Present developments in British primary health care – what could be of interest for Sweden?

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Inom det brittiska sjukvårdssystemet, National Health Service, har nyligen stora förändringar genomförts i primärvården. Flera av dessa har direkt intresse ur ett svenskt perspektiv. Enläkarmottagningar har omvandlats till gruppmottagningar med starkare administrativ styrning. Det nya avtalet för allmänläkare från 1990 innefattar starkare betoning av förebyggande insatser, bl a genom att dessa kopplas till lönemässiga konsekvenser för doktorn. År 1991 infördes ett system som innebär att ett urval av allmänläkare fått ansvar för en stor del av sjukvårdsbudgeten för sina patienter så att det är de som köper tjänster från sjukhusen. Denna s k "fundholding" innebär en rad möjligheter och problem som belyses i artikeln.

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Within the United Kingdom (UK), there has been a well developed system of primary health care. Patients see general practitioners (GPs) as the first point of contact in the case of illness. GPs and other members of the primary health care team deal with approximately 90 per cent of patients' illness episodes without the need for hospital or specialist treatment.

This is one of the factors which helps to explain why the Nationel Health Service (NHS) offers good value for money. Expediture on health care in the UK is only 6 per cent of the Gross Domestic Product (GDP) which is low by international standards. One of the reasons for this is undoubtedly the well established primary health care system that exists. This helps to reduce the demands made on secondary care services. During the lifetime of the NHS, there have been many positive developments in primary care. First, there has been an increase in the number of GPs in relation to the population served. As a result, on everage each GP today serves 2 000 patients.

Second, GPs have moved away from single handed practice to operate in groups. Single handed GPs now comprise only 10 per cent of all general practitioners. Third, linked to this, GPs have come to work as part of a primary health care team. They operate alongside nurses, health visitors, social workers and other staff to provide a full range of care.

Fourth, the distribution of GPs has become more equitable, where GPs practice is controlled by the Medical Practices Committee. This Committee has evened off the location of GPs in different parts of the country.

Problems have emerged

Despite these successes, a number of problems have emerged. To begin with, there are varible standards of primary care. The best practices are very good indeed, the worst leave a lot to be desired. We have not yet been able to achieve consistently high standards across the NHS as a whole.

One particular problem is the poor standards of care in inner city areas. It is precisely in these areas that good care is needed because of the health problems that exist. Yet high standrds are often absent and as a consequence patients use hospitals in place of GPs. As Julian Tudor Hart noted a number of years ago, there is an inverse care law in which the best care is most available where it is least needed.

There are also wide variations between GPs in their

GPs har övergivit enläkarmottagningar för att arbeta i grupp

Julian Tudor Hart formulerade ''the inverse care law'' enligt vilken den bästa vården är mest tillgänglig där den är minst behövd

rates of referral to hospital. At the extremes, it has been estimated that there are 24- fold differences. In practice, the range is rather smaller, but there are still 2 to 3-fold variations between GPs in different parts of the country.

A futher concern is about the cost of prescribing. To tackle this, governments have taken a number of initiatives in recent years. They include the development of a limited list of drugs, the introduction of the prescribing analysis and cost (PACT) system for monitoring prescribing patterns, and the introduction of indicative prescribing amounts.

Turning now to recent developments, there are three issues I would like to highlight:

– the new role of family helth services authorities
– the new contrct for GPs
– the GP fundholding scheme

I will comment on each of these in turn.

The new role of family health services authorities

Family health services authorities are the bodies which run family practitioner services at a local level. In the past, they have been mainly involved in administration. This has involved keeping lists of GPs, helping patients to find GPs, and making sure GPs are paid properly.

In the last few years they have moved to take on more of a managerial role. For example, they are expected to visit and inspect GPs' premises.
They now control a budget for staff to support GPs. They monitor the use of deputising services by GPs. And they operate the PACT system for reviewing prescribing patterns.

To help them in these responsibilities, the Government has recently changed the membership of family helth services authorities. They are no longer dominated by professionals but instead have a mainly lay membership. They have also appointed general managers to take on a more active managerial role.

New contract for GPs

The new contract came in April 1990 amid much controversy. It was strongly opposed by some doctors but the Government persisted with the contract. It has a number of purposes.

One objective is to increase the proportion of a GP's income that comes from capitation payments. This has risen from 46 per cent to 60 per cent. It is intended to make GPs more responsive to their patients.

The second objektive is to put more emphasis on prevention and health promotion. For the first time, special payments have been introduced for GPs who hold health promotion clinics. Also, GPs get extra income if they achieve targets for vaccination and immunisation and cervical cancer screening.

Recent evidence indicates that GPs have responded to the new contract by working harder. As a consequence they have exeeded the income targets set by the Government. Overall, GPs have been overpaid by almost £6 000 each on average. This is a nice illustration of the fact that medical practices do respond to financial incentives. The Government is now commited to clawing back some of this increase in future years.

GP fundholding

The GP fundholding scheme is part of a much bigger programme of reforms introduced by the Government. It is intended to give GPs in lager practices a budget with whitch to buy some services for their patients. The scheme is voluntary and relies on GPs coming forward to participate. Originally, only practices with 11 000 patients or more were eligible, but this has been reduced to 9 000 patients. Indeed, recently a single handed GP with only 3 ooo patients was accepted as a fundholder. In ballpark terms, the budget controlled by GP fundholders amounts to about £1 million a year for

Andelen av en GPs inkomst som kommer från den befolkningsrelaterade ersättningen har stigit från 46 procent till 60 procent

Ett tänkbart problem med ''fundholding'' är att GPs kan komma att avstå från remittering av patienter för att spara pengar

10 000 patients. The biggest single element in this is money for prescribing drugs.

Fundholding has a number of potential benefits. It gives GPs more power to negotiate improvements in services with hospitals. It also makes GPs more conscious of the cost of their decisions. Fundholding includes new financial incentives for GPs. In particular, it encourages GPs to cut prescribing and to employ more staff. It also includes an incentive to encourage GPs to do more themselves and to reduce demands made on hospitals.

There are also risks involved. For example, GPs may be more careful in their selection of patients. This may be to the benefit of younger, healthier patinets at the expense of those who are older and sicker. Another risk is that budgets may be overspent because of random factors. The fundholding scheme involves relatively small numbers of patients and a budget could be blown off course not because of mismanagement but because of the difficulty of anticipating demands. A further potential problem is that GPs may under-refer patients to save money. This could delay necessary treatment until it becomes an emergency and has to be paid for by the health authority, not the GP.

One issue already under active debate is whether fundholding affects equity. In practice, it is difficult to stop patients of fundholding GPs receiving quicker or better treatment than patients of other GPs. This after all is part of the purpose, to empower GPs to have more negotiating ability with hospitals.

Det är för tidigt att säga om ''fundholding''-systemet har lyckats eller misslyckats

One of my concerns is that fundholding will diminish the purchasing role of district health authorities. The money that GPs recieve is taken away from the budget of the health authority. This inevitably weakens the purchasing power of the health authority.

It is too early to say whether the fundholding scheme has succeeded or failed. It only started on 1 April 1991 and more experience is needed before a clear judgement can be reached. Already, there is the prospect of another wave of fundholding practices coming into operation on 1 April 1992. In the longer term, much depends on who wins the next general election in the UK. If a Conservative government is returned, then a futher expansion of the fundholding scheme can be anticipated. On the other hand, if a Labour government is elected, it is likely the scheme will be reversed or at least significantly modified.

Conclusion

This is a time of considerable innovation and excitement in British primary health care. The combination of a new role for family health services authorities, the new contract for GPs, and the GP fundholding scheme has meant major change in a short period of time. Although teething problems have occurred, in general the experience has been positive. From the point of view of GPs, the reforms involve a lot more hard work, but there are also extra rewards in the system. A major question mark is about the future of GP fundholding and whether the benefits will outweigh the risks in practice.