Funding, franchising, and effective primary care

Iliffe's review of the developments in general practice since 1980 (Part I, this issue, 201–6) gives a historical perspective to the current stormy debates. Should general practitioners continue to be responsible for patients on their lists for 24 hours a day, 365 days a year? Should fundholding practices be allowed to spend their 'savings' on improving their premises, even when those premises are owned by the doctors? How should the profession ensure that its members keep abreast of rapidly changing medical science? Is the 'independent contractor status' really so precious that alternative models such as a salaried service cannot be entertained?

General practice in the UK has undergone a major upheaval since 1990, when the 'new contract' between the National Health Service (NHS) and individual general practitioners was introduced. The nature of this 'contract' is, however, by no means fixed. Fundholding arrangements are being revised each year: 'community fundholding' (limited to the purchase of drugs and community-based services) is being offered to smaller practices, while 'total fundholding' (covering everything including emergencies) is to be piloted in others; locally organised salaried doctor schemes are being set up; and general practitioners have become at one time both 'purchasers' and 'providers' of healthcare services. It is this purchaser-provider split which lies at the heart of the NHS reforms, and which has probably influenced the changes in general practice more than the 'new contract' itself. Fundholding has given practices greater control over the way patients receive care in the secondary sector, both directly in the greater freedom of referral, and indirectly through the setting of contracts with providers.

The 'reforms' were vigorously opposed by the profession's representatives through the British Medical Association when introduced in 1990, but it is now acknowledged by the General Medical Services Committee that 30% of practices are fundholding, and that there are identifiable benefits for patients. Iliffe calls for a moratorium on recruitment to fundholding, but it would appear that with 'total fundholding' being promoted as the ultimate model, alongside 'community fundholding' for smaller practices, the NHS thinks otherwise.

Purchasers and providers

As general practitioners come to terms with learning the 'price' of healthcare, they need to be careful not to lose sight of its 'value'. Other countries are following the UK in setting up 'purchaser-provider splits',¹ while the US, in its primarily commercial system, has always had this separation. Healthcare has always had a cost, but only recently, in the NHS, an explicit price. Price and cost should in theory be closely related, but in practice wide variations exist

between providers. Mason and Morgan's review¹ of four emerging purchaser-provider systems, and the managed care systems found in the US, clarifies the present situation in the NHS, and sets it in a wider perspective.

The franchise model

Iliffe suggests that general practitioners are like 'franchises', local small businesses, all purveying the same commodity to their customers, but under total quality control from the franchisor, the NHS! In some ways this 'McDonald's' model fits: the NHS is the major source of income for most general practices, but there is little evidence that the NHS through its Family Health Service Authorities exerts effective control over the quality of the 'product'. Iliffe's powerful critique of fundholding raises uncomfortable questions about the effect of this uncontrolled experiment in re-organisation, which only rigorous research will answer.

What of the future?

'Vision' is a fashionable term in management circles, which has recently appeared in the general practice literature.² My vision for general practice would be for every individual and family to have access to a well-qualified doctor whom they knew by name, and who knew them; and for every doctor working in primary care to be fully qualified to handle the initial presentation of any problem, and to hold in the highest esteem that relationship between doctor and patient that is central to 'good general practice'.³ There should be available within primary care teams a range of health professionals, all sharing a common understanding of healthcare, and of the therapeutic relationship.

The model of primary healthcare found in the NHS remains, despite its recent changes, the best opportunity for realising that vision: every person registered with a named doctor trained to a recognised standard, with adequate time for consultations, and appropriate referrals to the full range of healthcare services, the supply of which is regulated by need, grounded in evidence-based criteria.⁴

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- 2 Sainsbury P, Dowrick C. Vision workshops – a planning tool for general practice. *Educ Gen Pract* 1995; 6: 62–8.
- 3 Horder J, Moore GT. The consultation and health outcomes (editorial). *Br J Gen Pract* 1990; 40: 442–3.
- 4 Smith R. Towards a knowledge-based health service (editorial). *BMJ* 1994; 309: 217–8.