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# **The Cornerstone of Labour's 'New NHS': Reforming Primary Care**

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***DISCUSSION PAPER 168***



**THE CORNERSTONE OF LABOUR'S 'NEW NHS':  
REFORMING PRIMARY CARE**

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## **ABSTRACT**

Two remarkable aspects of the Thatcher 'internal market' reforms of the NHS were the focus on creating a market for hospital services and the way in which primary care was treated almost peripherally in the 1989 White Paper (Department of Health 1989a). The 1991 NHS reforms introduced general practitioner (GP) fundholding almost as an afterthought, and the revision of the GP contract in 1990 Paper (Department of Health 1989b) was conducted separately from the implementation of other health care reforms.

In contrast the principal focus of Labour's 'new NHS' reform is primary care (Department of Health 1997). The intention of the government is both to improve the efficiency and equity of primary care provision and to develop Primary Care Groups and Primary Care Trusts which both provide care efficiently and act as agents who purchase secondary and tertiary care on behalf of patients. This is an ambitious agenda.

This paper explores the policy context of Primary Care Groups in sections 1 and 2, describes and appraises the government proposals in section 3, and identifies major issues involved in the implementation of change in section 4.

## 1. THE SUPPLY OF PRIMARY CARE

The 1911 National Insurance Act created a system of primary care for employees. Their agents were non-profit making Friendly Societies, which collected contributions and paid general practitioners on a capitation basis.

Negotiations preceding the introduction of the National Health Service, between the Atlee Labour Government and the British Medical Association (BMA), were fierce. The Labour Minister of Health, Aneurin Bevan, adopted the proposals of the BMA's Medical Planning Commission of 1942, and proposed a mixed remuneration system of basic salary, capitation and fees per item of service. However, he also wished to adopt planning controls to restrict entry of new GPs into 'over doctored' areas (Timmins 1996). The BMA resisted such controls, arguing that the plans:

would lead to a full time salaried service under either the state or local government. Doctors would be reduced to civil servants, clinical independence and freedom of speech would be threatened, and Bevan himself as Minister of Health would have enormous powers to direct them.

Thus salaried service was avoided, and GPs had independent contractor (self employed) status, with local Family Practitioner Committees (FPCs) replacing the Friendly Societies as the 'bank clerk' which paid GPs according to agreed financial rules. FPCs, like their predecessors, the Friendly Societies, were price takers, making no attempt to purchase primary care efficiently. *De facto*, they left the profession to ensure 'value for money' in health care.

For the first ten years of the NHS, the role of family doctors was ill defined. Around 40 per cent of GPs were single handed, and many had lists of 3000 patients, working from their own homes with little or no additional support. By the end of the 1950s there was a declining trend in the number of young doctors electing to work in general practice, and recurrent themes of 'low morale' and 'crisis' in general practice were firmly established by the early 1960s. After protracted negotiation between the Ministry of Health and the profession, a 'Doctors' Charter' was introduced in 1965. This created a remuneration system combining capitation and practice allowances, with additional item of service fees. It also increased funding for premises and practice staffing, encouraging the formation of partnerships and establishing a stronger academic base for the specialty of general medicine.

The Doctors' Charter maintained the independence of general practice and the passive role of funding agencies. The 'red book', which set out the terms and conditions of a practitioner, declared that a GP 'should provide those services generally provided in general practice'. This circular definition went unnoticed by government, which trusted the doctors to practice efficiently and be rigorous 'gatekeepers' to the expensive hospital system. It has since been described as the John Wayne contract - 'a GP's got to do what a GP's got to do ...!' (Dowson and Maynard 1985).

The system appeared to operate frugally because of the conservative practices of the GPs and the modest demands of the population up until the 1970s. In the 1980s, general medical services (GMS) expenditure, in real terms and per capita, began to inflate more rapidly (table 1). The growth rates from 1975-76 to 1989-90 were significant. However, there has been an even greater increase in real expenditure in the 1990s, and sharp differences in funding of primary care have emerged between the constituent parts of the United Kingdom. By 1996-97, annual spending per capita was £57 in England, £156 in Wales, £85 in Scotland and £40 in Northern Ireland.

**Table 1: Increases in General Medical Services Expenditure per capita, United Kingdom, 1975-1997. Index 1974-75 = 100**

Year	England	Wales	Scotland	Northern Ireland	United Kingdom
1975-76	102	104	106	105	103
1979-80	107	107	108	105	106
1985-86	147	151	148	149	147
1989-90	176	176	172	172	172
1995-96	233	542	288	170	248

Source: *OHE Compendium of Health Statistics, 1997.*

This marked growth trend is the product of price and volume effects particularly for pharmaceuticals and personnel.

The rate of growth of expenditure on pharmaceuticals over the last 20 years has been considerable, with over 12½ per cent of NHS expenditure now devoted to drugs. This is partly due to net ingredient costs (NICs), which have increased by a quarter from 1985-95 (table 2), again with marked national variations. Volume has also increased by one third over the same period, again with national variations. The rate of inflation in volume has accelerated considerably since 1985.

**Table 2: Pharmaceutical volume (prescriptions per capita) and net ingredient cost**

Year	England		Wales		Scotland		Northern Ireland		United Kingdom	
	N	NIC	N	NIC	N	NIC	N	NIC	N	NIC
1985	6.8	101	8.8	100	7.1	100	8.5	111	6.9	101
1990	7.5	112	9.8	110	8.3	110	9.7	125	7.8	112
1995	9.0	125	11.8	124	9.9	127	11.9	155	9.2	123
% growth rate	32	24	34	24	39	27	40	44	33	25

N: annual average prescriptions per capita

NIC: Net ingredient cost per prescription

Source: *OHE Compendium of Health Statistics, 1997*

The other main cause of cost inflation in primary care has been expenditure on staff. Between 1985 and 1995 the number of GPs in England grew by over 11 per cent. However, more noticeably, the number of practice nurses and other staff increased even more rapidly, by 350 per cent and 117 per cent respectively (table 3). Thus, the average list size has fallen and new staff are available to substitute for GPs in providing care for patients in primary care.

**Table 3: General Medical Services Staffing**

Staff (England)	1985/86	1995/96	Growth rate (%)
General medical practitioners	24035	36702	11.1
GP practice staff (whole time equivalent)	27394	59476	117.1
Practice nurses (whole time equivalent)	2211	9966	350.7
Average list size	2068	1887	-8.8

The primary care sector has grown rapidly during the last fifteen years, with expenditure of £10.5 billion in 1999. The Thatcher government constrained hospital expenditure vigorously in the 1980s but did not focus on efficiency and cost control in the rapidly expanding GMS budget (Bloor and Maynard 1993). The Secretary of State for Health at the time of the 1991 reforms, Kenneth Clarke, was concerned about the 'black box' of primary care. He sought to tackle pharmaceutical expenditure, encouraging generic prescriptions and introducing a negative list, and to monitor GP activity more systematically.

The principal obstacle to improved control was the combination of inadequate information and little management capacity. There was no systematic measurement of the volume, quality and cost of services provided. 'One-off' studies demonstrated major variations in medical practice (e.g. hospital referral rates varied over 20 fold in the late 1980s) and evidence of 'on the job leisure': a study in Salford identified average patient contact time by GPs of only 26 hours per week.

The Thatcher government's response to such data was not to measure better and evaluate, but to impose a new contract on GPs in 1990 (Department of Health 1989b). This increased the average GP's compensation from capitation funding to around 60 per cent. The politicians believed, in the absence of adequate evidence, that practitioners would be made more sensitive to patients' needs: if they did not provide what patients wanted, the patient might move to a different GP, although this rarely happened. A new system of fees per item of service was also introduced. There were graduated fees, depending on coverage achieved, for immunisation, vaccination and cervical cytology, which have been successful in achieving increased coverage. Some of the other fees, for example those for health promotion clinics and minor surgery, have been less successful. Minor surgery fees led to increased activity in primary care which did not appear to translate into savings in the hospital sector, and health promotion clinics were inadequately defined. In one case a GP had to be reimbursed for showing a Jane Fonda Workout Video in his practice! The divergence in success demonstrates that fee for service payments can be useful only if 'success' is easy to measure and manage.

For the rest of the Conservative term of government, political rhetoric was to favour a 'primary care led NHS' (NHS Executive 1995). This was ill defined but could be interpreted as primary care being 'A Good Thing' although the evidence base for such rhetoric is absent. Primary care in the United Kingdom over the last 50 years has been characterised by dominance of the general practitioner, and failure to manage resources efficiently and openly. During the 20 years preceding the current government, the efficiency of GPs and their staff as providers of primary care was little questioned. Expenditure was demand determined and grew rapidly. Resource allocation formulae did not address the significant inequities in the geographical distribution of funding, as these applied only to the hospital sector (Bloor and Maynard 1995). In retrospect it is remarkable that primary care not only survived but thrived financially during successive Conservative governments.

## 2. PRIMARY CARE PRACTITIONERS AS PURCHASERS

### 2.1 General Practice Fundholding

Despite the insulation of the supply of primary care from the 1991 reforms, GPs were developed as purchasers of secondary care, taking on the role of fundholders. General practice fundholding was an ‘add-on’ to the 1991 reforms, derived from academic discussions in the early 1980s (Marinker 1984, Maynard 1986, Maynard *et al* 1986). The rationale for fundholding was to increase the awareness of opportunity costs in health care. It was thought that if budgetary responsibilities were combined with clinical responsibilities, GPs would contain costs and use resources more efficiently.

Initially general practices with patient lists exceeding 11,000 were allowed to join the fundholding scheme. Practices could apply for their own budgets from which to purchase a limited list of hospital services, including outpatient services, diagnostic tests and some non-emergency inpatient and day case treatment. The budgets also included all the primary care services provided by general practitioners. A minimum list size was specified to reduce the risk involved with practice fundholding and a stop-loss arrangement was also included: if the annual cost to the practice of hospital treatment for a patient exceeded £5,000, the excess was funded by the host district health authority. Subsequently, the scheme was extended, and fundholders ranged from practices with only 3,000 patients (community fundholders) to schemes involving multiple practices, such as total purchasing pilots. Figure 1 outlines some of the more common examples of GP commissioning arrangements which developed over time.

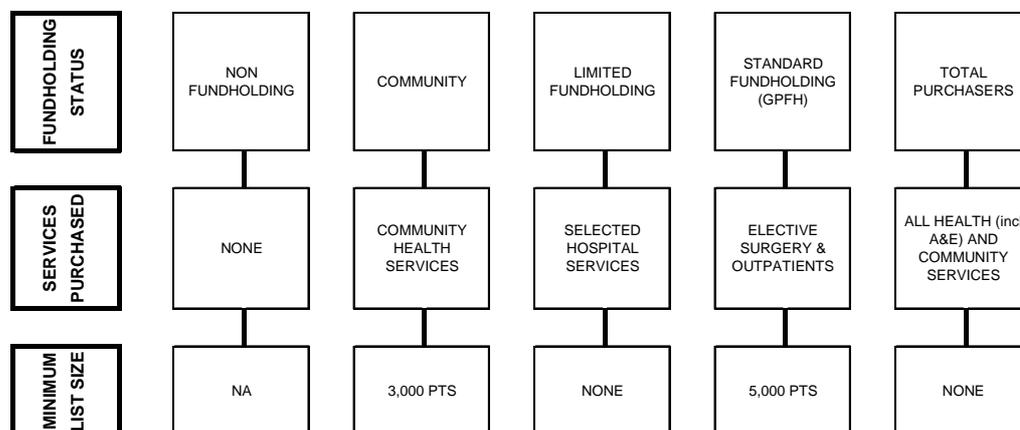


Fig. 1 GP commissioning arrangements

GP fundholders acted both as providers of primary care and purchasers of services on behalf of their practice populations. Despite their secondary importance in the 1989 White Paper (Department of Health 1989a), they appear to have been major catalysts for change, shifting marginal business between Trust hospitals (Glennerster 1994). The scheme was introduced cumulatively, and by 1996 GP fundholders served over 50 per cent of the population in England (Department of Health 1996). It was introduced with considerable additional funding, which both encouraged participation in the scheme, and opposition to it, on the grounds of inequity and a ‘two tier service’ (Bevan 1998).

The Conservative government claimed great success from the scheme, but the evidence to support these claims of success is equivocal. Fundholding was introduced in the absence of formal monitoring and evaluation procedures, and the majority of studies are observational and fail to isolate fundholding effects from other concurrent influences. The published evidence focuses on identifying changes in three broad areas: in primary care, in referrals to the secondary care sector, and in prescribing.

One of the main benefits that fundholding was supposed to realise was a shift from secondary to primary care. As fundholding embodied incentives to reduce referrals, increased primary care activity was expected, as a substitution for secondary care activity. There was some evidence for this. A comparison of 18 fundholding practices and 81 non-fundholders in Lincolnshire, found that fundholders achieved better cervical cytology uptake, child health and pre-school surveillance and undertook higher amounts of paid minor surgery (Baines and Whynes 1996). Fundholders also began to diversify their practices by providing new services (eg physiotherapy) and developing specialist outreach clinics (Corney 1994).

GPs were better contractors than health authorities as they had better information and more motivation to improve service standards and because they could make marginal decisions without causing the confrontation that health authorities would face if they changed provider (Glennester 1994). GPFHs also had financial incentives to limit referrals which were not strictly necessary so that the practice could save money and to encourage patients with private insurance to accept private treatment, the cost of which did not fall on the practice budget. The extent to which these incentives influenced practice remains unclear (Dixon and Glennerster 1995). In a small study of ten first wave fundholding practices and six non-fundholding practices in the Oxford region, which were matched according to various practice characteristics, Coulter and Bradlow (1993) found no evidence that hospital referrals were influenced by budget holding. In contrast, a study of fundholding practices in Scotland revealed a significant reduction in referral rates, matched by an increase in the use of direct access services (Howie *et al* 1995). In another study (Surender *et al* 1995) it was found, that 3 years into the scheme, NHS referral rates by GPFHs had actually increased slightly, and that, contrary to expectations, referrals to private clinics had generally fallen. There was no evidence of a substitution away from specialist care.

Critics of the scheme have argued that fundholding embodies incentives to have patients admitted through casualty rather than via referral, because fundholders do not have to pay for emergency care, but evidence that this happened is weak. In an analysis of more than 50,000 episodes in the South West Region, no indication was found that fundholding had an impact on the proportion of emergency admissions to hospital (Toth *et al* 1997). Baines and Whynes (1996) found referrals were contrary to the hypothesis: their comparison of 99 practices in Lincolnshire showed fundholders had a lower ratio of emergency to elective admissions. The authors suggest this may have been because GPFHs were more successful in placing elective contracts than health authorities.

The impact of fundholding on prescribing has received more attention in the literature than any other single aspect of GPFH activity. Early studies suggested that GPFHs were more successful than non-fundholders at containing drug costs (Bradlow and Coulter 1993, Maxwell *et al* 1993, Wilson *et al* 1995), but longer term analyses are less clear (Glennerster *et al* 1994, Harris and Scrivener 1996). Over the period since the introduction of fundholding there has been a general and pronounced rise in overall prescribing costs, irrespective of the fundholding status of practices. Evidence about whether the rate of inflation has been lower for GPFHs than other practices remains a subject of debate.

The most comprehensive study of prescribing costs, featured all general practices in England for the six years from April 1990 to March 1996 (Harris and Scrivener, 1996). This analysis demonstrated that prescribing costs had increased by up to 59% in fundholding practices and by 66% for non-fundholders over the period. For each fundholding wave, a small relative reduction in prescribing costs was observed in the year prior to fundholding. Maximum reductions occurred in the first year but tailed off to the extent that increases in costs were similar to that for non-fundholders beyond the third year of fundholding status. Fundholding was associated with cost escalation of 6% less than that of non-fundholding over the five year period of its existence. This is not a particularly substantial return on the significantly more generous investment received by fundholding practices. This was the conclusion reached in an Audit Commission report: fundholders made relatively modest changes to patient benefits and management capacity, and may not have provided sufficient improvements to justify their higher cost (Audit Commission 1996).

Limited though these benefits were, questions have been raised about whether they could be attributed to fundholding at all. Fundholding was a voluntary scheme and it may be that those practices which participated would have been successful anyway. In an examination of the possibility of selection bias, Baines and Whynes (1996) concluded that 'practices obtaining fundholding status in the early waves were those most capable of achieving success as officially assessed'. Consequently, caution should be exercised in attributing changes in activity to the fundholding status of the practices. Moreover, innovations were not exclusive to fundholding practices: practices were reviewing prescribing protocols and investing in new facilities long before fundholding was introduced (Corney 1994).

Fundholding also generated vociferous opposition, most particularly because it was perceived to be inequitable. This inequity took two forms (Bevan 1998). First, patients registered with fundholders appeared to enjoy preferential access to secondary care compared to those registered with non-fundholders in the same health authority (Dowling 1997, Beecham 1997, Audit Commission 1996). Second, per capita funding available for fundholder patients was more generous than that for patients funded directly from health authority budgets (Dixon 1994, Dixon *et al* 1994, National Audit Office 1995).

In summary, it seems that fundholding was inequitable and had failed to generate benefits of significant enough magnitude to justify the expense of the scheme. The experiment was poorly evaluated and had not run its course. Various alternatives were being adopted toward the end of the Conservative government's final term in office. The most innovative of these was total purchasing.

### 2.1. Total purchasing

The NHS Executive introduced the total purchasing pilot (TPP) initiative in 1994, following local developments in GP fundholding (NHS Executive 1995). Standard fundholders took responsibility for purchasing a much wider range of services, such as maternity services and inpatient mental health (Mays and Mulligan 1998). Unlike standard fundholding and other aspects of the 1991 reforms, the total purchasing pilots were constructed as experiments, and evaluated in a three-year 'before and after' study. Total purchasing pilots were implemented with minimal central guidance, leading to considerable variation among them (TP-NET 1997). Mays and Mulligan (1998) refer to the TPPs as 'selective purchasers' because most were not, in fact, 'total' purchasers: many gave responsibility back to their health authority for the purchase of some services, such as accident and emergency and forensic psychiatry.

There were 53 first wave TPPs, which went 'live' in April 1996. A year later, they were joined by 35 second wave TPPs. 37% of TPPs comprised single practices, the median population covered was 23,000 patients and approximately 5% of patients in England and Wales were covered by TPP (Mays *et al* 1998).

Direct management costs of running TPPs over and above fundholding varied from £10,000 to £99,000 for single practice projects and from £1,000 to £339,000 for multi-practice projects, reflecting diversity in scale, scope, ambition and managerial infrastructure (Posnett *et al* 1998). Overall, it was expected that rolling out total purchasing more generally would have led to a net increase in the management costs of primary care commissioning (Killoran *et al* 1998). The highest performing TPPs, in terms of their reported achievements, had considerably higher management costs than the lowest performing projects. They also appeared to have more GP involvement, contributing to these direct management costs (Place *et al* 1999).

Evidence relating to total purchasing has been summarised by Mays and Mulligan (1998)

- TPPs varied greatly in size, management arrangements, budget arrangements and reported achievements.
- Total purchasing is more ambitious and more costly to run than standard fundholding.
- There was limited evidence on whether TPPs have achieved service efficiency objectives, but projects have altered the use of acute services in terms of admissions and bed days, reporting achievement of around half their self-defined objectives.
- Total purchasing probably had greater scope for promoting equity than standard fundholding, depending on budget negotiations with the Health Authority.
- Little was known about the quality of services delivered under total purchasing, and most TPPs did not formally assess their patients' needs or systematically use research evidence to inform their service provision.
- There was limited accountability other than ensuring financial accountability, and TPPs did not give high priority to informing or involving patients in purchasing decisions.

### 3. PRIMARY CARE IN THE 'NEW NHS'

#### 3.1. Introduction

While acknowledging that it was not without benefit, New Labour's White Paper formally announced the demise of fundholding:

Despite its limitations, many innovative GPs and their fund managers have used the fundholding scheme to sharpen the responsiveness of some hospital services and to extend the range of services available in their own surgeries. But the fundholding scheme has also proved bureaucratic and costly. It has allowed development to take place in a fragmented way, outside a coherent strategic plan. It has artificially separated responsibility for emergency and planned care, and given advantage to some patients at the expense of others. (Department of Health 1997 s5.5)

The rhetoric of New Labour is that GP fundholding has failed. This voluntary and partial system was replaced in April 1999 with a comprehensive and compulsory system of Primary Care Groups (PCGs) many of which, in time, are expected to evolve into Primary Care Trusts, which will be freestanding organisations.

PCGs were introduced in the White Paper 'The new NHS: modern, dependable' (Department of Health 1997), with similar concepts presented in consultation documents for Scotland (Scottish Office 1998), Wales (Welsh Office 1998) and Northern Ireland (Northern Ireland Office 1998). Plans for primary care outside England are less developed, due to devolution of power to the constituent parts of the United Kingdom. Legislation to change the organisation of primary care will be undertaken by the legislative assemblies in Scotland, Wales and Northern Ireland. The policy was described as 'going with the grain', aiming to 'keep what has worked about fundholding, but discard what has not'. PCGs have been established across the country, 'bringing together GPs and community nurses in each area to work together to improve the health of local people' (Department of Health 1997).

#### 3.2. Primary care in England: Primary Care Groups

The functions of primary care groups are described in the White Paper (Department of Health 1997), and developed in later guidance (HSC 1998a-e).

The government intends that PCGs will:

- commission health services for their populations from NHS Trusts, within the framework of the Health Authority's Health Improvement Programme (HImP), ensuring quality and efficiency;
- monitor performance against the service agreements they (or, initially, the Health Authority) have with NHS Trusts;
- develop primary care, by joint working across practices, sharing skills, providing a forum for professional development, audit and peer review, assuring quality and developing the new approach to clinical governance, and influencing deployment of resources for general practice locally. Local Medical Committees (LMCs) will have a key role in supporting this process;

- better integrate primary and community health services and work more closely with social services on both planning and delivery;
- contribute to the HImP, helping to ensure that it reflects the perspective of the local community and experience of patients;
- promote the health of the local population, working in partnership with other agencies.

Performance criteria for these functions have not been articulated. The form of PCGs is intended to be flexible and to reflect local circumstances, building on existing arrangements such as total purchasing, locality commissioning groups and multifunds. There will be four optional and progressive forms of involvement, and PCGs are expected to progress so that in time all assume fuller responsibilities:

I Supporting the Health Authority in commissioning care for its population, acting in an advisory capacity.

II Taking devolved responsibility for managing the budget for health care in their area, formally as part of the Health Authority.

III Become established as freestanding bodies accountable to the Health Authority for commissioning care.

IV Become established as freestanding bodies accountable to the Health Authority for commissioning care and with added responsibility for the commissioning of community health services for their population

The Government has legislated to introduce freestanding level III and IV Primary Care Trusts (PCTs). PCTs may include community health services previously provided by existing NHS Trusts, and community NHS Trusts may merge with PCTs to integrate service and management support. Ultimately, PCTs will be able to run community hospitals and other services but will not take responsibility for mental health or learning disability services, although links with these services will be developed.

A core set of requirements applies to all levels of PCG/Ts. They are to be accountable to the Health Authority (HA) and required to:

- be representative of all GP practices in the PCG;
- have a Governing Body which includes community nursing and social services as well as GPs drawn from the area;

- take account of social services as well as HA boundaries, to help promote integration in service planning and provision;
- abide by the local HImP;
- have clear arrangements for public involvement including lay representation on the Governing Body and open meetings;
- have efficient and effective arrangements for management and financial accountability.

Each PCG has a Governing Body, consisting of between 4 and 7 GPs, 1-2 nurses, a local social services authority representative, a Health Authority representative, a lay member and the PCG Chief Executive. This will be quorate only when there are a majority of GPs present and GPs will have first refusal on the chair (Milburn 1998). This policy permits continued medical dominance of primary care, which sits uneasily with the move towards multidisciplinary primary health care teams.

PCGs were intended to develop around natural communities and existing local groups, taking account of the boundaries with social services and typically serving around 100,000 patients, with the largest serving more than twice this number. It is unclear how this recommended figure was determined as it exceeds the optimum size to minimise management costs or to spread risk (Place *et al* 1999, Bachmann and Bevan 1996). It may be that by covering large 'natural' communities perceptions of a 'two-tier' service and rationing by postcode will be less in evidence.

Beyond level I, PCGs will be funded with a unified cash limited budget and will have the opportunity to 'deploy resources and savings to strengthen local services and ensure that patterns of care best reflect their patients' needs' (HSC 1998b). This budget covers hospital and community health services, prescribing and GMS infrastructure. For the first time this effectively cash limits the overall prescribing budgets, as overspends on prescribing will mean reduced expenditure on other services to stay within the overall budget. Up to now, prescribing budgets have been 'demand-determined', without an overall limit. Indicative budgets will be used for individual practices, but the PCG will have to develop mechanisms for ensuring that these budgets are not overspent. Practice level incentive arrangements are encouraged to promote best use of resources. Such incentives will require careful specification and monitoring. The inclusion of the practice infrastructure component of general medical services (GMS) in the budget has been of particular concern to GPs, but subsequent policy indicates that expenditure on staff, premises and computers will be subject to a minimum guaranteed floor (Milburn 1998).

Management costs for PCGs will be combined with that for the Health Authority, with a limit of £3 per head estimated for management costs initially, increasing as PCGs take on more responsibilities or merge with community trusts. Analysis of the transactions costs of TPP suggests that PCGs may have difficulties living within this envelope, particularly if contributing parties (GPs, nurses and other professionals) are to be adequately reimbursed for their (management) time devoted to the PCG (Killoran *et al* 1998; Place *et al* 1999). Over time as PCGs move to higher levels, the balance of monies between the PCG and HA may change, although this will require a scaling down of HA duties, perhaps facilitated by further HA mergers. It is also possible that PCGs will start to share functions without full merger (Smith *et al* 1999).

Health Improvement Programmes of Health Authorities determine much of the work of a PCG. PCGs should influence the development of HImPs and will be accountable for their implementation. Preparation of documents such as Primary Care Investment Plans and Organisational Development Plans will also be required from PCGs. PCGs will specify and maintain service agreements with NHS Trusts about the quality and level of care provided in hospitals.

Accountability is maintained through an Accounting Officer to the Health Authority. HAs will monitor and advise PCGs, offering additional direction if an individual PCG falls behind its peers, and has the power, in extremes, to withdraw or reduce responsibilities, or change leadership and management. As well as financial accountability through an Accounting Officer, a senior professional within the PCG will be nominated to be responsible for clinical governance and quality of clinical care. Individual practices will also be encouraged to identify a leader for clinical governance. To achieve Trust status, PCGs must demonstrate that they have a systematic approach to monitoring and developing clinical standards in practice. The Primary Care Investment Plan and annual Accountability Agreements, containing key targets, objectives and standards, will be required by the Health Authority.

These plans are ambitious and novel. The surviving dominance of GPs, much of it ceded by ministers in negotiation in 1998, makes them liable for the successes and failures of PCGs. The novelty of these reforms lies in seeking to manage (control) primary care, to reduce practice variation and enhance quality, openly and efficiently. Previously GP practices, particularly when acting as providers rather than purchasers, have been independent 'islands' in the uncharted waters of primary care. This era of no accountability is clearly at an end: price taking is being translated into price making.

### *3.3. The current situation*

481 primary care groups were introduced in England in April 1999. These are all constituted as committees of their local Health Authority with the Chairs (usually GPs) accountable to the Chief Executive of the Health Authority. From 1 April 2000, 50-60 PCGs in England will be selected to move to Trust status. The requirements for this move are not yet known and will be determined by future guidance.

The heterogeneity of PCGs is considerable. Some are based on existing arrangements, such as GP multifunds or total purchasers, and may find 'promotion' to Trust status straightforward. Others are fragmented in terms of their previous status and the development of internal management and external collaboration. Such organisations have limited management capacity and lack the information systems required for the efficient development of practices within PCGs and appropriate collaboration across groups.

It is unlikely that the existing stock of PCGs will survive many years. As Trust status spreads, amalgamation seems likely, and Chief Executives and other staff currently being recruited may be reorganised and even made redundant in such mergers.

## 4. FUTURE CHALLENGES

### 4.1. Introduction

An underlying motivation for the introduction of PCGs is the belief that patients will benefit by further extending the role of primary care so that more (and, supposedly, better) decisions are made by those who are the first port of call for most users of the NHS. Moreover, by obliging all GPs to adopt one or other option, the two tier system associated with fundholding will be less in evidence. Also, because PCGs have responsibility for more than simply a practice list they may be able to plan more strategically for their local population than fundholding allowed, particularly as they will be expected to commission in accordance with their local HIMP. But, in making primary care the cornerstone of their health care reforms, the current Labour government faces challenges. Four particular challenges relate to organisation structure, clinical governance and maintenance of quality, financial accountability and rationing.

### 4.2. Organisational size and structure

PCGs are to be larger organisations than most preceding models of primary care commissioning in the NHS. It may be that this will make them better able to manage risk but, apparently, larger groupings are not required for this. A simulation exercise exploring the budgetary implications of rare costly referrals suggested that a risk pool of 30,000 may be adequate (Bachmann and Bevan 1996). Moreover, risks may be more manageable over the longer time frames that Health Service Agreements, rather than contracts, allow.

PCGs may be able to realise economies of scale from amalgamating practices. As GPs commission for a wider range of services for a larger population the fixed costs associated with needs assessment, writing the purchasing plan and contracting can be spread among more patients. This suggests that costs will fall as PCGs grow in size. However, at some point such economies will be exhausted. Evidence from analysis of Health Maintenance Organisations (HMOs) in the USA, which have been likened in certain respects to PCGs (Ham *et al* 1998), does not provide a clear answer. Given (1996) suggests that returns are exhausted at 115,000 enrollees, while Wholey *et al* (1996) argue that economies are realised at only 50,000 enrollees. The continuing amalgamation of managed care companies on the basis of asserted economies of scale casts some doubt on these figures.

One crucial difference between HMOs and PCGs (at least in the short term) is the contractual status of their medical staff. The staff of HMOs are typically salaried employees while GPs are likely to remain as independent contractors. While it is relatively straightforward to achieve harmony among GPs and to get them to accept budgetary responsibility when managing a single practice's fundholding budget, the administrative burden associated with coordinating GPs from the practices comprising the PCG may compromise any economies derived from creating larger commissioning groups. Analysis of the transactions costs associated with Total Purchasing suggests a substantial amount of management time is spent on co-ordinating GPs and communicating organisational objectives. Furthermore this cost increases the more GPs are involved (Place *et al* 1999). To mitigate these coordination

problems, PCGs may adopt a range of organisational structures which allow them to balance strategic against day-to-day management (Street and Place 1998, Smith *et al* 1999).

Reform is likely to bring with it the gradual alteration of the GP contract of employment. In 1997 the Conservative government, with Labour support, passed legislation to facilitate pilots of salary paid GPs. In late 1998 the then Minister of Health, Alan Milburn, indicated that it was the government's intention to reform doctors' contracts. Such reform has always been expensive (Klein and Maynard 1998) and this time is unlikely to be different. The creation of a new salaried system of GPs would require shift working, skill substitution and careful management of the new contract with performance criteria to ensure activity and quality.

#### 4.3. *Quality and clinical governance*

The recent NHS reforms promise profound changes in the government of general practice. With acceptance by the General Medical Council and the Royal College of General Practitioners of the need for re-accreditation of all practitioners every five years, quality guidelines will be central to the professional development of medical and other staff. The reforms also place a statutory duty of maintaining quality of clinical care on the Chief Executives of hospital, community and primary care Trusts. At present they have only a financial responsibility under the law (to break even and make a 6 per cent return on historic capital investment). The creation of this new duty of 'quality' introduces a new agenda in risk management, clinical audit and quality assurance for all managers.

The initial definition of clinical governance was vague (Department of Health 1998):

a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

However, since then it has become clear that quality relates not just to clinical effectiveness but to cost effectiveness. The discussion document about the role of the National Institute of Clinical Excellence (NICE) (Department of Health 1999) makes it clear that companies wishing to have their products accepted for reimbursement by the NHS must demonstrate cost effectiveness if they are to be incorporated into NICE guidelines.

General practitioners will receive these NICE guidelines, which will have varying levels of application depending on the robustness of the data. One of the earliest guidelines is likely to be for the use of beta interferon in the treatment of multiple sclerosis. This is an area where medical practice variation is considerable and 'postcode' rationing is much criticised.

A guideline like this will be issued with a degree of obligation to GPs: they will be expected to adhere to the guideline or face management interference. An interesting issue, given the independent contractor status of GPs, is to consider how implementation of NICE guidelines will be monitored, and what are the implications if a GP refuses to adhere to the guidelines. Such behaviour will incur the displeasure of a PCG or PCT Chief Executive, who has a duty of quality related to NICE guidelines. Also it will attract the attention of the Commission on Health Improvement (CHI). This organisation will audit Trusts thoroughly every three to

four years and will respond to high profile incidents where quality is in question. The pressures for GPs to conform will be considerable.

However, with the focus of NICE being predominantly on pharmaceuticals, at least initially, the need for improved management information will be acute. An obvious source of pharmaceutical prescribing information is the Pharmaceutical Pricing Authority (PPA). At present all dispensing chemists send their prescription forms to PPA, who reimburse pharmacists and collate information. This information role could be developed by augmenting prescriptions with a diagnostic code and a patient identifier. This would create an invaluable data set for epidemiologists and managers. NICE practice guidelines will target interventions at particular patient groups and an augmented PPA information system could be used to measure speed and the extent of adherence to guidelines by practitioners. There will be economies from a national system and such data will be an invaluable source for research.

The costs of introducing clinical governance have not been estimated. At present plans are vague and evolving, but the resource consequences of professional, Trust, NICE, CHI and PPA investments will be considerable. There is a risk that parsimony and poor management may lead to the fragmentation and failure of some elements of this long overdue process of regulating the quality of primary care.

#### *4.4. Financial accountability*

In general, attempts to increase GP involvement in commissioning have been rationalised either as a means to improve patient access and service delivery through the inclusion of a primary care perspective in the commissioning process or to make GPs directly accountable for the resource consequences of clinical decisions. The former aim may be achieved by introducing PCGs as advisory bodies only (ie PCG I), but clearly the government envisages a more substantial role.

Experience suggests that in order to make GPs financially accountable they must be actively engaged in the management of a budget. In many of the multi-practice sites forming TPPs, GPs were content to delegate financial responsibility to the lead GP and the TP management team, but this reduced the extent to which GPs faced direct incentives to alter their own practice. Unless peer pressure is strong, the aim of engaging all GPs within a local group will probably require notional budgets set at practice level (even if budgets are aggregated for management purposes) and it requires significant investment in co-ordinating the views and actions of GPs.

In order to make GPs financially responsible they must be sufficiently motivated to work with their colleagues in the PCG towards developing and realising common organisational objectives. All GPs are obliged to participate in a PCG of one form or another. However, the incentive for these independent (and generally individualistic) contractors to cooperate with one another and accept interference in their decision making is not obvious (Butler and Roland 1998).

For those who were not opposed to fundholding on ideological grounds, there were clear incentives to taking on fundholding status, as it promised GPs greater leverage and autonomy about where, when and how their patients were treated and the prospect of generating savings to plough back into the practice. As much larger conglomerations it will be interesting to see how individual GPs, particularly fundholders and non-fundholders, grouped in the same PCG reconcile their differences and come to a shared vision about the overall objectives of the PCG. Compared to practice based fundholding it is likely to prove more difficult to reach consensus and to ensure that all GPs consider the wider interests of the PCG when making clinical decisions which have financial implications. We should not be surprised if some GPs resist any attempt to make them participate in a scheme which has the prospect to reduce their own autonomy.

Nevertheless if PCGs are to be financially accountable and manage within their budgets, they will have to develop mechanisms for monitoring and perhaps limiting GP referral and prescribing behaviour. This is a major challenge and requires a balance of rewards and penalties. Health authorities have found it difficult to manage activity and their global budgets, in part because they are a step removed from the GPs who make many of the decisions which determine the pattern of service provision. It is hoped that PCGs will be in a better position to operate within a global budget by virtue of involving GPs in the management structure.

However, with a comprehensive budget set at PCG level, GPs will face restrictions on their referral and prescribing behaviour in order to meet the constraints of this global budget, despite the government having given assurances that restrictions will not be imposed:

*Patients will continue to be guaranteed the drugs, investigations and the treatments they need. If a primary care group overspends, the overspend will be managed within the funds made available to health authorities generally and to the NHS more widely, much as health authority overspends are handled now. There is no question of anyone being denied the drugs they need because a GP runs out of cash. GPs' participation within a PCG, or membership of a PCG board will not affect their ability to fulfil their terms of service obligation always to prescribe and refer in the best interests of their patients. I can guarantee that the freedom to refer and prescribe remains unchanged. (Milburn 1998).*

One of the central concerns of the White Paper and subsequent documents is the variability in access to and use of services throughout the country (Department of Health 1997; 1998). This is being addressed at all levels of the NHS, with the National Institute for Clinical Excellence providing overall guidance about effective and cost-effective practices, Health Authorities being monitored according to their performance in reducing variations, and Trusts and PCGs introducing clinical governance mechanisms.

Clearly, referral and prescribing variations will have to be managed by PCGs to ensure greater efficiency and to remain in budget. Alignment of clinical and financial accountability and the desire to reduce treatment variations is incompatible with political assurances that the freedom to refer and prescribe remains unchanged. The get-out clause from the Department's perspective is that the Milburn letter states that 'patients will continue to be guaranteed the drugs, investigations and the treatments they *need*' [emphasis added].

Responses to patient needs must be cost-effective: the freedom to refer and prescribe remains so long as it is justifiable.

GPs appear to be under no illusion that limits are to be placed on their clinical freedom and that the 'best interests of patients' should be defined as the overall interests of the broader population for which the PCG is responsible, rather than merely the patient in the consulting room. Among the challenges facing those working in PCGs is their ability to manage a global budget and, in particular, what mechanisms they should employ to prevent over-spending.

The Department of Health, after 50 years of pressure from the Treasury, is attempting to cash limit the GMS budget. However, it is realising only partial success. The non-GP part of the budget is to be cash limited and allocated by weighted capitation formula similar to that used in the hospital sector. The reluctance to tackle the issue of the gross inequities in the distribution of GPs (e.g. many more per capita, even with need weighting, in the South West than the North East) is related to the power of the medical profession to resist change and influence policy makers.

#### *4.5. Rationing*

A paradox of the NHS debate is that the government denies the existence of rationing but, like its predecessor, it reforms the structures of the NHS to improve the efficiency of resource allocation (rationing). The allocative goal of the NHS is to use resources efficiently so that potential population health gains are maximised from its limited budget. The pursuit of this goal requires the practice of economics based medicine. However, whilst governments vigorously espouse the cause of 'value for money', they are reluctant to confront the rationing issue explicitly and fully. The logical consequence of Milburn's statement and the constitution of NICE is that resource allocation will be informed, if not determined, by cost-effectiveness criteria.

The Labour government also expresses concerns about equity. The Acheson report on inequalities in health (Independent Inquiry into Inequalities in Health 1999) described familiar findings about the growth of inequality, but failed to cost and prioritise its recommendations. This leaves a lack of clarity about the equity goals of the government, their ranking in relation to other goals, and the preferred nature of trade offs.

What principles of rationing might be implied from the behaviour of politicians and the electorate? Williams (1996) suggests the following three criteria, which may form a basis for debate and consensus formation:

1. Equals should be treated equally and with due dignity, especially when near to death.
2. People's needs for health care should be met as efficiently as possible (imposing the least sacrifice on others).
3. Inequalities in the lifetime health of the population should be minimised.

At present, government policy, through the creation of clinical governance, NICE and CHI, is focusing its rationing efforts on efficiency (2 above). This is incomplete. Health care professionals may at times practice inefficiently because of social objectives, such as the high valuation of new born children, which may require resources not to be used cost effectively. This implies a strong equity objective (i.e. 3 above). The policy question is therefore how much efficiency (health gain) is society prepared to sacrifice to pursue equity goals? Ignoring such issues makes medical practice difficult and undermines the acceptability of evidence based practice guidelines to be produced by NICE.

## 5. CONCLUSION

The historical failure to manage primary care provision in an efficient and open manner has been condoned, as politicians continued to advocate a 'primary care led NHS' and developed the capacity of primary care to purchase secondary care services. The paradoxes implicit in these policies are as significant as the variations in primary care practice and the relative absence of management systems.

The government's reform of primary care is of great importance to the sector itself and to the NHS as a whole. In the last decade there has been a failure to ensure openness and accountability in primary care performance, as reform energy has previously been directed at the hospital system. This failure means that the task of primary care reform is more difficult. For example, GPs are now having to respond to activities such as audit which were imposed in the hospital sector around a decade ago. The government have an ambitious agenda which is yet to be determined fully and which will be costly. As ever this will raise hopes and antagonism. Aneurin Bevan's view was that 'the only way to get a message across to a doctor is to write it on a cheque'. Primary care reforms in the next decade may well require increased expenditure, but will also require clearly articulated objectives, shrewd management and careful performance assessment.

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