

Primary Care — From Fundholding to Health Maintenance Organisations?

The introduction of fundholding in 1991 could be seen as an experiment, moving towards an insurance-based health care system by allowing GPs to hold budgets for selected conditions and groups of patients. For the first time since 1948, those holding the budgets for NHS care could pick and choose patients, diseases and conditions on the basis of risk and cost.

Because the UK has a universal health care system, GP Fundholders were able to pass risk back to their district health authority, but the effect of this policy, nevertheless, was to breach the principle of equity. The advantages for health authorities of being able to pool risk across the whole population were lost, leading to a two tier system and undermining equity. The extension of fundholding budgets to other conditions and patient groups was simply an extension of the insurance function.

Ironically, far from abolishing fundholding, the Labour government's White Paper *The New NHS* could be in danger of allowing it to evolve. Unlike its predecessors, the Labour government has not had a blueprint for the NHS. As a result, the NHS is moving rapidly towards a private delivery system, where hospitals and

ultimately Primary Care Groups and Trusts will be controlled by the private sector.

HMOs

In the United States, Health Maintenance Organisations (HMOs) have become large for-profit multibillion dollar businesses. Some of them are owned by doctors, who in turn employ and salary or contract with other doctors. HMOs have three features:

- First, they combine the insurance function with the provider function.
- Second, they do not provide universal coverage: as provider organisations, they are free to pick, choose and select the patients they will cover on the basis of risk. Because of this, they neither serve local geographic areas, nor do they have any direct accountability to local communities.
- Third, they are not restricted in size and are free to compete for patients and populations and buy-out competing services. In many deprived inner city areas, this has led to the buy-out and closure of local services because they are unprofitable and public hospitals are left to serve the most vulnerable groups without the benefit of pooling risk. In many cities, these public hospitals are also threatened or being closed,

leaving virtually no safety net for the poor and the forty million uninsured.

Those left within a largely private and for-profit health care system are more preoccupied with defending their entitlement and benefits than with the failures of the system as a whole. The current middle class revolt against managed care in the US has distracted attention from the 40 million uninsured, of whom 10 million are children.

PCGs

Primary Care Groups (PCGs) are likely to be configured around practice lists rather than serving a population within a defined geographic area. This will make equity in resource allocation and monitoring of health care a challenging if not impossible task, since practice populations are neither stable nor representative of the community as a whole. The difficulties of working with local authorities and social services will also be compounded.

Although it is suggested that PCGs should serve around 100,000, these limits are arbitrary. At the first level they will fulfill an advisory function to health authorities and at the second level they will be allowed to manage their health care budget, but the third and fourth level PCGs will be able to become free standing bodies or

Primary Care Trusts, managing and providing community services, as well as holding the total budget for NHS care.

Risks and dangers

GPs in PCGs will be allowed to hold and combine both the GMS and the HCHS budgets, but the budgets will be capped. There will no longer be the safety valve of emergency admissions and, for non fundholders, the prescribing budget.

The effect of capping budgets means that GPs within primary care will now be rationing care at the point of consultation. Alternatively or additionally, they will have to make careful decisions about which patients they enrol.

PCGs with a cash limited budget may turn to income generation: private health insurance, or encouraging patients to become selfpays. They may develop health care products for sale as a sideline, e.g. nursing homes and rehabilitation, that can be accessed dependant on what the patient can afford.

This is already happening as PCGs buy up community hospitals deemed surplus to NHS requirements, a situation aggravated by current policies on the disposal of NHS assets. All NHS land and estate deemed 'surplus to requirement' under health authority purchasing strategies has to be offered first to other interested NHS parties.

All around the country, GP Fundholders, with private sector backing, are buying up NHS estate deemed 'surplus to requirement'. In Epsom, GP Fundholders in partnership with the private sector have bought up the Epsom and Ewell Cottage Hospital.

Alternatively, GPs and Trusts are entering into joint partnerships with the private sector. South Devon Health Care Trust and the Dawlish Medical Group have entered a PFI deal with McAlpine Healthcare to replace a 17 bed NHS community hospital.

Of course, the transfer of NHS assets to private ownership and management is funded ulti-

mately from NHS revenue. With a cash-limited system, whereby GPs can shift income away from NHS Trusts to commercially owned enterprises in which they hold a leading stake, it is not difficult to see the potential for further destabilisation of publicly owned NHS Trusts. The temptation to mortgage NHS assets to the private sector will increase as GP budgets come under pressure and they look for ways of generating income.

By devolving rationing decisions to primary care, the government can sideline the issue of rationing and it can also continue to keep an ever shrinking NHS service free at the point of delivery. However, PCGs and Primary Care Trusts will not only have to contend with capped budgets, but also the effect of acute service strategies which will take out up to 30% of capacity and shift roughly the equivalent in acute caseload to the community over the next five years in some areas¹.

Substitute services for displaced caseload do not yet feature in government policy or health authority plans, making it a matter of speculation as to whether the government intends ever to assume responsibility for the patients who will be denied care for displaced caseload.

Does the story of long term care foreshadow the rest of the NHS, where the funding responsibility was devolved to individuals, their families and local authorities and where a system of eligibility criteria determines eligibility for care?

Avoiding the HMO route

As the private sector punctures the NHS with an increasing number of entry points, the NHS public sector resistance and immunity will be overcome. The government's uncertainty over PCGs means that the NHS currently has no defence over the inroads being made by the private sector.

Government must rebuild the public sector infrastructure and restore public confidence, using

the values of social justice which shaped the NHS in the first place. It could do four simple things:

First, make PCGs serve geographic populations, so that they provide universal coverage to the whole population, thus avoiding the tendency to cream, skim and select. In so doing, it would need to separate out the responsibilities for managing practice populations from holding the budgets and planning services for the population living within the defined geographic area. The advantage of this approach is that it would inhibit entrepreneurial commercial activity and identify those who are truly interested in public health and planning, while restoring a population focus for health care. It would also support the government's stated objective of separating out planning from administration of services.

Second, it could restrict commercial activities, the sale of private health insurance and use of private sector with NHS funds and the purchase of private assets by PCGs.

Third it needs to introduce proper mechanisms for local accountability, so that PCGs serve and are seen to serve their local communities.

Fourth, it must introduce a proper monitoring system across the whole of the health care system, including standardised data sets for public and private care across all sectors.

Fifth, staff terms and conditions of service must be protected and staff should be retained within the NHS as salaried employees of the NHS. The government also needs to consider how to salary GPs within the NHS. If HMOs evolve, a salaried service will inevitably occur, with some GPs as employers while the rest will be salaried within a private sector.

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