointments are given only where clear objectives are identified. These provisions may reduce the potential for out-patient experience for psychiatric trainees.

To change to a different provider

Ultimately, the influence of fund-holding GPs depends on their power to go to another provider and thereby take away the funding of their local unit. However, most practices will wish to remain with a local provider, and retain their goodwill. Fund-holders are aware of the dangers of accepting cheaper deals from private providers, which can be renegotiated once the NHS provider has been abandoned ('loss-leaders'). However, there have been reports of practices which straddle district boundaries switching between NHS providers for community nursing services (Kingman, 1993).

Implications for users of mental health services

If fund-holders divert money from CMHTs to pay for practice counsellors, patients with long-term mental illness may receive fewer services as a result. The guidance outlined above, stressing the needs of the severely mentally ill and the care programme approach, is aimed at avoiding this scenario (NHS Management Executive, 1992). However, the changes have potential implications for longer-term users of psychiatric services.

Since the purchaser/provider split, user groups have begun to work with DHA purchasers, helping them to define needs for services, revise draft contracts, monitor existing services through visits or surveys, and contributing to planning (Campbell, 1993). Where a district contains many fund-holders, however, the power of the DHA is weakened, and user groups must try to influence many different purchasing decisions by many different practices, a less focused task.

Ideally, users should be informed when their practice becomes fund-holding, and be encouraged to help their GPs make decisions about the placing and content of contracts. However, in many cases users will be unaware of their practice's fund-holding status, and the GPs may not have had the time so far to have held meetings to discuss purchasing with users.

Implications for working arrangements with purchasers and providers

Consultant psychiatrists and nursing managers should participate in negotiations with fund-holders, or they may be asked to change their practice in ways they find unacceptable.

Consultants have been reminded that clinical need should dictate the priority of cases, rather than financial considerations (Ross, 1992). However, consultants may face a difficult task when this implies that they should ignore contracts negotiated between fund-holders and their units.

It behoves consultants, in particular, to work together with fund-holders to develop protocols for referrals. Providers have been asked to watch for cost-shifting by fund-holders (whether by inappropriate referral to the less expensive members of the CMHT, or by encouraging patients to refer themselves), and to alert the RHA to follow up any such instances through the FHSA.

International perspective

The basis of funding the NHS from its inception in 1948 until 1991 was to give money directly to hospital and community units. The problem with this system was a lack of any external accountability as to how such funds were used. The ever-present waiting-lists for hospital treatment were blamed on widespread inefficiency as much as on under-funding.

The purchaser/provider split was intended to introduce accountability on the part of service providers, by giving them money indirectly, through purchasing agencies. Fund-holding general practices share some of the features of health maintenance organisations (HMOs) in the USA, in which family doctor services are provided to registered members, and secondary care services are purchased on their behalf. However, the fund-holding practices are much smaller units than HMOs.

Two problems may result from the NHS reforms, which will be familiar to doctors working in systems based on individual or group health insurance schemes. The first is 'cream-skimming', or biased selection, through which the purchaser tries to exclude patients who are likely to need a lot of expensive care from joining the scheme. So far there have been no reports of fund-holders adopting such practices.

The second problem is an increase in administration costs. This is especially likely where service providers have to gather detailed information about the patients of particular practices,

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which is what fund-holders demand. The Labour Party (1993) has already suggested that fund-holding is too expensive in terms of administration and computing costs.

Conclusions

Although fund-holding has been regarded as the 'wild card' of the NHS reforms, as it did not fit in with the general aim of giving purchasing power to districts responsible for assessing their populations' needs for services, fund-holding nevertheless has had a remarkable effect. This is because fund-holders have been prepared to change provider altogether, which the understandably more cautious DHAs have not been prepared to do.

Psychiatrists have been urged to beware the shift in power and resources away from secondary care into primary care, and to start paying more attention to GPs' perceptions and needs. More than ever, it is time for psychiatrists to define their own role very clearly, or risk being replaced by cheaper, more flexible providers of mental health services (Thomas, 1992).

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