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Institute for Health Policy Studies
Southampton

"Why do GPs choose not to apply for fundholding?"

by

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A short paper based upon this study appeared in the BMJ 1995; 311: 166.

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1. INTRODUCTION

The Executive letter Developing NHS Purchasing and GP Fundholding issued on 20 October 1994 makes it clear that the expansion and development of GP fundholding is high on the Government's agenda. The booklet accompanying EL(94)79 states that:

> *"The experience of the past four years has shown that purchasing delivers more appropriate services for patients when GPs are involved, and particularly where they are involved by taking on the direct control of resources used by their patients."*

Certainly the last four years has seen a dramatic expansion in the extent to which GPs have taken direct control of resources through fundholding. When the scheme was introduced on 1 April 1991 there were 306 first wave practices in England covering seven per cent of the population. By April 1994 over two thousand practices had become fundholders (1673 funds) and these practices covered 35 per cent of the population. Over the same period, there have been a number of independent studies carried out which have sought to document the reasons why many GPs have chosen to become fundholders, and the impact that the scheme has had on the way in which they purchase and deliver services. (Glennerster et al.,1992,1994a,b; Duckworth et al.,1992; Newton,1993; Bradlow et al.,1992; Coulter and Bradlow,1993).

In contrast, there has been little systematic attention focused upon the reasons why most GPs have chosen not to apply for fundholding status. One exception is a pilot study carried out by Leese and Bosanquet (1994). As part of a more general study of the impact

of the 1990 Contract, they asked 37 practices in one FHSA for their views on fundholding. This study, which was carried out in 1992, highlighted concerns about a two tier service, adverse effects on the doctor-patient relationship, unnecessary administration and increased workload. Elsewhere, a 1993 survey of 66 non-fundholding practices reported in the magazine Fundholding indicated that ethical objections were the main reason cited by non-fundholders for not wanting to join the scheme, although differences in views between partners were also a stumbling block (Fundholding, 1993). Other indirect evidence about views of non-fundholders has been made available in the course of descriptions of alternative models of GP led purchasing (Black et al., 1994).

In general, however, attitudes among non-fundholding GPs towards fundholding have not been well researched. This represents a serious omission if a major expansion of GP fundholding is indeed to be a central plank in the development of primary care led purchasing in the future. How will existing non-fundholders view this policy thrust? How will they respond? Will the factors that have deterred them from applying for fundholding status in the past continue to deter them in the future? These are the types of questions upon which this study sought to throw some light.

The study took place in the South & West Regional Health Authority over the period 1 September - 30 November, 1994 and involved in-depth interviews with 19 non-fundholding practices. In each practice we endeavoured to interview, separately, the senior partner, one other partner and the practice manager. This aim was achieved in the case of 17 practices; in the other two, only one partner and the practice manager were able to be interviewed. In each interview a semi-structured questionnaire was used in order to examine the attitudinal

and organisational factors which had led the practice to decide against applying for fundholder status. This report contains our findings.

The report is divided into five main sections. Following this introduction, Section Two provides some background data on the growth of fundholding nationally and within the South & West Region. It also describes some recent developmental work undertaken in the region on fundholding recruitment and places our study in this context. The next section describes how our sample of practices was chosen and outlines the way in which the interviews took place. Section Four presents some information on our sample practice characteristics in relation to their size, location and the strength of fundholding within their local areas. Section Five is the main part of the report. It contains our survey findings and is organised around seven themes; namely, philosophical objections to fundholding, perceived practical disadvantages, sources of information and support on fundholding available to practices, actions undertaken by practices in relation to fundholding, possible advantages of fundholding, a reflective overview and Health Authority levers for change. Finally, Section Six offers some concluding comments.

2. BACKGROUND

2.1 The National Picture

Table 2.1 contains national data and shows the number of GP funds and the percentage of the population registered with them, on the basis of pre 1994 Regional Health Authority boundaries, for the first four waves of fundholding. As the table indicates, there are considerable variations in levels of coverage between regions. In 1994/95, population coverage ranged from 20 per cent in North East Thames to 46 per cent in Oxford.

The decision to reduce the number of RHAs from fourteen to eight has meant the merger of several "old" regions which had different levels of fundholding. The resultant pattern of population coverage by new regions for 1994/95 is shown in Table 2.2.

2.2 South & West RHA

The national picture shows that the old Wessex and South Western Regions stood 10th and 11th respectively in rank order among the 14 regions in terms of the proportion of the population covered by fundholding in April 1994. As a combined region, South & West currently has a smaller proportion of the population covered by GP fundholding than any other region with the exception of North Thames. Moreover, on the basis of present indications about the number of fifth wave practices likely to join the scheme in April 1995, North Thames would overtake South & West, leaving it as the region with the lowest population coverage.

Table 2.1: GP Fundholding: 1991/92 to 1994/95 (Old Regions)								
	1st Wave: 1991/92				*2nd Wave: 1992/93*			
Region	**Funds**	**Practices**	**GPs**	**Population covered %**	**Funds**	**Practices**	**GPs**	**Population covered %**
Northern	27	29	168	12	38	40	231	16
Yorkshire	34	39	208	12	59	66	365	21
Trent	28	28	155	7	58	60	312	14
E. Anglian	9	9	57	5	13	13	84	8
NW Thames	22	23	123	7	43	49	233	14
NE Thames	13	13	73	4	23	23	116	7
SE Thames	15	15	85	5	28	30	162	9
SW Thames	21	21	125	8	39	39	225	15
Wessex	17	18	98	7	34	36	207	15
Oxford	25	25	155	13	46	48	279	23
S Western	20	21	127	7	38	41	235	14
W Midlands	26	26	144	6	58	59	322	13
Mersey	21	22	109	9	46	51	228	19
N Western	16	17	88	5	29	32	160	9
ENGLAND	294	306	1715	7	552	587	3159	13

Table 2.1 (cont):

	3rd Wave: 1993/94				*4th Wave: 1994/95*			
Region	**Funds**	**Practices**	**GPs**	**Population covered %**	**Funds**	**Practices**	**GPs**	**Population covered %**
Northern	**69**	72	392	24	84	90	480	29
Yorkshire	108	118	587	33	133	148	703	39
Trent	138	159	736	31	212	272	1048	43
E. Anglian	48	51	278	25	78	82	441	32
NW Thames	88	95	458	27	105	119	555	37
NE Thames	48	52	229	14	71	88	349	20
SE Thames	77	88	374	21	143	200	715	37
SW Thames	66	69	360	24	116	137	612	40
Wessex	54	57	325	22	85	98	495	30
Oxford	74	76	431	34	107	120	595	46
S Western	69	75	414	20	100	115	574	29
W Midlands	131	139	767	26	219	283	1102	41
Mersey	84	101	423	35	101	122	509	42
N Western	66	83	329	17	119	166	582	30
ENGLAND	1120	1235	6103	25	1673	2040	8760	35

Table 2.2: GP Fundholding, 1994/95 (New Regions)

Region	Funds	Practices	GPs	Population Coverage (%)
Northern & Yorkshire	217	238	1183	34
Trent	212	272	1048	43
Anglia & Oxford	185	202	1036	39
North Thames	176	207	904	27
South Thames	259	337	1327	38
South & West	185	213	1069	30
West Midlands	219	283	1102	41
North West	220	288	1091	34
England	1673	2040	**8760**	**35**

Within the region, there are substantial variations in levels of coverage between Health Authorities. Table 2.3 shows the number of funds and proportion of the population registered with them for each Health Authority over the first four waves. The table indicates that in April 1994 population coverage at the top of the distribution ranged from 84 per cent in the Isle of Wight, and 42 per cent in North & Mid Hampshire, to 20 per cent in Portsmouth & South East Hampshire.

Given the national emphasis upon the development of fundholding, regional fundholding managers have focused upon ways forward in the recruitment of fundholding GPs. Surveys among FHSA/Health Authority managers with lead responsibility for fundholding, and among RHA fundholding leads, carried out in June and July 1994 respectively, sought to identify the main reasons why there are not more fundholders in the region. Reasons cited by the respondents are shown in Tables 2.4 and 2.5.

Subsequently, a regional seminar was held in July 1994 at which some of the obstacles to recruitment to fundholding were considered and ways of circumventing them identified. Approaches to the encouragement of fundholding were summarised under three main headings: namely, practical, political and cultural. Some of the main features of these approaches are summarised in Box 2.1.

Table 2.3: GP Fundholding in the South & West RHA

FHSA/HA	1991/92	1992/93	1993/94	1994/95	Total
AVON					
Funds	3	4	12	12	31
Practices	3	4	12	13	32
GPs	15	20	60	59	154
% of Population	3	5.6	10.6	14.4	33.6
CORNWALL					
Funds	2	2	4	3	11
Practices	2	2	4	3	11
GPs	12	13	28	15	68
% of Population	4.5	4.7	9.7	5	23.9
PLYMOUTH & TORBAY					
Funds	5	1	4	5	15
Practices	5	1	5	7	18
GPs	33	4	19	28	84
% of Population	9.4	1.3	5.9	8.3	24.9
EXETER & NORTH DEVON					
Funds	3	4	5	2	14
Practices	4	6	5	2	17
GPs	23	29	28	10	90
% of Population	7.4	10.4	10.6	3.6	32
GLOUCESTERSHIRE					
Funds	3	3	5	5	16
Practices	3	3	5	6	17
GPs	19	16	25	26	86
% of Population	5.9	5.1	8.8	7.8	27.6
SOMERSET					
Funds	4	4	1	4	13
Practices	3	3	5	6	17
GPs	29	32	6	25	92
% of Population	11.6	7.5	2.6	6.7	28.4

Table 2.3 (cont):

FHSA/HA	1991/92	1992/93	1993/94	1994/95	Total
DORSET					
Funds	1	7	4	1	13
Practices	1	7	5	2	15
GPs	7	50	23	4	84
% of Population	2	15	6	1	24
NORTH & MID HAMPSHIRE					
Funds	6	5	7	2	20
Practices	7	6	7	2	22
GPs	39	38	48	10	135
% of Population	13	13	13	3	42
PORTSMOUTH & SE HAMPSHIRE					
Funds	2	0	2	6	10
Practices	2	0	2	6	10
GPs	13	0	14	34	61
% of Population	4	0	4	12	20
SOUTHAMPTON & SW HAMPSHIRE					
Funds	4	1	3	3	11
Practices	4	1	3	3	11
GPs	41	6	18	16	81
% of Population	8	3	6	7	24
WILTSHIRE & BATH					
Funds	1	1	6	12	20
Practices	1	1	6	15	23
GPs	7	9	32	68	116
% of Population	3	2	12	14	31
ISLE OF WIGHT					
Funds	3	1	0	7	11
Practices	3	1	0	12	16
GPs	18	5	0	39	62
% of Population	26	9	0	49	84

Table 2.4: "The Main Reasons that we do not have more Fundholders"
Survey of FHSA/HA Fundholding Lead Managers, June 1994

Main Reasons Cited	Responses (N = 11) * response identified as particularly important / other response
<u>Regulations and Scope of the Scheme</u>	
List size requirement: can't or won't group.	** ///////
Limitations on the scope of the scheme.	/
<u>Fundamental Attitudes</u>	
Political/moral/ethical objections	**/////
Scheme too bureaucratic, costly	///
Labour victory (and abolition) expected	//
Clinicians not accountants	/
<u>Alternatives Available</u>	
Other options for involvement in purchasing	*///
Other options for primary care development	*/
<u>Lack of Service Incentives</u>	
Satisfaction with providers/consultants	///
Good waiting times for non-fundholders	*
Little benefit perceived from FH	//
Purchasing directorate strong	/
<u>Perceived Self-Interest</u>	
Too much hard work	*/////
No personal benefit perceived	/
Conflict of interest in a dispensing practice	/
<u>Practical Issues in the Practice</u>	
Lack of management capability	*
Low morale/existing pressures	//
Waiting for older partners to retire	/
Lack of space	/
Other practice priorities e.g. premises	/
<u>FHSA/HA Approach</u>	
Lack of coherent policy or focus for FH	*/
Organisation not pro-active	/
Organisation under resourced	/
<u>Budget Allocations</u>	
Reluctance to accept drug budgets	//
Harder to make savings now	/
Capitation will reduce budget flexibility	/
<u>Advice</u>	
Lack of unbiased advice	/

Table 2.5: "The Main Reasons that we do not have more Fundholders"
Survey of RHA Fundholding Lead Managers, July 1994

Main Reasons Cited	Responses (N = 7) * response identified as particularly important / other response
<u>Fundamental Attitudes</u>	
Negative leadership from profession	*//
Rationing affecting GP/patient relationship	*//
Scheme too bureaucratic/costly	*/
Labour victory (and abolition) expected	///
Takes doctors away from patients	/
<u>FHSA/HA Approach</u>	
Lack of commitment from key players	***//
Putting too much resource into alternatives	*/
Poor marketing, not involving GPFHs	*/
Perceived as not giving practical support	/
<u>Alternatives Available</u>	
Other options for involvement in purchasing	*////
Primary health care now mainstream	*
<u>Practical Issues at the Practice</u>	
Lack of organisation and enthusiasm	*
GPs concerned that they will fail	*
The organisational development may be painful	/
Underdeveloped management in urban practices	/
<u>RHA Approach</u>	
Lack of regional commitment	*
FHSAs/HAs not given training/support	/
<u>Infrastructure</u>	
Problems with the software widely aired	/
Management allowance insufficient	/
<u>Provider Approach</u>	
Hostility and pressure from powerful providers	/
<u>Lack of Service Incentives</u>	
Contentment with HA purchasing	/
<u>Budget allocation</u>	
Unattractive to low baseline practices	/
<u>NHSE Approach</u>	
Lack of clarity gives poor image	/

Box 2.1: Approaches for Encouraging Fundholding

Practical

Encouragement prior to preparatory year

- Chief Executive promotion of fundholding.
- Pre-preparatory allowance from Health Authority.
- Getting non-fundholders together with fundholders (resourced by Health Authority).
- Sharing information via visits, leaflets, seminars (e.g. for promoting clustering or consortia).

Support for active fundholding

- Mentorship: practical support from experienced fundholders.
- Management agencies: short term basic management and support.

Capitalising on developments to the scheme

- Community fundholding
  - open to small practices,
  - easier to manage,
  - stepping stone to full fundholding.

Political

Top Down

- NHS Executive to organise a national conference for regional Chairs.
- Paper to South & West RHA.
- Regional leader as advocate.
- New HAs' "fitness to trade" must include support for GPFH.
- Stop or convert other primary care developments.

Accountability

HAs:-

- Agenda item, mid and end of year reviews.
- Corporate contracts, a top ten issue.
- IPRs to contain recruitment targets.

GPFHs:-

- Publicise existing extensive accountability to both patients and FHSAs.
- National requirements about to be published.
- NAFP guidance.

Bottom up

- Publish benefits to patients e.g. from King's Fund survey.
- Submit views to Gerald Malone.
- Share GP enthusiasm (what you could do tomorrow, and professional pride).
- Share enthusiasm of the more committed HAs.

Cultural

Inducements

- Remove discrimination between FHs and non-FHs.
- Cease persuasion and reward of non-FHs to remain so.
- Will be the route for change in a cost-controlled environment.

Recompense

- Publicise existing method of recompense for secondary care.
- Encourage national extensions to scheme.
- Publicise ability to determine use of savings for benefit of own patients.

Future Vision

- Links between GP, patient and consultant are enhanced, not eroded.
- Role for HAs as accreditors/purchasers of primary care.
- Fundholding is the leading edge for the development of primary care.
- Prevents planning being over-centralised.
- Ceases to be divisive when (almost) all practices hold funds.

The present study, commissioned by the South & West RHA, is part of the strategy aimed at the development of fundholding in the region. It was designed to obtain a more in-depth understanding of the reasons why some GPs have chosen not to apply for fundholding status. It was not part of the research brief, however, to seek to influence GPs' opinions and actions. Rather we simply sought to elicit their views and to record information and actions that they reported as having taken in relation to fundholding. We would not claim that the results are generalisable to the entire population of non-fundholders within the region. The sample is not random and is too small to substantiate this claim. On the other hand, we believe that the in-depth interviews which have been carried out do add to our understanding of the attitudes and organisational situations that are common to many non-fundholding GPs.

3. STUDY DESIGN

3.1 Sample Selection

We chose a purposive sample of 20 practices for interview, comprising 2 practices from each Health Authority in the South & West RHA (The Isle of Wight Health Authority was not included in the sample because another Institute for Health Policy Studies (IHPS) study of purchasing was already underway on the Island).

The 20 sample practices were identified for us by Regional and Health Authority/FHSA managers. A number of criteria were used in selecting these practices. Most importantly, only those practices that were known not be considering an application for fundholding status in the fifth wave were included in the sample. Within each Health Authority an attempt was made to include one practice from an area in which fundholding was strong (in terms of the number of existing fundholders) and one from an area in which it was weak. In addition, practices were selected to reflect different patient list sizes and urban/rural locations. Beyond this, an attempt was made to include practices displaying a range of personal characteristics. These included;

- a pro-active practice with well developed services which might have been expected to become a fundholder,
- a non-innovative practice,
- a practice which was a member of a strong anti-fundholding alliance,

- a practice that had shown initial interest in fundholding but had then decided against applying,
- a vocal, paternalistic, "old-style" practice,
- a practice known to have strong political objections to fundholding.

Following the selection of the 20 practices, a letter was sent from IHPS to the senior partner in each of the practices at the beginning of September 1994 (see Appendix 1). The letter described briefly the nature of our study and requested interviews of around 30 minutes each with the senior partner, one other partner and the practice manager. We explained that one of the researchers would be telephoning the practice subsequently in order to arrange a time and date for the interviews.

In the event, seven of our original sample of 20 practices declined to take part in the study and so reserve practices were contacted. In total, it proved necessary to contact some 29 practices in order to achieve a final sample of 19 practices. This represented 2 practices per Health Authority with the exception of Dorset where 4 of the 5 practices contacted declined to participate (see Table 3.1). Because of an extremely tight timetable, we were not able to devote any further time to the recruitment of a second Dorset practice and so settled for just one practice from this Health Authority.

Table 3.1: Practices Contacted and Participating in the Study

Health Authority	Number of Practices Contacted	Unwilling to Participate	Participated in Study
Avon	5	3	2
Cornwall	4	2	2
Devon	3	1	2
Dorset	5	4	1
Gloucester	2	0	2
North & Mid Hampshire	2	0	2
Bath & Wiltshire	2	0	2
Portsmouth & SE Hants	2	0	2
Somerset	2	0	2
Southampton & SW Hants	2	0	2
Total	29	10	19

In passing, it is worth noting that of the 10 practices that declined to take part in the study, three said that they would have done so if payment was offered, two mentioned difficulties arising from pressure of time, another two cited practice changes/partner unavailability as reasons for not taking part and one expressed scepticism about the RHA's motives in commissioning the study. (This last practice offered to relay its views directly to the relevant RHA officer and so we passed on the offer!).

From the research point of view, it is also worth pointing out how time consuming it is becoming to arrange interviews with GPs. In the case of the 19 practices which eventually agreed to take part in the study, 150 telephone calls with a total duration of over 30 hours were necessary in order to make appointments and schedule the interviews.

3.2 The Interviews

The study interviews took place over a two month period 8 September to 10 November, 1994. Our aim of interviewing the senior partner (or the designated practice chair, team-leader, longest established partner etc), one other partner and the practice manager was achieved in the case of 17 practices. For the remaining 2 practices it only proved possible to interview one partner and the practice manager. Overall this meant that we carried out 36 interviews with GPs and 19 interviews with practice managers.

Each interview followed a semi-structured format in which questions were asked about a range of attitudinal and organisational factors which we expected would influence decisions about applications for fundholding status. (See Appendix 2). The duration of these interviews was rather longer than we had anticipated taking, on average, around 45 minutes per respondent.

4. PRACTICE CHARACTERISTICS

Table 4.1 summarises some of the main features of the practices included in our sample. As the table shows, there are 3 practices below the current 7,000 patient list size which, at the time of the study, was the minimum threshold for becoming a fundholder. At the other extreme, there are 3 large practices with over 15,000 patients including one very large practice with over 20,000 patients. Most practices, however, fall into the 7 - 10,000 patient category (8 practices) and the 10 - 15,000 patient category (5 practices).

As far as practice locations are concerned, we relied upon each practice's own definition of its patient catchment area rather than seeking to define this independently. As such, there is likely to be a degree of imprecision and possibly some inconsistency of definitions between practices. Nonetheless, our own observations suggest that these definitions convey a broadly accurate picture of the relevant practice locations.

In these terms, practices with a mixed urban/rural population are the most numerous (7 practices). Typically these practices are located in or on the periphery of small to medium sized country towns. Six practices described themselves as urban, with 2 of these referring to their practice locations as inner city areas. Five practices described their locations as semi-rural (3) or rural (2). The remaining practice describes itself as in a suburban location.

We wanted to identify the strength of fundholding within an area as we anticipated that this was likely to be an important influence on a practice's decision about whether or not to apply for fundholding. The designation of an area as one in which fundholding is high,

moderate or low is based upon a composite view of the practice partners themselves and those of FHSA/HA managers. Once again this means that there is a degree of subjectivity about these measures. However, we believe that they convey a general impression of the fundholding environment within which each practice works. As Table 4.1 shows, there was some departure from the 50/50 split between practices in high and low strength fundholding areas, with six practice areas described as high, four practice areas identified as moderate and nine practice areas defined as low strength in fundholding terms.

Some other practice characteristics are summarised in Figures 4.1 to 4.3. Figure 4.1 indicates the size distribution of practices in terms of partners and shows that the range extends from two partners to over ten partners, with ten of the practices having five or six partners. Figure 4.2 shows the number of years that GPs have worked in their respective practices. As would be expected, the decision to interview the senior partner in each practice means that our sample includes a large number of long serving practice members. Thus, ten partners had been with their practices for over 20 years with two of these having been in their practice for 30 years. The length of service among practice managers - as shown in Figure 4.3 - is far less skewed toward long lengths of service with six of the practice managers having been in post for less than two years. Even here though there is a strong representation of long serving practice members, with six practice managers having been with their practices for over ten years.

Table 4.1: Practice Characteristics

Practice	Patient List Size	Location	Strength of fundholding in area
1	L	Suburban	High
2	S	Urban	High
3	M	Semi-rural	Moderate
4	SM	Urban/semi-rural	Low
5	L	Urban/rural	Moderate
6	SM	Rural	Moderate
7	M	Urban	Low
8	SM	Urban/rural	Moderate
9	SM	Urban/semi-rural	Low
10	M	Urban	High
11	S	Urban/rural	Low
12	L	Urban/rural	High
13	M	Urban	Low
14	M	Inner city	Low
15	SM	Urban/inner city	High
16	SM	Semi-rural	Low
17	SM	Semi-rural	High
18	SM	Urban/rural	Low
19	S	Rural	Low

Note: Patient List Size:

Small	(S)	< 7,000 patients
Small/Medium	(SM)	7 - 10,000 patients
Medium	(M)	10 - 15,000 patients
Large	(L)	> 15,000 patients

Figure 4.1: Partners per Practice

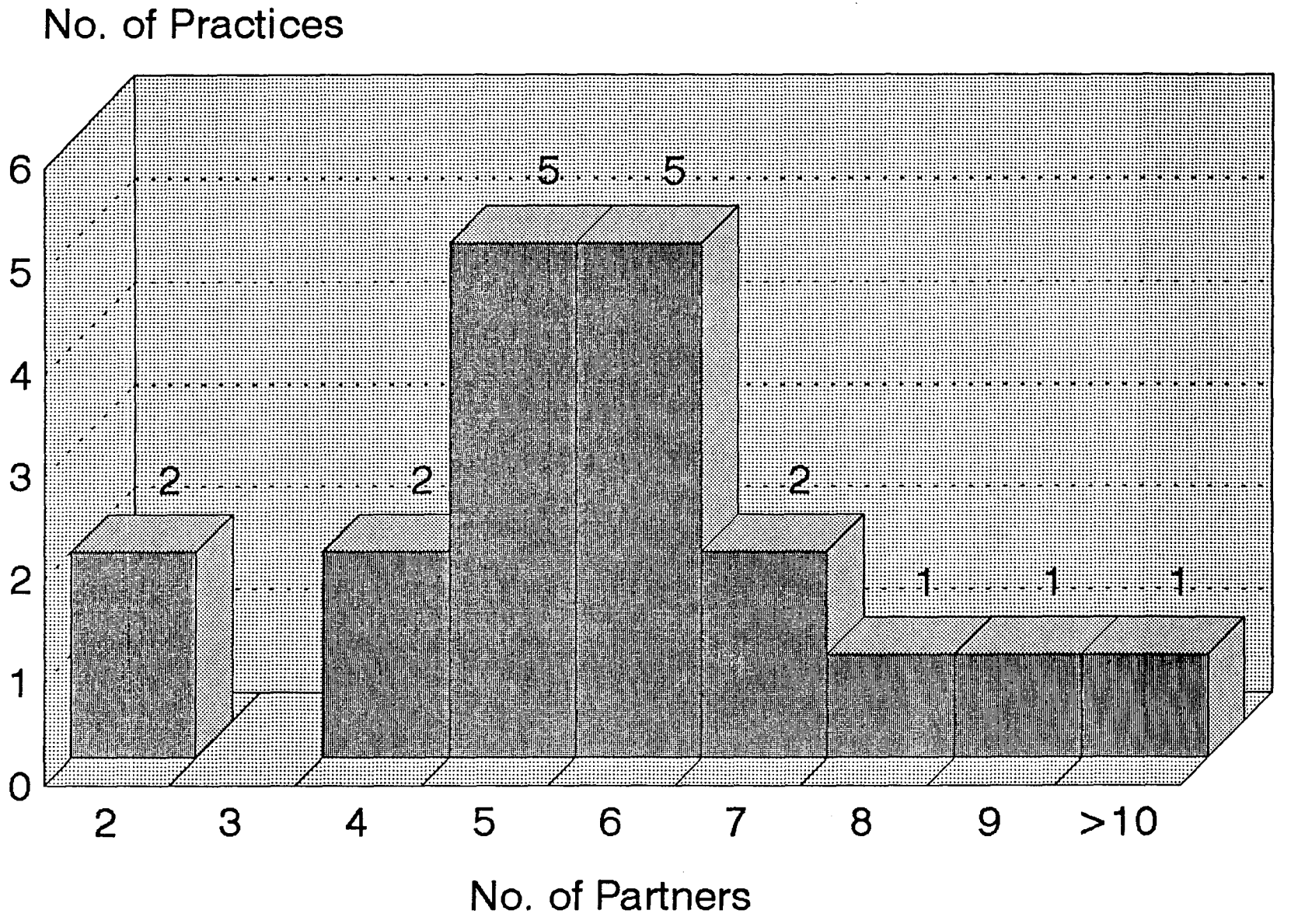


Figure 4.2: GPs: Years Served in Practice

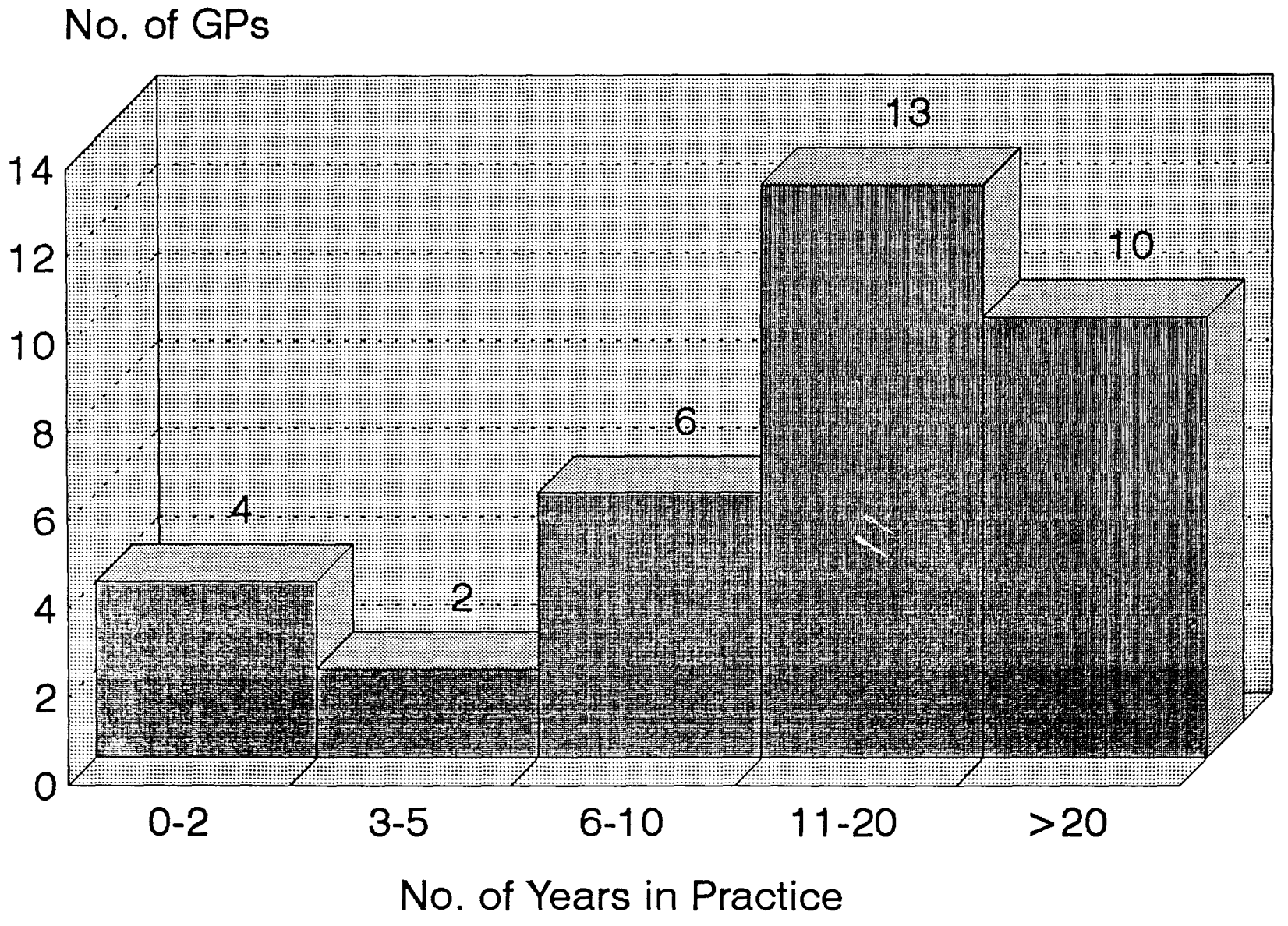
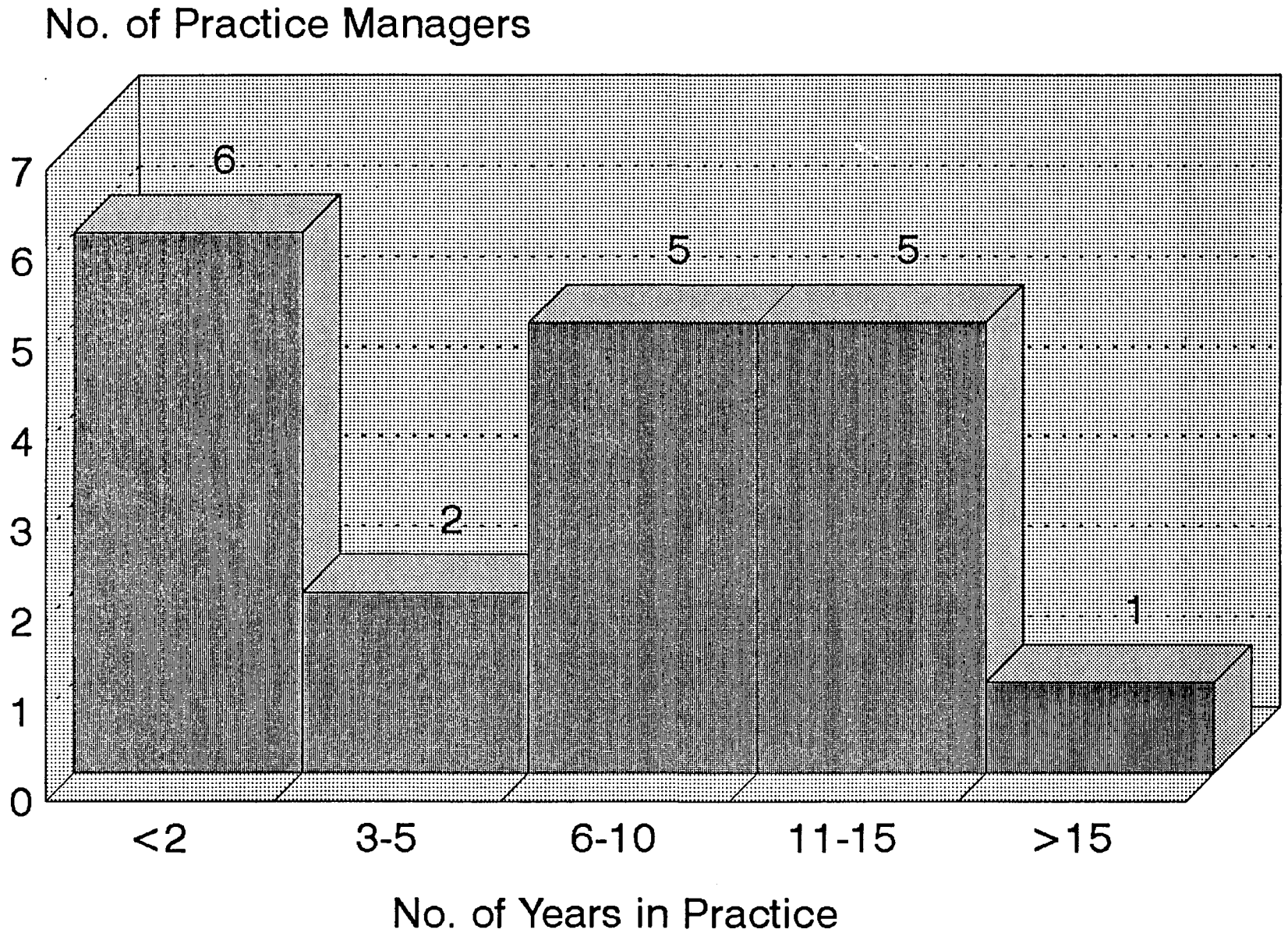


Figure 4.3 Practice Managers: Years Served in Practice



5. SURVEY FINDINGS

5.1 Philosophy, Principles and Politics

Each interview started with a question about possible objections to fundholding on the grounds of philosophy, principles or politics. A summary of the responses to this question is shown in Table 5.1. As the table indicates, two thirds of GPs stated clear/strong objections to fundholding on these grounds, with the proportion being somewhat higher among senior/lead partners. The possible association between seniority/length in practice and opposition to fundholding on philosophical grounds is supported by the responses of the three "other partners" who expressed no objections to fundholding. Two of these had been in their practices for two years or less.

Table 5.1: Philosophical Objections to Fundholding

"Do you have any philosophical objections to fundholding on grounds of principle, politics or ideology?			
	GPs		Practice Managers
	Senior/Lead Partners	Other Partners	
Clear/strong objections	14	10	7
On balance, object	3	4	4
No objections	2	3	6
TOTAL	19	17	17

Note: Two practice managers were unable to provide an answer to this question on the grounds that it was not strictly relevant to their work.

In the course of explaining the reasons for their objections to fundholding on grounds of principle, a number of recurring themes emerged. One third of GPs mentioned the two tier system and unequal access to health care between patients of fundholding and non-fundholding practices. A related point which caused concern among a number of GPs was a perceived inequality in funding arising from the various financial incentives offered to fundholding practices.

Ten respondents felt that fundholding was shifting rationing decisions to GPs and they were unhappy about this. Box 5.1 provides a flavour of some of the comments made in this connection. A closely related point repeated by a number of respondents was the conflict between financial and clinical management when practised at the GP level. This was seen as being detrimental to the doctor-patient relationship.

Box 5.1: Objections to Rationing through Fundholding

"The principle of the National Health Service is that the government is responsible for health care, so I resent the shift of responsibility from central government ... It is not the role of the medical profession to bale out the government on the rationing of health care ... This is wrong and immoral."

Senior partner of 19 years standing in a five partner, semi-rural practice.

"My philosophical objections are very strong. I do not like being put in the position of being a decision maker for individual patients' care with regard to rationing health care. I am the patient's advocate and should not have to juggle with rationing health care resources."

Principal partner in a large (15,000 patients) suburban practice.

"All that fundholding has done is to shift prioritising of patients on waiting lists from hospital consultants to GPs ... Fundholding is about changing the demagogue from consultant to GP."

Partner in a medium sized (9,500 patients) urban/semi-rural practice.

"GPs at the local level should not have personal responsibility for resource allocation. As a GP I am not a health economist. Resource allocation needs a detached view and should not be made by those who have relationships with patients."

Chair of a large (over 15,000 patients) urban/rural practice.

The question of a possible conflict between financial and clinical judgements was picked up later in the interview when respondents were asked who they thought should decide upon the allocation of resources in health care. A list of potential decision makers was identified, as shown in Table 5.2, and the GPs and managers were asked to state where they thought responsibility should lie.

Table 5.2: Who should decide about the allocation of scarce health care resources?

Decision Makers	GPs	Practice Managers
Government/politicians	16	4
DoH/NHS Executive	12	2
Health Authorities	15	5
GPs/PHCTs*	11	9
Hospital Consultants/Managers	7	7
Patients/Public	13	1

Note: Entries in the table refer to the number of times a particular level of decision maker was cited by GPs and practice managers, usually as one of a number of parties to joint decision making.

* Primary Health Care Teams.

As might be expected, most respondents felt that the responsibility should be shared between more than one level of decision maker, although there were differences of opinion about precisely which parties should be involved and over the extent of their involvement.

A typical response from a senior partner in a medium sized, semi-rural practice was:

> *"Patients and the public should be able to vote on what percentage of taxation should be spent on health care. This should then be administered by government with priorities decided by the NHSME including Regions".*

In the light of views on multiple responsibility, Table 5.2 records the number of times that each level of decision maker was cited by GPs and practice managers as one of the necessary parties in joint decision making. Interpretation of these results is not easy. On the surface, the GPs' answers seem to indicate the desirability of a rather greater level of GP involvement in the allocation of resources than their own previously stated objections to rationing at the GP level would seem to imply. On the other hand, however, many GPs expressed the view that the ultimate responsibility for resource allocation decisions should lie with government, DoH/NHS Executive and HAs, but that these higher level bodies should consult and listen to the views of GPs, patients and the public.

In general there was an appreciation of the complexity of the task of allocating scarce health care resources between competing users. One senior partner in an inner city practice explained that in recent years he had developed a respect for managers who need to make judgements about the relative strengths of competing advice and demands for scarce resources. He went on to explain how he now had a greater appreciation of the ambiguous world within which they live.

Returning to the philosophical objections to fundholding, other reasons mentioned by GPs included perceptions of burgeoning management costs and bureaucracy, the alleged divisiveness which fundholding has introduced among GPs and ethical objections to personal financial gain. On the last point, one partner of 30 years standing in a large practice pointed out that although fundholding savings were patient oriented, the outcome was "doctor benefitting". She expressed grave discomfort at the probity of partners realising an increased personal equity when they retire as a result of savings having been put into practice premises.

Following the discussion of their philosophical objections to fundholding, GPs were asked if they were able to give specific examples, from their own experience, of ways in which the factors to which they objected had led to developments in general practice which they disliked. It was noticeable that many GPs were unable to provide actual examples of the developments to which they had referred previously. Nonetheless, some examples were provided, mainly in relation to the two tier system and differential access to hospital services between patients of fundholders and non-fundholders. Some of the examples cited to us are outlined in Box 5.2.

Box 5.2: GPs' Examples of a Two-Tier Service

- Preferential treatment given to fundholder's patients for hip operations. Patient admission date changed from next week to 18 months' time on discovering that patient was registered with a non-fundholder.
- Differential access to an Eye Clinic.
- Consultant ophthalmologist sent a notice to the practice stating that waiting time for non-fundholder practices is 18 months compared with 3 months for fundholder patients.
- Chair of local trust sent fundholding practices' waiting times to the practice in error; revealed major discrepancies with their own waiting times.
- Orthopaedic waiting times are lengthy and so a local fundholder is referring privately.
- Differential waiting times for ENT services; fundholder patients seen within weeks, our patients wait years.
- Preference given to fundholder patients in gynaecology.

Other examples of alleged adverse consequences of fundholding mentioned to us included the threat to a hospital based haematology service posed by fundholders' decision to develop their own services, and hence a reduction in non-fundholders access to this service; alleged excessive "profits" of fundholding practices in a particular town; and the divisiveness within two nearby practices since they had become fundholders.

Practice managers' attitudes towards the principle of fundholding were less strongly expressed than those of GPs. As Table 5.1 shows, around one third of practice managers who expressed an opinion claimed that they had no objections to fundholding. Among those who were opposed, the reasons cited were an undesirable two tier system (mentioned five times), a conflict between clinical and financial decision making (mentioned three times) and excessive bureaucracy (mentioned three times).

Practice managers also felt that they were less well qualified than GPs to express opinions about who should be responsible for decisions relating to the allocation of health care resources. However, it is interesting to note that those who did express an opinion placed a greater relative emphasis on the roles of GPs than the GPs did themselves (see Table 5.2).

5.2 Practical Disadvantages of Fundholding

After our discussion of philosophical attitudes towards fundholding, we moved on to consider what were seen as some of its practical disadvantages from the practice's point of view. The main reasons given to us in response to this question are shown in Table 5.3.

Table 5.3 Practical Disadvantages of Fundholding

"Leaving aside your philosophical objections, what do you think would be the practical disadvantages if your practice went fundholding?"		
Reasons cited	**GPs**	**Practice Managers**
Extra workload	18	7
Extra time commitment	9	3
Divisive/disruptive within practice/lower morale	8	3
No space	5	6
Stress	4	-
No disadvantages	2	1

By far the most common response from GPs was to refer to the extra administrative workload that would result from becoming a fundholder. Reference was made to the need for endless meetings to discuss contracts, "umpteen" audits on referral patterns and a general deluge of paperwork. These points were often linked to the need to appoint extra staff and/or a new practice manager, and to the fear that the management allowance would not be sufficient to cover the extra costs.

When asked directly whether they thought that their practice had sufficient management capacity to contemplate becoming fundholders, only about one quarter of GPs who replied to the question said yes. Approximately 30 per cent said they would need a new practice/finance/business manager and another 40 per cent said that some form of additional general management capacity would be needed. Practice managers felt that their organisational preparedness was somewhat higher with just over one third of them claiming that they had the management capacity to become fundholders. However, just over another

third thought that some extra management capacity would be needed, with three practice managers claiming that a new fundholding manager would be required. Lack of space was also mentioned as a problem by a number of practices.

Another perceived disadvantage of fundholding was the fear that it would be divisive and disruptive within the practice. Some GPs mentioned that it would force them to address variations in referrals and prescribing rates between partners and that these would be difficult issues which they would prefer not to confront. Others referred to the additional stress that would result from fundholding. Taken together, divisiveness and stress were disadvantages cited by one third of GPs.

On another aspect of organisational readiness for fundholding - namely, the adequacy of their existing computing systems - 40 per cent of GPs claimed that their systems were capable of dealing with the requirements of fundholding. However, 37 per cent of GPs felt that their systems would require upgrades and/or extra software whereas 23 per cent thought they would require totally new systems if they were to become fundholders.

5.3 Networks, Information and Support

GPs' attitudes towards fundholding are likely to be influenced by their contacts with other GPs, through the information they obtain from literature, workshops and meetings, and through the support that is offered to them by FHSAs and Health Authorities. Accordingly, we investigated GPs' exposure to some of these sources of influence.

All but seven of the GPs we interviewed reported that they met regularly with other GPs from outside their practice. These meetings took place in a variety of contexts including: local medical groups, FHSA meetings, LMC meetings, purchasing groups, MAAG meetings, meetings at post-graduate medical centres, GP consultative committees, young doctors' groups and on a range of social occasions. In most cases, these meetings included both fundholders and non-fundholders, although there were a number of instances where it was reported that fundholders were excluded. Fundholding tended to arise as a topic of conversation at these meetings but was not usually a regular agenda item. Overall, contacts through the GP network seemed to be extensive and obviously constitute an important source of information and means for transmitting views, experiences and opinions.

The medical literature can also be expected to be a source of information about fundholding and so we asked GPs about the professional journals, magazines and newspapers which they read regularly and which informed their views about fundholding. Table 5.4 indicates the number of times that a particular publication was cited. It shows that the BMJ is the most frequently mentioned publication followed by the newspapers Pulse and GP. (In fact newspapers aimed at GPs are read more widely than indicated in Table 5.4 because a number of respondents referred to the GP "comics" or "freebies" without naming them specifically).

Table 5.4: Information through Literature

"What professional magazines/journals do you read which inform your opinions about fundholding?"	
Journal/Magazine	**Number of times cited by GPs**
BMJ	21
Pulse	17
GP	12
Medeconomics	9
Financial Pulse	6
Medical Monitor	6
Journal of RCGP	5
Doctor	3
BMA News Review	3
Practitioner	3
Fundholding	2

We also asked whether GPs and practice managers had ever attended any training events, workshops or conferences on the subject of fundholding. As Table 5.5 shows, only about 30 per cent of practice managers and 40 per cent of GPs had attended such events. Among GPs some had attended workshops organised by the FHSA or RHA, others had attended meetings as trainees, while some had simply heard talks at the post-graduate medical centre. This did not appear to be a source of information that had been particularly important to the GPs involved. Among fundholding managers, on the other hand, although training events were less widely attended, those that were reported to us were obviously high-profile - sometimes national - events which seemed to have made considerable impact upon the managers who had attended.

Table 5.5: Attendance at Training Events

"Have you ever attended any training events/workshops/conferences on the subject of fundholding?"		
	GPs	**Practice Managers**
Yes	14	6
No	20	13
Total responses	34	19

Apart from the organisation of training events, we asked GPs whether they felt that their FHSA, DHA or RHA had offered any practical advice or support in applying for fundholding. Answers to this question displayed a good deal of variation but fell into four main categories. First, there were those FHSAs that were seen to have offered strong support if needed, but the GPs had generally chosen not to take it up. Second, there were some FHSAs/Health Authorities that were seen as being opposed or not very keen on fundholding. Third, there were those GPs who reported that their views about fundholding were well known and so the FHSA were seen as not bothering with them. Fourth, there were those GPs who were unaware of any support, either positive or negative, on the part of their FHSA/Health Authority.

The role of the FHSA/Health Authority was probed further in relation to alternatives to fundholding that had been offered to GPs. In this connection, it is clear that a whole raft of initiatives based upon practice sensitive purchasing have been developed throughout the region. Locality purchasing groups, consortia of non-fundholding GPs and collectives are terms that are variously used to describe arrangements whereby information about GPs'

views and preferences are transmitted to the Health Authority which purchases on their behalf. In some cases, Health Authorities have provided financial support for these groupings, including the appointment of managerial staff. In one area a practice is taking part in a practice based commissioning pilot project which is managed by a public health doctor employed by the Health Authority.

In reviewing these arrangements, it is noticeable that they are at very different stages of development in different parts of the region. Some GPs report that discussions about methods of practice sensitive purchasing have taken place but little is yet underway. Others report early stages of development or pilot schemes in practice based commissioning. While some GPs have the actual experience of working in consortia, purchasing groups and collectives. In the latter connection, it was reported to us that the recent heightened emphasis on the development of GP fundholding has led one Health Authority to reduce its support for locality based alternatives, resulting in disillusionment among GPs and a view that they were being "set up" for fundholding.

In general, however, it is clear that there is a rich variety of primary care based purchasing arrangements around the region. These are capable of offering alternatives to fundholding for those practices which continue to choose to follow the non-fundholding route, and for some practices have been a strong reason for them choosing not to go fundholding.

5.4 Action on Fundholding

The next stage of our interview asked about the specific activities that had taken place within each practice in relation to possible applications for fundholding status. Our questions focused around the following three main themes:

- Discussions about fundholding that had taken place in the practice.
- Discussions that had taken place with the FHSA or Health Authorities.
- Decisions that had been taken.

As is to be expected with a subject of such high profile as GP fundholding, all of our sample practices reported that they had held numerous discussions about whether or not they should apply. Sometimes these discussions took place as part of formal meetings at which minutes were recorded and votes taken. On other occasions, it was reported that fundholding tended to crop up periodically as a topic of discussion at regular practice meetings. Events such as partners attending external meetings, articles on fundholding which may have appeared, or the decision of a nearby practice to go fundholding all tended to prompt these informal discussions. Moreover, annual invitations to apply for fundholding in its successive waves naturally acted as a trigger for discussion. One practice reported that they had recently held a weekend away in order to discuss fundholding in the light of what they perceived as an increased national pressure to join the scheme. Discussions about fundholding tended to involve all partners and, in most cases the practice manager as well, although there were three practices where practice managers reported that they did not take part in these discussions. Overall, we gained the impression that fundholding was discussed

frequently and that there was a fluidity of attitudes towards applications as the local and national environment was perceived to be changing.

As far as contact with FHSAs and Health Authorities were concerned, a very mixed picture emerged. Four different FHSAs were reported as "not seeming keen to encourage applications", not having fundholding "high on their agendas", not showing "enough moral support towards applications" and having latterly been "very cautious" in their approach to fundholding. In contrast, two other FHSAs were described as "on at us all the time to become fundholders" and sending out "frantic letters" encouraging applications. In the latter FHSA a management consultant had recently been sent to one practice in order to advise on fundholding. In two other FHSA/Health Authority areas visits from the Chief Executive to sound out a practice and the organisation of a seminar on multi-funds were described.

The general picture to emerge from these reports is one in which there has been considerable variation in the support for fundholding offered by FHSAs/Health Authorities around the region and, in some cases, changes in their stance over time. The picture is, however, complicated by differences in perceptions of the FHSA/HA stance between practices in the same area - which may be attributable to a selective approach adopted by individual FHSAs/HAs towards particular practices - and sometimes by differences in perception between GPs in the same practice!

The outcome of the discussions held both within practices and with FHSAs/Health Authorities had been that no practice had decided to apply for fundholding, with the exception of one which had been part of a multi-fund proposal covering some 90,000 patients

which had been rejected by the FHSA. In all but three practices decisions were described as having been made on the basis of a unanimous or consensus view. In the remaining practices a majority view prevailed.

When asked whether their practice was likely to apply for fundholding in the future, 16 practices replied no. The other 3 practices indicated that the option was: "under constant review", that they "could apply but were not totally convinced", and that they would "not apply at the moment but would keep an eye on what other local practices did". There were, of course, sometimes differences of opinion between individual partners in the same practice. In one case, one partner reported that he was opposed in principle but might consider applying, while another partner in the same practice announced that it would only happen "over my dead body". (This variation between partners was also reported in the 1993 Fundholding study referred to previously in which less than 50 per cent of non-lead fundholders reported that they were in favour of the scheme with 66 per cent saying that they were forced to join in spite of their reservations).

5.5 Any Advantages to Fundholding?

Despite the fact that 16 of the 19 practices we interviewed reported that they did not anticipate applying for fundholding, a majority of the GPs and practice managers conceded that certain advantages would accrue to their practices if they did become fundholders (see Table 5.6).

Among GPs, patient benefits in terms of shorter waiting times for hospital appointments (mentioned nine times) and better quality or additional services (mentioned five times) were the main factors cited. The enhanced scope for fundholding GPs to offer physiotherapy and counselling services was mentioned several times. Another practice saw fundholding as a means whereby it could protect its access to community nursing in the face of Health Authority plans which were seen as a threat to its availability.

Table 5.6: Any Advantages to Fundholding?

"Setting aside the disadvantages, do you see any potential advantages for your practice in fundholding compared with your present situation?"		
	GPs	**Practice Managers**
No	15	5
Yes	19	12
No answer	2	2

If Yes, Factors Cited	Number of Times Cited	
	GPs	**Practice Managers**
Shorter waiting times	9	3
Able to secure better/additional services	5	4
More flexibility over staffing	3	2
Improved premises	3	1
More control over hospital doctors	3	0
More freedom over referrals	2	0
Financial assistance with computing costs	2	2
Other	4	1

The ability to vire between different parts of their budgets and also to invest savings in the practice were seen as offering fundholders greater flexibility over staffing and opportunities for improving practice premises. Similarly, scope for improving computing facilities through the financial assistance available to fundholders was seen as another potential advantage. In terms of clinical freedom, both the greater freedom of referral and the increased power they have assumed in relation to hospital doctors were seen as advantages associated with fundholding. Among the other factors cited as potential advantages of fundholding were incentives for greater efficiency within the practice, being better off financially and by being more accountable.

5.6 Reflective Overview

Most interviews took approximately forty-five minutes and covered a good deal of ground. The format was highly interactive with the interviewer probing the GPs and practice managers about their views and activities in relation to fundholding. Because this approach offered the respondents the opportunity to develop and expand their views as the interview progressed, we decided to include a final question which invited them to reflect upon previous discussion and, in the light of this reflection, to identify three main reasons why their practice had decided not to apply for fundholding. A summary of the replies to this question is given in Table 5.7.

To some extent these categories overlap. The reasons are not mutually exclusive. Nonetheless, by combining all of the reasons cited for not applying for fundholding into one composite response, some idea of the relative strength and extent of the different reasons can

be obtained. As the table shows, objections to fundholding on ethical or philosophical grounds were the most numerous and were cited by two thirds of GPs and just over half of the practice managers. Practical disadvantages associated with increased workloads were the next most common reason given. This view was expressed by over 40 per cent of GPs and

Table 5.7: A Reflective Overview

"Reflecting back on our discussion, what would you say were the <u>three main reasons</u> why your practice has not applied for fundholding?"		
Reasons	**No. of times cited by:**	
	GPs	**Practice Managers**
Philosophical objections	24	10
Extra workload	16	9
No benefit for partners	12	4
Waste of resources/not cost effective	6	-
Don't want to ration care	5	-
Satisfied with present situation/no need to change	5	4
Practice management inadequate	5	-
Divisive/disruptive within practice	4	3
Diverts resources from clinical care	3	-
Stress on doctor-patient relationships	2	-
Want to be a doctor not a manager	2	1

nearly half of the practice managers. One third of GPs said that they did not believe that there was any overall benefit to be gained by patients through fundholding. Other reasons cited less frequently by GPs were a belief that fundholding wasted resources; that they did not want to be put in a position of rationing care; that their present practice management was

not able to take on fundholding; and that they were generally satisfied with the present situation and saw no reason to change. This last point came out more strongly in the "flavour" of our interviews than is possibly conveyed by the reasons cited explicitly. Many GPs were getting on with their work in what they saw as a generally satisfactory manner and simply did not see the point in applying for fundholding.

5.7 Levers for Change

Although it was not part of our research brief to seek to influence GPs' views on the subject of fundholding, at the request of the RHA fundholding leads , we included a question which asked about the effect that a range of different policy developments and instruments would have upon GPs' decisions about applying for fundholding. The form of this question and the responses we received to it are shown in Table 5.8. It should be pointed out that because this question was delivered late in the interview, and sometimes led to lengthy discussion about the precise meaning of particular parts of it, we failed to obtain a complete set of responses to the full question. Nonetheless, we believe that the distribution of responses that we did obtain offers some illuminating insights about potential management levers for change.

Undoubtedly the most striking aspect of Table 5.8 is the fact that 44 per cent of GPs said that if other practices in the locality started to become fundholders they would have to apply. In addition, another 29 per cent said that such developments would possibly lead them to apply for fundholding. Answers to this part of the question conveyed a very real sense in which non-fundholding GPs feel that they are in competition for patients, and/or

their patients will suffer, if they remain outside the scheme while surrounding practices join. The answers displayed a heavy dose of fatalism, adopting the stance that "if we have to go we will". While they might have strong philosophical objections, most GPs seem prepared to act pragmatically if the need to do so becomes irresistible.

As far as the form of fundholding is concerned, both consortia arrangements with other practices (favoured either strongly or marginally by 42 per cent of respondents) and a management agency arrangement to manage the fund (favoured by 58 per cent of respondents) commanded noticeable levels of support.

Few of the other proposals were seen as likely to increase significantly the prospect of a practice applying for fundholding. In this connection, it is noticeable that an entry level fundholding scheme of more limited scope - such as that subsequently outlined in EL(94)79 - was supported by only about one third of GPs. Finally, it should be pointed out that many respondents replied that better support from their FHSA/Health Authority would not make much difference because the level of support offered from this source was already high.

Table 5.8: Levers for Change

"Which of the following would significantly increase the prospect of your practice applying for fundholding?"					
	Yes	**Possibly**	**No**	**Don't know**	**Total responses**
1.Other practices in the locality becoming GPFHs	15	10	9	0	34
2.A Consortium with other practice	5	9	19	0	33
3.A management agency to manage the fund	5	10	10	1	26
4.A pre-preparatory year management allowance	3	1	16	1	21
5.A mentorship scheme in pre-preparatory year	0	3	19	0	22
6.Better support from FHSA/HA	0	0	17	3	20
7.Better fundholding software	0	0	13	2	15
8.An entry level scheme of more limited scope	2	7	19	0	28
9.More knowledge of the pros and cons	1	2	18	0	21
10.Simplification of the scheme	1	3	15	4	23
11.A different method of funding	0	5	14	3	22

6. CONCLUDING COMMENTS

We made it clear at the outset of this report that the findings of our small scale sample survey cannot be generalised to the whole population of GPs. Nonetheless we believe that the information which we have assembled does add to our insights about the views of non-fundholding GPs. This information is of particular relevance at a time when Government policy appears to be about to require Health Authorities to apply renewed vigour in their quest to attract new recruits to fundholding.

The extensive opposition to fundholding on grounds of principle among non fundholders must remain a concern. It is not, however, necessarily an obstacle to the recruitment of new practices. A national study reported in the magazine Fundholding in 1993 suggested that two thirds of non-lead partners in fundholding practices were forced to join the scheme despite their reservations. Having unwilling recruits may not produce a healthy long term situation but it does not appear to have acted as an insuperable short term barrier.

On the other hand, fears of extra workload expressed by half of our GPs and the fact that only about one quarter of them believed that they had the management capacity to cope with fundholding means that considerable practical assistance is likely to be necessary if new recruits are to join the scheme successfully.

On the subject of assistance and support, a very mixed picture emerges regarding the roles adopted by FHSAs/Health Authorities. Encouragement to become fundholders is

reported as varying from "frantic" to "luke warm". Similarly, practice sensitive alternatives to fundholding are widespread throughout the region but appear to display very different stages of development. Attitudes towards this variability on the part of FHSAs/Health Authorities will, no doubt, depend on the extent to which local autonomy is to be encouraged on the one hand, and the importance attached to centrally defined initiatives on the other.

Finally, possibly our most striking finding, is that despite the strong objections on the grounds of principle, and widespread concerns among practices about their capacity to cope with the management aspects of fundholding, over 40 per cent of GPs said that if other practices in the locality started to become fundholders they would have to apply. Additionally, just under another 30 per cent said that such developments would "possibly" lead them to apply for fundholding. These findings suggest that peer pressure and pragmatism are strong among GPs and are likely to be important determinants on how fundholding develops.

Appendix 1: Letter to GP Practices

24 August 1994

Dear

Non-Fundholders' attitudes towards GP Fundholding

My Institute has been asked to carry out a study for South & West Regional Health Authority on non-fundholding GPs' attitudes towards GP fundholding. The aim of the study is to get a clear idea of the views on fundholding held by those GPs who have not taken part in the scheme.

We hope to carry out short interviews with a sample of twenty practices within the South & West Region and my purpose in writing to you is to ask if your practice would be willing to take part in the study.

Ideally we would like to interview you, as senior partner, one other partner and your practice manager, if you have one. I realise that you are very busy and can not be expected to spare much time and so, for this reason, we aim to keep the interviews down to around 30 minutes per person.

I do hope that you will feel able to spare a little time to help us as we are anxious to gain as accurate a picture as possible on this important subject. We will be happy to share our findings with you, on an anonymised basis, when the study is complete. We have also informed the Royal College of General Practitioners that we are undertaking this study.

Either my colleague Mrs Philippa Hayter, or myself will telephone your practice shortly to see if you are willing to help and, if so, to try and arrange a time and date for the interviews.

With best wishes.

Yours sincerely

RAY ROBINSON
Professor of Health Policy
Director

Appendix 2: Questionnaire

INSTITUTE FOR HEALTH POLICY STUDIES
UNIVERSITY OF SOUTHAMPTON

ATTITUDES TO GP FUNDHOLDING

QUESTIONNAIRE

1. Interviewer:

2. Date of interview:

3. Name and address of practice:

4i. Name of respondent:

4ii. Position of respondent in practice:

4iii. Number of years in practice:

I PRACTICE DETAILS [OBTAIN FROM PRACTICE MANAGER]

5. Number of Partners:

Senior Partner: f/t ..... Other Partners: f/t .....

p/t ..... p/t .....

6. Other staff employed by the practice:

	f/t	p/t	hours per week
Practice Nurses			
Practice Managers			
Receptionists			
Other			

7. Other staff working with the practice:

	f/t	p/t	hours per week
Health Visitors			
District Nurses			
Other			

8. Patient list size:

9. Practice Location: (Tick, delete or name)

   i) "Old" Wessex RHA or "Old" South Western RHA

   ii) FHSA

   iii) DHA/Health Commission

   iv) Geography/Demography (describe)

10. Strength of fundholding in the local area

    high / moderate / low

11. Practice Premises (physical description, tenancy arrangements)

12. Do you have any branch surgeries?

13. Are you a dispensing practice?

II ATTITUDES TOWARDS THE PRINCIPLE OF FUNDHOLDING

14. Do you have any philosophical objections to fundholding on grounds of principle, politics or ideology

    Yes/No

    If yes, please explain.....

15. Can you give some specific examples, from your experience, of the way in which the above factors have led to developments in general practice which you don't like?

16. Leaving aside your philosophical objections, what do you think would the practical disadvantages if your practice went fundholding?

III ACTION ON FUNDHOLDING

17. Have you had a formal discussion within your practice about applying for fundholder status? How? When? Please describe.

18. Did you discuss the possibility with the FHSA/DHA/HC/RHA?

19. Who was involved in the discussions?
[Prompt: all partners, seniors,...?]

    i) within the practice

    ii) with the FHSA/DHA/HC/RHA

20. What was the decision?
[Prompt: no/ reconsider/ wait and see/ application refused]

21. Who made the final decision?
[Prompt: senior partner(s) / consensus / majority]

IV SOURCES OF INFORMATION AND SUPPORT

22. We would like to ask about your contact with other practices, both non-fundholders and fundholders.

	Fundholders	Non-fundholders
Do you meet?	regularly/infrequently	regularly/infrequently
Do you discuss fundholding	regularly/infrequently	regularly/infrequently

Please elaborate:

Who convenes/facilitates these meetings?

Do the meetings include/exclude fundholders

23. What professional magazines/journals do you read which inform your opinions about fundholding?

24. Are there any other sources that have informed you about fundholding? (e.g. audio tapes)

25. Have you ever attended any training events/workshops/conferences on the subject of fundholding?

If so, please give details: [Prompt: What/when? Who organised?]

26. Has the DHA/FHSA/HC/RHA offered you any practical advice or support in applying for fundholding?

If so, please give details...

27. Has the DHA/FHSA/HC/RHA offered you any alternative arrangements to fundholding as part of its general primary care strategy? (eg other models of practice sensitive purchasing).

If so, please give details:
[Note: Probe about GP led initiatives eg. consortia]

V ORGANISATIONAL PREPAREDNESS FOR FUNDHOLDING

28. Do you think that your practice has the management capacity to contemplate becoming a fundholding practice? [Probe]

29. What computing facilities do you have?

30. Is the minimum list size an obstacle to an application for fundholding?

If so, how do you feel about grouping with other practices for fundholding purposes?

VI ISSUES FOR THE FUTURE

31. Fundholding has been criticised for introducing a conflict between clinical and financial considerations. In relation to the allocation of health care resources who do you think should decide:

Government/politicians

DoH/NHS Executive

HAs/HCs

GPs/PHCTs

Hospital consultants/managers

Patients/public

Other, please specify

Other Comments:

32. Leaving aside differences in the practice population profile, do you think that it is reasonable for one practice to have different priorities for its patients to another practice? [Note: explain and probe, give examples]

33. Setting aside the disadvantages, do you see any potential advantages for your practice in fundholding compared with your present situation? [Note: chance to reflect on earlier answers]

34. Are you intending to apply for fundholding in the future?

    If so, please give details:

35. Which of the following would significantly increase the prospect of your practice applying for fundholding:

    i) other practices in the locality going GPFH

    ii) a consortium arrangement with other practices

    iii) a management agency to manage the fund

    iv) a preparatory management allowance

    v) a mentorship scheme in the preparatory year

    vi) better support from your FHSA/HC

    vii) better fundholding software

    viii) an entry level fundholding scheme of more limited scope

    ix) more knowledge about the pros and cons of fundholding

    x) simplification of the scheme

    xi) a different method of funding?

    xii) other, please specify

36. Reflecting back on our discussion, what would you say are the <u>three main reasons</u> why your practice has not applied for fundholding?

37. Thank you for your help. Is there anything else that you think we should know about?

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