Recent Developments in Primary Care in the United Kingdom

From Competition to Community-Oriented Primary Care

Marek Koperski, MB, MSc, and Jonathan E. Rodnick, MD
San Francisco, California, and London, England

In 1990, changes to the National Health Service (NHS) in the United Kingdom introduced a form of US-style competition that broadened the role of general practitioners (GPs). However, the changes (called GP fundholding) produced greater inequality between practices and reduced the capacity of the NHS to plan strategically. Alternative models have been developed that retain the increased influence of primary care, promote community-oriented primary care (COPC), and facilitate strategic planning. A recent proposal from the government turns away from the competition model of 1990 to encourage GP commissioning. It offers the opportunity to create an NHS that is led by a primary care agenda, including better links with the community, and a focus on public health and social services with the goal of improving the health of populations.

KEY WORDS. Primary care; public health; United Kingdom; family practice. *(J Fam Pract 1999; 48:140-145)*

In 1990, 1 year after the Loma Prieta earthquake shook California, the United Kingdom's National Health Service (NHS) experienced a shake-up of a different nature but of similar proportions. Margaret Thatcher's government introduced the most extensive reorganization in the history of the NHS.[1] That reorganization created an internal market that encouraged controlled competition among existing NHS facilities.[2] Its design was influenced by an American, Alain Enthoven, one of the gurus of managed care.[3] The current state of this reorganization is, therefore, of particular interest to a US audience. Furthermore, in 1997 the Blair government introduced its own radical proposals for "The new NHS—modern, dependable."[4] This paper focuses on the primary care aspects of these reorganizations and makes comparisons with changes occurring in the United States.

THE NATIONAL HEALTH SERVICE

Last year marked the 50th anniversary of the NHS, an organization that was developed by a post-World War II Labour government in response to a national consensus. It guarantees universal access and a comprehensive range of services provided to patients without charge. There is central control over the budget, 96% of which is funded through taxation and 4% through patient copayments.[5] Private medical insurance accounts for approximately 5% of all spending on health care.[6] Hospitals are geographically located in proportion to local populations. Specialists are hospital based and salaried by the NHS according to nationally set pay scales. They provide both inpatient and ambulatory care for patients coming from general practitioner (GP) referrals or emergency situations.

Submitted, revised, November 16, 1998.
From the Department of Family and Community Medicine, University of California, San Francisco (M.K., J.E.R.) and the Department of Primary Care and Population Sciences, University College London and Royal Free Schools of Medicine (M.K.). All requests for reprints should be addressed to Jonathan E. Rodnick, MD, Department of Family and Community Medicine, University of California–San Francisco, Box 0900, San Francisco, CA 94143. E-mail: rodnick@itsa.ucsf.edu

GENERAL PRACTITIONERS

The primary care system in the United Kingdom is well developed, and each person chooses a GP for first contact care and primary care. GPs then take care of a defined group of patients (and families) who sign on with him or her. The average list size is 1850 patients who generate an average of 3.5 office or home visits per patient per year.[5] Approximately 80% of the patients on a GP's list will consult the GP in any 1 year.[6] Although most GPs do not provide care for hospitalized patients, they work closely with nurse midwives in delivering babies. Most GPs still do home visits and provide care for their patients in nursing homes. GPs are self-employed but sign a contract with the NHS to be responsible for the health of the patients on their lists in return for a mixture of capitation and fee-for-service (FFS) payments. GPs' responsibilities include preventive care; for example, they are rewarded financially if they ensure that more than 90% of eligible children on their lists have been immunized. GPs accept that some of

their work is population based. That work includes social as well as biomedical care, such as decisions about eligibility for public housing.[7]

GPs make up approximately 50% of all trained UK physicians, and completion of a 3-year residency program is compulsory. An important aspect of the residency is the assignment of third-year residents to teaching practices where they function as junior partners and cease to care for hospital patients. GPs typically practice in small groups and lead primary care teams that consist of their group of GPs (usually 4 or 5 physicians), other health professionals (eg, home- and practice-based nurses, midwives, community nurses, psychotherapists, physiotherapists, and social workers), and an administrative staff. GPs usually own the buildings (health centers) in which they work and can sell these on retirement, but they cannot sell the business.

THE THATCHER REORGANIZATION

Health Authorities and Trusts

Health authorities are geographically based NHS administrative organizations that cover a population ranging from 250,000 to 1,000,000 and allocate funds to all health providers. Health authorities assess and plan for the health needs of their local population. Before 1990, they administered and funded hospitals within their area. In the 1990 reforms, health authorities became "purchasers." Hospitals and community services providers became self-managing trusts, and instead of a global budget, hospital trusts had to compete for contracts from purchasers. Hospital trusts managed hospitals, and community trusts were responsible for community services not provided by GPs, such as specialist mental health, community nursing, and podiatry.

GP Fundholding

Selected GP practices were also encouraged to become purchasers (fundholders) by applying to the health authorities for a budget to cover drugs and the purchase of up to 20% of all specialty and hospital services for patients on their lists. GP practices could apply for fundholding if they were computerized and had more than 11,000 patients on their lists (this number was later reduced to 5000). Inevitably, these were the better-run practices.[8] Purchasing was usually done by direct negotiation with providers (eg, for all hip replacement operations for the upcoming year). To determine their future fundholding budget, practices started with a preparatory year during which use of hospital and specialty services and their associated costs were tracked. Fundholders were given an additional annual allowance of $55,000 per practice to spend on personnel to help manage the fundholding process. A stop-loss provision ensured that annual costs in excess of $9000 for any single patient were picked up by the health authority. Fundholders could use any funds remaining in the budget at the end of the year to enhance patient services provided by their practices but not to increase their own salaries. There was no financial risk to fundholders and little personal financial gain. Health authorities continued to purchase all hospital and specialty services on behalf of nonfundholding GPs, as well as the remaining 80% of these services for the patients of fundholders.

Successes of Fundholding

Unfortunately, the government did not set up any process for evaluating the fundholding experiment, so it has remained controversial.[9,10] Studies of prescribing costs have shown mixed results. Fundholding practices did decrease prescribing costs initially, mainly through generic prescribing, but the subsequent rate of increase paralleled that of other GPs.[11,12] There is some evidence that fundholders have shorter waiting times for hospital inpatient and outpatient procedures.[13] These savings, if any, have come with substantial administration and transaction costs.[14]

By 1995-1996, approximately 41% of the population was covered by fundholding practices,[15] though many GPs participated reluctantly, and the geographic distribution was uneven. Fundholding reached 90% in some prosperous areas, while in inner city London the proportion of patients affected was less than 5%. In 1995-1996, $97 million that had previously been spent on hospital and specialty care was transferred to spending on innovations and services in GP practices, as a result of fundholder contracting.[9] There was a perceived shift in the balance of power between GPs and specialists with GPs controlling more medical resources.[10,16]

Problems of Fundholding

Despite some reduction in hospital charges, fundholders produced no evidence of reduced hospital use.[17] Fundholders had strong bonds with local hospitals and were often reluctant to disrupt traditional patterns.[18] The cost-effectiveness of fundholding remains dubious.[8,9,13] Hospitals that had not generated patient bills before initially underpriced their services, and sometimes did not bill the GP fundholders. But the transaction costs of small-group purchasing and fundholders' management allowances added $365 million in administrative costs in 1996.[8] Inequities developed because prosperous areas had more fundholders and gained more resources. Practices had an incentive to inflate their costs in the preparatory year, because this gave them an overgenerous budget in future years.[16] Since there was a finite amount of money, overgenerous allocations to fundholders left nonfundholding GPs and their patients with less than their fair share.[16] Fundholders who overspent were bailed out by the health authority, using money allocated to nonfundholders. For successful fundholding, one of the 4 or 5 GPs (usually the senior partner) had to be a skilled manager and negotiator. Not enough GPs had these skills, and few fundholders developed sophisticated purchasing systems or initiated major changes.[8] In answer to many of these criticisms, fundholders say that they were not really "let loose" until

the plan had been running for 2 to 3 years. They had to maintain, for example, at least 80% of traditional hospital contracts in the first 2 years.[17]

Perhaps the greatest strength of fundholding was also its major disadvantage: the theory that small is beautiful. Fundholders were able to achieve rapid, tactical change in their contracts without destabilizing hospitals;[15] but their changes were demand-led, short-term, small-scale modifications of existing services.[10,19] Planning in the NHS became fragmented, because fundholders did not usually follow their health authority's annual plan to meet the health needs of the local population (for example, to expand services to the elderly). Administrative costs were high, as each practice had to develop its own purchasing data and staff.

Many fundholders understood these problems and merged into larger groups called multifunds.[20] Others felt that fundholding could never prove itself until it was able to purchase all services.[21] They persuaded the government to allow demonstration Total Purchasing Projects (TTPs) that would be externally evaluated.

Total Purchasing Projects

By 1997, there were 80 TPPs covering from 12,000 to 70,000 patients each. TPPs are essentially health authority subcommittees controlled by GPs. They involve multiple fundholding practices that not only contract for 20% of patient services under fundholding but also influence the remaining 80% through the TPP. They receive a budget for all medical services but give a large portion to existing health authority contracts, allowing them to focus on specific areas, such as emergency hospital admissions. They are conceptually similar to large US medical groups that have full-risk contracts with health plans. In many TPPs, GPs have to receive approval from a peer review committee before referring to nonselected providers, and nurse reviewers follow hospital patients to ensure appropriateness of admission and length of stay.[22]

The aim of most TPPs is to reduce hospital use and redirect money into primary care. But TPPs can only redirect up to 5% of savings; the rest must be returned to the health authority. As in fundholding, there is no financial risk, and savings cannot be used to increase GP remuneration. However, some TPPs give each member practice a development budget for new projects, provided the TPP makes its forecasted savings.

An Alternative Model—Commissioning

Many physicians remained vehemently opposed to fundholding, saying it contradicted the basic equity principles of the NHS.[23] Health authorities continued to purchase all consultant and hospital services on behalf of these nonfundholding GPs. It was natural for these GPs to seek other methods of influencing purchasing. The Medical Practitioners' Union had developed such a method, called GP commissioning.[24] GP commissioning groups theoretically commission (ie, grant authority to) hospitals and others to provide services to patients. Commissioning is a broad concept that involves a cycle of processes: (1) assessing health care needs in a defined population; (2) planning improvements; (3) specifying needed services; (4) purchasing and contracting with providers; and (5) monitoring and evaluating.[25] Commissioning is similar to community-oriented primary care (COPC), but this latter term is not widely used in the United Kingdom. Both concepts, commissioning and COPC, emphasize a model of primary care in which the health problems of a defined population are systematically identified and addressed. The development of commissioning groups was remarkably fast, and they received official government recognition in 1996, when they represented 25% of GPs.

Commissioning groups are formed when the GPs in a health authority area elect members who meet monthly with appointed health authority staff. Each member takes on an area of responsibility, such as women's health, and holds regular meetings with their constituent GPs. The health authority pays for administrative support, as well as support for data collection and analysis. Once a problem is identified, commissioning group members meet with specialist physicians and health authority and hospital managers to discuss and devise specific solutions. Cooperative change is preferred, but if progress is poor, financial penalties can be invoked. For example, a commissioning group noted poor local specialist care for people with major back problems and negotiated a contract with another center for back care. This forced the local hospital to appoint a new surgeon. Consequently, patients and their GPs had a choice of surgeons with shorter waiting times.[25]

Concerns about the effectiveness of commissioning groups, as they control no budget and only advise health authorities, have been summarized by the quote, "One GP with a checkbook is worth 10 GPs on a committee."[26] Commissioning groups have other problems, as well: like fundholders, they are not formally accountable to their patients; not all GPs will support their representatives' decisions; and many GPs are reluctant to take further responsibility for rationing services in an underfunded NHS.[10]

A Primary Care–Led NHS

Initially, the primary intention of fundholding was to create competition between purchasers rather than involve GPs in health care planning or resource allocation.[10] As a result of the development of commissioning groups, TPPs, and fundholding, the government has begun to recognize that GP involvement in health care planning might be beneficial: a bottom-up approach. By the mid-1990s, the term "primary care–led NHS" became commonly used in the NHS. Its features include provision of the maximum range of services in the community close to where people live, closer partnership between primary and secondary care, close involvement of primary care professionals in the commissioning of all health care and social care, reducing hospital dominance in decision making in the NHS, and

involvement of the public in decision making.[26] The primary care–led NHS seeks to involve patients, caregivers, and social services, as well as primary care professionals.

THE BLAIR PROPOSALS

In May 1997, the Labour party won a landslide victory at the polls. The new government committed itself to abolishing fundholding[27] and published its proposals in December 1997. Perhaps the most radical element of these proposals is that GPs will lead new organizations called primary care groups (PCGs). PCGs will eventually adopt responsibility for commissioning 80% to 90% of all health services (some mental health services, for example, are excluded). The NHS will become primary care led, but at a cost: All NHS services will have a fixed annual budget that can not be exceeded (currently, areas such as drugs prescribed by GPs have no fixed budget). PCGs will be geographically based and will usually be composed of approximately 50 GPs and 100,000 patients.[28] The goal of creating larger groups covering populations of 100,000 is to reduce transaction costs, inequity between practices' populations, and fragmentation of planning. PCGs will work within a local health improvement plan. The health improvement plan will be drawn up annually by the health authority and public health professionals after consultation with hospital and community trusts, PCGs, locally elected officials, and the public.

PCGs will be led by a board which will include GPs, community nurses, social services representatives, and members of the general public. Four stages of gradual development are proposed: (1) At minimum, PCGs will be responsible for GP prescribing costs and will support the health authority in commissioning care for its population, acting in an advisory capacity; (2) PCGs will take devolved responsibility for managing the budget for medical care in their area, formally, but as part of the health authority; (3) PCGs will become established as freestanding bodies accountable to the health authority for commissioning most medical care; and (4) PCGs will be given the added responsibility for the provision of community trust services, such as specialist mental health, for their population. PCGs are the next step in the evolution of the role of GPs in public health; they build on existing commissioning groups and TPPs. In US terms, stage 3 is similar to taking on a full global-risk contract.

Furthermore, demonstrations called health action zones have been created in areas of poverty and poor health. These will undertake other novel approaches to health care with NHS, local authorities, business representatives, and members of the community working collaboratively within a single budget to tackle health problems.

DISCUSSION

Fundholding grew out of the US-style managed care reforms but remained controversial throughout its short life. Similar reforms were introduced in Sweden and New Zealand, and in all 3 countries the reforms seem to have failed and have been substantially modified as a result.[4,29,30] However, fundholding spurred the development of commissioning groups, TPPs, and PCGs. These changes emphasize fairness, eliminate a 2-tiered approach, are GP-led, integrate health and social services more effectively, reinstate strategic planning, involve the public, and emphasize cooperation rather than competition.[31]

There will still be substantial differences between the US and UK health care systems. In particular, the NHS is centrally organized, offers universal access, and has a tight annual budget. GPs lead primary care teams and have good information systems (more than 90% have electronic medical records). More recently they have taken on a formalized public health role and have become more involved in strategic planning. However, the basic ingredients of a good family practice are similar in both countries: emphasis on treating common problems, maintaining the physician-patient relationship, and continuity of care. Gatekeeping and rationing decisions are being made daily by physicians in both systems. In both countries, GPs and family physicians have developed their own academic principles, which include a psychosocial approach,[32,33] prevention,[34] and a strong epidemiologic perspective.[35]

The changes in financing and organization in the United Kingdom and the United States reflect national cultural values. The initial UK reforms, based in part on US-style health care of 1990, emphasized competition for provision of services to individual patients. But the NHS had a culture of equity for all patients and national planning within tight, fixed budgets. The reforms did not succeed, in part because of the lack of a financial and administrative infrastructure to purchase health care, but more important, because they were contrary to important social values. The new synthesis, emphasizing a more COPC-like approach and regionwide planning, would have difficulty being accepted in the United States, where the needs and wants of the individual are paramount, and planning is done primarily to gain market share. Additionally, the NHS is trying to meld social and health services, particularly for its poor and elderly population, a proposition that would be impossible with the fragmented social and public health structure in the United States.

The new proposals will bolster the health authorities' strategic role by replacing the emphasis on competition and the internal market with cooperation. They place GPs in a pivotal position alongside health authorities and involve them in needs assessment. However, in exchange for this new power, GPs will become more accountable both financially and for the quality of primary care (a role some primary care physicians have already accepted in the United States). In both systems, if patient satisfaction and quality does not improve or costs are not held down, primary physicians are vulnerable to being blamed for broad-

er system failures. GPs could become the fall guys for an underfunded NHS, because the proposals offer little extra funding for the NHS. In a similar vein, US primary care physicians are experiencing a backlash, as their new gatekeeper role is perceived as a barrier to choice and access to specialists, a role well accepted by doctors and patients in the United Kingdom.

The Blair proposals offer the opportunity to develop commissioning (and the concept of COPC) through structured public involvement and cooperation between health care, public health, and social services. The potential of COPC to improve morbidity and mortality by putting these principles into practice has been demonstrated over 25 years by Julian Tudor Hart, a pioneering British GP.[36] However, the development of COPC in the United States has been slow because of the fragmented nature of the health care system and a lack of consensus on how to define a community and how to address its health problems.[37]

CONCLUSIONS

Can the United States learn from the recent UK reforms? There are a number of possible changes in the US managed care landscape that could be modeled on the UK reforms. Perhaps health maintenance organizations (HMOs) should be encouraged to develop physician advisory committees similar to commissioning groups. Perhaps indicators similar to those of the Health Plan Employer Data and Information Set (HEDIS) should be expanded to cover more social issues in health care to encourage HMOs to address broader issues, such as family violence or teenaged pregnancy? Could PCG-like super groups be developed to help primary care physicians negotiate with HMOs or directly with employers? Should formal mechanisms be set up to encourage physicians and hospitals to work with health departments and governmental agencies to address population health?

Medicine, including its allied industries, has developed during this century into a powerful force, its paradigm focusing on treatment of the individual with ever more complex and expensive technology.[35,38] Placing primary care groups in overall charge of the NHS budget will likely reduce the emphasis on this paradigm and shift resources away from high-tech individual treatment. A cooperative venture between local people, social services, and a GP-led NHS will be focused more on prevention, reducing inequalities, and improving the health of the population. It is an experiment US physicians should watch carefully.

ACKNOWLEDGMENTS

Marek Koperski thanks the following, who made his fellowship in the United States possible through their generous support: UK Department of Health, Fulbright Commission, Kings Fund, Clare Wand Fund, Royal College of General Practitioners, and his partners at the James Wigg Practice: Fred Kavalier, Roy MacGregor, Phil Posner, Jane Sackville-West, and Gill Yudkin.

REFERENCES

1. Secretary of State for Health. Working for patients. London, UK: Her Majesty's Stationery Office, 1989.
2. Light DW. From managed competition to managed cooperation: theory and lessons from the British Experience. Milbank Q 1997; 75:297-340.
3. Enthoven AC. Reflections on the management of the National Health Service. London, UK: Nuffield Provincial Health Trust, 1985.
4. Secretary of State for Health. The new NHS—modern, dependable. London, UK: Her Majesty's Stationery Office, 1997.
5. Orton P, Fry J. UK health care: the facts. Hingham, Mass: Kluwer Academic Press, 1995.
6. Fry J, Light D, Rodnick J, Orton P. Reviving primary care. Oxford, UK: Radcliffe Medical Press, 1995.
7. Day P, Klein R. Controlling the gatekeepers: the accountability of GPs. J R Coll Gen Pract 1986; 36:129-30.
8. Audit Commission. What the doctor ordered: a study of GP fundholding in England and Wales. London, UK: Her Majesty's Stationery Office, 1996.
9. Keeley D. General practice fundholding and health care costs. BMJ 1997; 315:139.
10. Coulter A. Assessing GP involvement in commissioning. In: Singer R. GP commissioning an inevitable evolution. New York, NY: Radcliffe Medical Press; 1997.
11. Rafferty T, Wilson Davies K, McGavock H. How has fundholding in Northern Ireland affected prescribing patterns? A longitudinal study. BMJ 1997; 314:166-70.
12. 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.
13. Dowling B. Effect of fundholding on waiting times: database study. BMJ 1997; 315:290-2.
14. Smith RD, Wilton P. General practice fundholding; progress to date. Br J Gen Pract 1998; 48:1253-7.
15. Smith R. The total purchasing group—relations between individual GPs, practices and the health authority. In: Smith R, Butler F, Powell M, eds. Total purchasing a model for locality commissioning. New York, NY: Radcliffe Medical Press, 1997.
16. Corney R, Kerrison S. Fundholding in the South Thames Region. Br J Gen Pract 1997; 47:553-6.
17. Surender R, Bradlow J, Coulter A, Doll H, Stewart-Brown S. Prospective study of trends in referral patterns in fundholding and non-fundholding practices in the Oxford region, 1990-4. BMJ 1995;311:1205-8.
18. Coulter A, Bradlow J. Effect of NHS reforms on GPs' referral patterns. BMJ 1993; 306:433-7.
19. Black N. Clinical governance: fine words or action? BMJ 1998; 316:297-8.
20. Smith R. An introduction to total purchasing. In: Smith R, Butler F, Powell M, eds. Total purchasing, a model for locality commissioning. New York, NY: Radcliffe Medical Press, 1997.
21. Smith R. Contracting for change. In: Smith R, Butler F, Powell M, eds. Total purchasing, a model for locality commissioning. New York, NY: Radcliffe Medical Press, 1997.
22. Henry S, Morris L. An alternative model-developing total purchasing in Wiltshire and Bath. In: Smith R, Butler F, Powell M, eds. Total purchasing, a model for locality commissioning. New York, NY: Radcliffe Medical Press, 1997.
23. Smith R. Challenging doctors: an interview with England's chief medical officer. BMJ 1994; 308:1221-4.
24. Medical Practitioners' Union. Before you consider fundholding, consider the alternatives. London, UK: Medical Practitioners' Union, 1991.

25. Jenner D, Dixon M, Morgan G. Commissioning group at work—the mid-Devon experience. In: Singer R, ed. GP commissioning an inevitable evolution. New York, NY: Radcliffe Medical Press, 1997.
26. Singer R. Bridging the divide. In: Singer R, ed. GP commission an inevitable evolution. New York, NY: Radcliffe Medical Press, 1997.
27. Mays N, Goodwin N, Bevan G, Wyke S. What is total purchasing? BMJ 1997; 315:652-5.
28. Dixon J, Holland P, Mayo N. Developing primary care: gatekeeping, commissioning and managed care. BMJ 1998; 317:125-8.
29. Whitehead M, Gustafsson RA, Diderichsen F. Why is Sweden rethinking its NHS style reforms? BMJ 1997; 315:935-9.
30. Malcolm L. GP budget holding in New Zealand: lessons for Britain and elsewhere? BMJ 1997; 314:1890-2.
31. Editorial. Primary care and the NHS white papers. BMJ 1998; 316:1687-8.
32. White KL. The task of medicine: dialogue at Wickenburg. Menlo Park, Calif: The Henry J Kaiser Foundation, 1988.
33. Balint M. The doctor, his patient and the illness. New York, NY: International Universities Press, Inc, 1957.
34. Royal College of General Practitioners. Health and prevention in primary care. Report from general practice. London, UK: Royal College General Practioners, 1981.
35. Tudor Hart J. A new kind of doctor: the general practitioner's part in the health of the community. London, UK: Merlin Press, 1998.
36. Tudor Hart J, Thomas C, Gibbons B, et al. Twenty-five years of case findings and audit in a socially deprived community. BMJ 1991; 302:1509-13.
37. Nutting PA, Nagle J, Dudley T. Epidemiology and practice management: an example of community-oriented primary care. Fam Med 1991; 23:218-26.
38. McWhinney IR. A textbook of family medicine. New York, NY: Oxford University Press, 1997.