

General practice

Unified budgets for primary care groups

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In April 1999 major changes will start to take place in the organisation and delivery of health services in England.^{1 2} For general practitioners, the most important changes will be the formation of primary care groups and the implementation of unified, cash limited budgets for health services. How will current methods of allocating NHS budgets in England change, and what can be learnt from experience in New Zealand and from total purchasing pilots?

Health authority budgets

Health authority budgets are largely used to pay for hospital and community health services, community prescribing, and the services supplied by general practitioners (general medical services).³ Health authorities are unable to transfer money from one budget to another and cannot use one budget to make up for a shortfall in another. For example, they could not use an "underspend" on the community prescribing budget to cut hospital waiting lists. However, general practice fundholders have had limited ability to move funds between different budgets. Unified budgets for health services will increase this ability to transfer funds between budgets and will extend it to all general practitioners.

Unified budgets in the new NHS

The new primary care groups in England will comprise about 50 general practitioners from all practices in a locality of around 100 000 patients. Although primary care groups will have differing levels of responsibility, all groups will have a unified budget for hospital and community health services, community prescribing costs, and general medical services infrastructure costs (used to reimburse general practices for their practice staff, premises, and computing costs). There will be no immediate changes to the national general practitioner contract, and general practices will continue to receive directly the various fees and allowances for providing general medical services that make up the bulk of their earnings.

The New NHS, published at the end of 1997, did not discuss unified budgets in great detail (see box), and it took some time for general practitioners to become aware of the implications.¹ The main factor behind the introduction of unified budgets is the belief that making general practitioners accountable for the cost as well as the quality of health care will prove to be an

Summary points

Implementation of unified, cash limited budgets for health services means that resource decisions taken by any one practice in a primary care group will impact directly on others

General practitioners will have to take responsibility for limiting the growth in prescribing costs and hospital budgets

To manage their unified budgets effectively, general practitioners will have to work collaboratively with other practices in their group

Primary care groups will have to establish integrated information systems that include utilisation and expenditure data for all practices

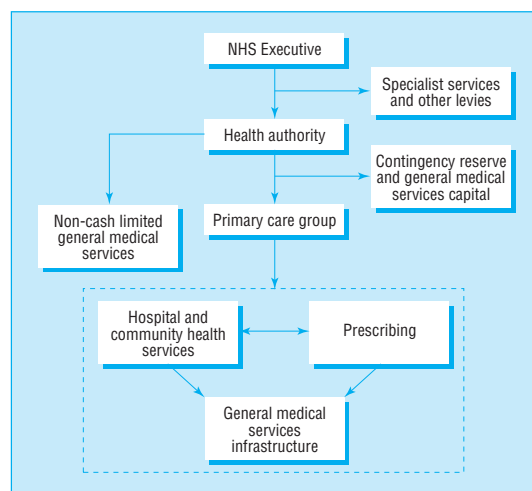
Experience from New Zealand shows that professional leadership and a minimum of bureaucratic control are the key factors in success

effective method of tackling many of the problems facing the NHS.

Before a budget is allocated to a primary care group, some funds will be "top sliced" by the regional office from health authority allocations to pay for specialist services and other levies such as NHS research and development (see figure). Some funds will, in turn,

The New NHS and unified budgets

"Clinical and financial responsibility will be aligned. Primary Care Groups will take devolved responsibility for a single unified budget covering most aspects of care so that they can get the best fit between resources and need. It will provide local family doctors and community nurses with maximum freedom to use the resources available to the benefit of patients, with efficiency incentives at both primary care group and general practice level . . . Over time, the government expects that groups will extend indicative budgets to individual practices for the full range of services . . . It will be open to the group to agree practice-level incentive agreements associated with these budgets, approved by the health authority, where this helps promote the best use of resources."¹



Allocation of budgets in the new NHS

be retained by the health authority to fund its own activities, to cover any overspending by primary care groups, and to act as a contingency reserve. The bulk of the remaining funds will then be allocated to primary care groups (figure). Primary care groups will have differing degrees of control over these funds depending on which of the four levels of responsibility they have achieved.

A striking feature of primary care is the wide variation between practices in the use of resources; and to many managers, these variations suggest that resources are being used inappropriately by some general practices.⁴ Undoubtedly, one of the key factors behind the introduction of unified budgets is a desire to reduce these variations. Hence, primary care groups will need to examine what factors influence variations in the use of resources and utilisation of services, and the extent to which these can be modified through feedback of data and through non-judgmental educational initiatives in general practice.^{5,6}

Protection of general medical services funds

The proposal to pool funds for general medical services infrastructure with prescribing and other health service budgets led to concern among general practitioners that resources earmarked for practice development might be used for other purposes—such as to cut hospital waiting lists. Many general practitioners were concerned that this might lead to a direct cut in their practice's income and hence in their own earnings. To alleviate these concerns, the Department of Health agreed that the general medical services infrastructure component of the unified budget will increase annually in line with inflation and cannot be used for other purposes without the agreement of the local medical committee. In effect, general practitioners can veto any decision to use general medical services funding for any other purpose. However, as the protected part of the unified budget will rise only in line with inflation, while the total NHS budget will increase more rapidly than this, the former will become an increasingly small proportion of the total NHS budget. General practitioners will be under pressure, therefore, to control their prescribing and

hospital costs if they wish to invest a greater proportion of their group's budget in primary care services.

Implications of unified budgets

The formation of primary care groups and the introduction of unified budgets give general practitioners the opportunity to shape their local health services. At the same time, the alignment of clinical and financial responsibility means that primary care groups will have to monitor prescribing, referrals, and admissions more closely than at present. Although the Department of Health has stated that individual general practitioners will have the freedom to prescribe and refer as they see fit, primary care groups will inevitably have to introduce some curbs on general practitioners' clinical freedom. At first these are likely to be voluntary, but in the longer term primary care groups could use financial incentives such as extra investment in a practice to reward those practices which prescribe and refer in line with locally agreed formularies and protocols.⁷

Successful development and implementation of these policies will require greater collaboration between practices than occurs at present.⁸ Total purchasing pilots found that it was very difficult to ensure that practices stayed within budget and adhered to prescribing and referral protocols.⁹ Clinical governance will have a key role in ensuring that improving the quality of clinical care drives these changes and that primary care group meetings do not become dominated by financial issues alone.¹⁰

Monitoring the use of resources

Once primary care groups are in place they will need to set up systems for monitoring how their general practices use resources (box).^{11,12} Whether low or high cost in any particular area of expenditure is associated with improved quality of care or better outcomes for patients is not well understood at present. There is some indication from New Zealand that general practitioners with low prescribing costs provide higher quality care than those with high prescribing costs.¹³ In the United Kingdom, however, the association between the use of resources and the quality of care provided by general practitioners is less clear, largely because this association has been little investigated.

Although it is often assumed that practices with high prescribing costs are poor quality prescribers, table 1 shows that this is not necessarily always the case.

Main areas of expenditure of primary care groups

- Elective admissions to hospital
- Emergency admissions to hospital
- Referrals to outpatient clinics
- Attendances at accident and emergency departments
- General practitioners' prescribing costs
- Cash limited general medical services
- Community health services
- Diagnostic investigations

Table 1 High and low cost prescribing—costs and quality

	Poor quality prescribing	High quality prescribing
Low cost	Poor management of chronic diseases	High generic prescribing rate and cost effective prescribing
High cost	Low generic prescribing rate and inappropriately high use of expensive drugs	Good management of chronic diseases in primary care

Some practices with high prescribing costs may be prescribing appropriately and some practices with low prescribing costs may be prescribing inappropriately. Similar differences in the use of other health services such as laboratory investigations and outpatient referrals are likely. Hence, the association between cost and appropriateness in the use of health services is not always clear.

Despite this, the boards of primary care groups will inevitably take more interest in practices with high costs to ensure that the group as a whole remains within its cash limited budget. To help achieve this, the group will require good comparative data from its main providers about the use of hospital and community services. As NHS information systems are largely geared towards meeting the requirements of health authorities and trusts, some major developments will be needed to meet this objective.^{14 15}

Implications for hospital sector

Since about 75% of the budget of a typical primary care group will be for hospital and community health services, unified budgets will also have important implications for hospital specialists (box).¹⁶ Demand for hospital care has risen steadily in recent years, and if primary care groups are unable to contain these pressures on hospital services their ability to stay within budget will be threatened. The total purchasing pilots were more successful in achieving the objectives they set for primary care services than for hospital services.¹⁷ Primary care groups may well find that this is also the case. Even if they can limit the growth in the demand for hospital services, the poor financial

Implications of primary care groups for hospital specialists

- Hospital specialists may be employed directly by primary care groups, on either a full time or a sessional basis
- There will be primary care physicians with dual accreditation in general practice and another clinical specialty
- There will be public-private partnerships between primary care groups, hospitals, and the private sector
- Greater integration of hospital and community prescribing will develop through joint formularies and better methods of funding high cost drugs
- Hospitals will be under pressure to cut lengths of stay for inpatients and increase day case treatment
- Conflicts may arise between primary care groups (which will want to expand primary care services) and hospitals (which will want keep resources in secondary care)
- Hospitals will face increased competition from primary care groups providing services traditionally seen as appropriate to secondary care

position of many hospital trusts will make it difficult to transfer funds to primary care without destabilising the hospital sector.

Improved prescribing

Some of the prescribing that goes on in primary care is the direct result of decisions taken by hospital specialists. Hence, where primary care groups develop prescribing formularies and guidelines, this will have to be done in collaboration with hospital specialists. Primary care groups can also use their unified budgets to end some aspects of hospital prescribing that many general practitioners find irritating. For example, patients could be discharged with 14 or 28 days' supply of medication rather than the usual seven days' supply. Unified budgets will also provide an opportunity to improve the arrangements for the prescribing of high cost drugs. The cost of prescribing these drugs can be top-sliced from primary care group budgets to ensure that practices who take on patients who require them are not penalised for doing this. Furthermore, if general practitioners do not wish to prescribe such drugs because they feel that the clinical responsibility lies with hospital specialists, unified budgets should allow hospital specialists to prescribe them instead.

Lessons from New Zealand

The new primary care groups have many similarities to New Zealand's independent practitioner associations (table 2). Formed in 1993, these associations now represent the interests of more than 70% of general practitioners in New Zealand. Like primary care groups, they involve formal contracts with the health authority or other funders of health services for collective professional accountability for both the quality of care and financial management.¹⁸ These contracts now include the monitoring and management of clinical activity with collective professional accountability for both quality of care and financial management in general practice.

At the outset, as in England, there was strong opposition from many general practitioners to any form of association or contract. Initial incentives included protecting the status of general practice and being a more effective contracting body. These incentives have now been broadened to encompass more positive goals such as improving quality of care and achieving better outcomes for patients within limited resources.¹⁹ Although there is a wide range of views about these goals and policies such as integrated capitation based budgets, especially within the membership, there is generally strong commitment from the leadership. Associations are now taking responsibility for advancing both the quality and status of general practice and developing more integrated relations with secondary care. The collective nature of the associations means that a wide range of collaborative activities can be organised including the development of guidelines, the development of information systems, education programmes, and the introduction of new services.

The New Zealand associations represented a radical change in the organisation and governance of general practice. As the name indicates, members are

Table 2 Independent practitioner associations and similar groups in New Zealand compared with English primary care groups

Feature	New Zealand	England
Size	At present, from 6 to 340 general practitioners; minimum proposed population is 30 000	A typical group will comprise 50 general practitioners, covering 100 000 patients. Individual groups will cover from 50 000 to 250 000 patients
Type	Independent practitioner associations, local community, Maori and Pacific Island trusts	Initially general practice based groups only, developing into combined general practice and community health trusts in the future
Incentives or motivation	Opportunities to improve quality of care and provide new services, and better integration with hospital services	Opportunities to shape local health services and invest resources in primary care
Membership	Optional	Compulsory
Service budget	At present, general practice services and laboratory and pharmaceutical expenditure	Almost all primary and secondary care services covering around 90% of the NHS budget
Legal entity	Choice of association, usually a limited liability company	Remain accountable to the health authority
Governance and management	Board of directors elected by members	Board of directors of which up to seven, including the chairperson, can be elected by general practitioners
Goals	Improving quality of care and health outcomes	To commission health services and manage the unified budget. Working with the health authority to improve the health of the population
Funding	Moving from historical fee for service to integrated equitable capitation	Current arrangements for paying general practitioners will remain for the foreseeable future
Activities	Wide range at primary care level with increasing emphasis on integration with secondary care	Encouraged to develop primary care, to integrate primary and secondary care, and to collaborate with local social services
Information systems	Well developed at primary care level	Further work required to develop systems
Practice registers	Merged and integrated at association level	Not yet merged at group level
Community participation	Range of initiatives being implemented	Groups will have to consult the local population and take their views into account

independent practitioners competing among themselves for patients. However the associations bring together a new form of leadership in general practice to achieve professional and public goals such as to improve quality of care, make better use of health resources, achieve better health outcomes for patients, and improve the health of the community. Accountability for quality and resource management lies with the board of the association and not at individual practice level. There is strong rejection on both ethical and professional grounds of individual practices retaining any part of the savings from budget management. This demonstrates a new form of governance of general practice that goes beyond the English concept of primary care groups, which is still practice based with some savings retained by practices.

Associations have been active in initiating a wide range of integration projects. These were originally motivated by a desire to achieve a better balance between primary and secondary care along total fund-holding lines. More recent approaches have been based on primary-secondary collaboration. For example, in Christchurch, the Pegasus Medical Group, an association of 208 general practitioners, together with specialists in the medicine of old age, other specialists, and hospital management, is planning to provide for the comprehensive and integrated care of the whole elderly population.

The New Zealand experience also indicates the need for the progressive devolution of funding to associations in order to foster entrepreneurial and innovative developments. As in England, there has been conflict between the associations and funding authorities about the poor financial support given to associations, the level of budgets, how savings are to be distributed, and the extent of power sharing.²⁰ While there seems to be political commitment to devolution in both countries, there is also grave concern in both countries about the scale of this commitment.

The key lesson from New Zealand is that professionally led development from within a group is much more likely to be successful than a bureaucratically imposed framework from above (box). Whether the opposition to

primary care groups currently expressed by many general practitioners in England will wane, as happened in New Zealand, is unclear given the compulsory nature of membership of English primary care groups. Moreover, many general practitioners may find it difficult to balance the budgetary responsibilities of primary care groups with their role as patients' advocates. General practitioners will have to take some tough decisions about the prioritisation of services, which will make them responsible at a local level for rationing decisions that many of them feel should be decided nationally by central government.

The New Zealand experience

Achievements

- Development of collective professional accountability in managing new internal and external relationships
- Collaborative approaches to integration both of primary care (involving general practitioners and other professionals, such as nurses and midwives) and of primary and secondary care
- Extensive development of information systems including merging and managing practice registers, analysing laboratory and pharmaceutical data, and providing personalised feedback to members
- Formulation and monitoring of guidelines on pharmaceutical and laboratory services

Lessons

- Thus far, only modest savings from budget holding, with wide variation in per capita utilisation and expenditure on services adjusted for age, sex, and deprivation indices
- Success in collective/collaborative action to improve clinical decision making requires much more than simple dissemination of evidence based practice and guidelines
- Emerging issues of identifying and achieving equity in association and practice budgets, especially with the low per capita utilisation adjusted for age, sex, and deprivation that is associated with poorer, less healthy populations

Conclusions

The introduction of unified budgets for primary care groups will have major implications for general practitioners. Key objectives for primary care groups will include greater interpractice working, improved financial and information systems, and methods of sharing data among practices. For many general practitioners, the most unpopular aspect of the changes will be that they will have to take much more responsibility for deciding about the prioritisation of services and for controlling prescribing costs and hospital budgets. General practitioners may find that these tasks do not fit well with their role as patients' advocates.

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Setting budgets for general practice in the new NHS

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The centre of the new arrangements for the NHS is the establishment of primary care groups.¹ Budgetary control will be a central concern of these new groups, and the principal instrument for securing that control will be the setting of an indicative budget for each general practice within a primary care group. Although this measure may go some way towards securing the required control, I believe that setting practice level budgets carries potentially serious adverse consequences. This article sets out the problems that health authorities and primary care group management will have to be alert to.

Primary care groups

Primary care groups will be based on all the practices within a geographically defined area covering a population of about 100 000. The groups will receive annual budgets, within which they will be expected to meet virtually all the health care needs of their population. The size of the budget will be determined by the health authority in which the primary care group lies and will be guided by a long term expenditure target set by the NHS Executive.²

Primary care groups are unusual managerial creations. Membership is compulsory, and the constituent practices of a primary care group will be jointly responsible for adherence to its budget. Yet it is not clear how individual general practices will be held to account for their expenditure. The white paper envisages four levels of primary care group, ranging

Summary points

Primary care groups about to be established in the "new NHS" will need to maintain budgetary control at the same time as securing health improvements and commissioning and providing services

An important mechanism for securing budgetary control is likely to be setting "indicative" health care budgets for individual general practices

However good the formula for setting such budgets, actual expenditure will diverge substantially from budget in many practices

Much of this divergence will be beyond the control of general practitioners

A system of budgets for general practices could also result in loss of fairness between patients and disillusionment among general practitioners

Any budgetary system should be implemented with great caution, and, at least initially, the associated rewards and penalties for general practices should be modest