Primary Health Care in the UK:Policy,Practice and Performance

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This paper(i)describes the main elements of the system of primary health care in the UK,(ii)identifies the major policy changes that have taken place in relation to the sector over the last 15 years, and (iii) analyses a number of key development in terms of the research evidence on policy and practice. Particular attention is devoted to the reforms involving general practioner(GP) fundholding, the total puchaisng(TP) pilot sites, the primary medical services(PMS) pilot sites and newly formed primary care groups(PCGs). The paper concludes with some preliminary comparative analysis between primary care in the UK and Japan.

1. Background

The UK National Health Service (NHS) was established in 1948 as a tax-funded system offering universal access to care provided free at the point of use. The fundamental components of the primary health care system were established at this time. A cornerstone of the system was an extensive network of general practitioners (GPs) with whom patients could register and receive care free of charge.

The terms on which GPs were to work for the NHS were, however, disputed fiercely by the British Medical Association and the government. GPs were anxious to retain their professional autonomy and opposed to measures which sought to introduce a salaried service. Eventually an agreement was reached that allowed GPs to work for the NHS on a contractual basis as independent, self-employed professionals rather than as direct employees. This system remains largely in force today with the terms and conditions of the GP's contract with the NHS negotiated annually between the doctors' representatives and the government (see below). GP services provided by the NHS remain free at the point of use to users.

Today the services of GPs (i.e. general medical services) are provided as part of Family Health Services alongside general dental, pharmaceutical and general ophthalmic services. (See Allsop [1995] for a fuller account of the development of primary care as part of the NHS since 1948).

The present GP payment system—as set out in the 1990 national contract—comprises a basic practice allowance together with an annual capitation fee for each patient on the GP's list. The amount of the capitation fee depends upon the age of the patient (i.e. under 65 years, 65–74 years and 75 years and over). In addition, GPs receive special payments for the provision of specific services, e.g. reaching targets in relation to immunisations, carrying out cervical cytology tests and making home visits at night.

By and large, the system has worked well. The UK has a highly developed system of generalist, primary care delivered by GPs and associated staff (e.g. practice nurses, community nurses, midwives). Everyone is eligible to register with a GP and over 90 per cent of the population are formally registered with GPs who provide 24 hour access to a range of preventative, diagnostic and curative primary care services (Those not formally registered with GPs tend to be mainly homeless people and those in temporary accommodation. The fact that they are not registered makes it more difficult for them to gain access to primary care services, but not impossible. Many GPs are prepared to see non-registered patients in emergency situations). Approximately 90 per cent of patient contacts with the NHS are with GPs. The average person contacts a GP about four times per year, although consultation rates vary between different population groups, with women having higher rates than men and elderly people having higher rates than those in younger age groups. Patients may select a GP of their choice, although choice is restricted within geographical areas. The incidence of people changing their GPs—other than for reasons of changed residential location—is low. Most people have a long-standing relationship with their GP.

GPs carry out an important 'gatekeeper' function. Patient referral to NHS hospital specialists is made by GPs. GPs usually refer patients to specialists at local hospitals although referrals to specialists in regional or national centres may be made in the case of complex cases/Unlike the health care systems in many other countries, NHS patients do not have direct access to specialists other than in special circumstances, e.g. attendance at hospital accident and emergency departments, treatments for sexually transmitted diseases. In 1994, about 11 per cent of GP consultations led to a hospital referral for tests, investigations or treatment (Office of Health Economics, 1998). The remainder of consultations were dealt with by GPs themselves. The existence of an effective gatekeeping system reduces pressure on the secondary care sector and is a major reason for control of the growth in expenditure in this sector.

There has been a steady increase in the number of GPs and a reduction in their patient list sizes over the last 20 years. In 1995 there were 32,939 GPs offering NHS services in the UK; this represents an increase of 22.4 per cent since 1980. As a result of this increase, the number of GPs per 100,000 population grew from 47.8 to 56.2 over the same period. This produced a reduction

in the average GP patient list size from 2,094 in 1980 to 1,779 in 1995. Over the period 1984 to 1991, there was a steady increase in the numbers of very elderly people (i.e. aged 75 years and over) on GP lists—rising from an average of 118 to 127 per GP—but since 1991 the numbers have started to fall (Office of Health Economics, 1998).

Another change in organisation has been the tendency for GPs to work together in larger partnerships. In 1995, for example, 26 per cent of GPs worked in groups comprising six or more partners compared with only 12 per cent of GPs working in partnerships of this size in 1980. At the other end of the range, the percentage of GPs working single-handed fell from 14 per cent in 1980 to 10 per cent in 1995. Single-handed practices tend to be concentrated in certain areas, particularly in inner-cities. (Office of Health Economics, 1998).

Alongside the growth in the size of GP partnerships, there has been a trend towards the creation of primary health care teams in which other health professionals work with GPs in the delivery of primary care. These professionals include practice nurses and community nurses such as district nurses, midwives and health visitors.

Practice nurses are generally registered nurses who are employed by GPs to work within practices. The number of practice nurses has increased by almost threefold over the last ten years so that by 1996/97 there were 9,821 full-time equivalents working in the NHS (i.e. about one for every three GPs). They undertake a variety of tasks including chronic disease management, health promotion activities, immunisations and health assessments.

Community nurses are formally employed by community hospitals but they are usually attached to, and work alongside GPs and other primary care professionals. District nurses provide skilled nursing care for patients in their own homes; health visitors visit families with babies and very young children in their own homes, offering advice on preventive health care and health promotion; and midwives concentrate on women's health during pregnancy and childbirth.

Expenditure on the primary care sector has grown rapidly over the last 15 years. It reached £10.2 billion in 1996. The Thatcher government kept tight control over the cash-limited hospital sector during the 1980s but did not exert similar control over the demand-led family health services sector (Appleby, 1992). The rate of growth of expenditure on pharmaceuticals has been particularly pronounced and now represents over 12 per cent of NHS expenditure (Bloor *et al*, 1999).

Despite this growth in expenditure, however, judged by international standards, the primary care sector in the UK is not expensive. Total NHS expenditure in the UK currently represents about 6.9 per cent of GDP and spending on primary care services represents about 25 per cent of this total. This is a relatively low fraction of total health expenditure compared with many other OECD countries; in the United States, Belgium and Switzerland, for example, it is over 30 per cent and in Japan it is over 40 per cent (Office of Health Economics, 1999).

These, then, are the rudiments of the UK primary health care system. It is a long-established system with strong continuity centring on the GP as an independent professional. Over the last ten years, however, there have been some radical experiments and changes in the organisation, finance and delivery of primary care. Current initiatives even involve the introduction of salaried GPs, a move that was resisted strenuously at the outset of the NHS. The remainder of this paper considers some of the main changes that have taken place over the last decade.

2. The policy shift towards primary care in the 1980s

Until the mid 1980s, primary care had received scant attention from policy makers in the UK. It was seen as less important than acute care and had been the subject of far fewer policy initiatives (Marks, 1988). The 1980s were, however, a period when the overriding emphasis of the then Conservative government, under prime minister Margaret Thatcher, was to increase efficiency in the public sector through stronger management and, where possible, through the introduction of competition. The primary care sector was caught up in this general policy thrust.

The first step was the granting of additional powers to Family Practitioner Committees (FPCs) in

1985 to enable them to 'manage' rather than 'administer' the contracts of GPs. (Taylor, 1991). Since their introduction at the outset of the NHS, FPCs had performed what became known as a 'pay and rations' function; that is, they simply reimbursed GPs according to a set of financial rules. They were 'price-takers' and made no attempt to use their payer function to bring about greater efficiency in the provision of primary care services (Bloor *et al*, 1999). However, the government's attempt to get them to 'manage' primary care revealed that they did not have the power or capacity to carry out this function and led to the more radical White Paper, *Promoting Better Health* (DHSS, 1987).

The 1987 White Paper contained a number of proposals designed to meet the objectives of: making services more responsive to consumers, giving patients more choice, raising standards of care and improving value for money. One of the stumbling blocks to achieving these aims was the GP national contract which was extremely vague about the duties of GPs and had been largely unchanged since 1965. Therefore, in 1990, the Secretary of State imposed a new national contract on GPs, despite widespread opposition from the profession. The aim of the new contract was to make GPs more accountable to Family Health Service Authorities (FHSAs, the successors to FPCs), to make services more responsiveness to patient needs and to give patients more choice, and to make payments more performance-related (Allsop, 1995). The 1990 contract heralded the introduction of a decade of change that is transforming primary care in the UK. The next step in this process was the introduction of GP fundholding in 1991.

3. GP fundholding

The NHS and Community Care Act of 1991 separated the responsibility for purchasing NHS services from the responsibility for providing them. On the purchaser side, the main organisation given responsibility for purchasing services was the district health authority (DHA). DHAs covering average populations of around 150,000 people received fixed budgets with which they were expected to purchase a mix of hospital and community health care services that met their population's health care needs. However, alongside the DHAs—on an experimental basis—303 GP practices with patient list sizes of 11,000 people or more were given budgets with which they could purchase a range of services directly on behalf of their patients (Glennerster *et al*, 1994).

The standard fundholding budget included most elective surgery (this included ophthalmology; ear nose and throat; thoracic surgery; procedures covering the cardio-vascular system; general surgery; gynaecology; and orthopaedics), most outpatient services, diagnostic tests and procedures and pharmaceutical prescriptions. In total, these services represented about 20 per cent of the total hospital and community health service cash allocation on fundholders patients. The remainder was still purchased for them by the relevant DHA. It is also important to stress that the budget did not include the GP's personal income: this continued to be paid separately in line with the national contract. Moreover, fundholding savings could be reallocated by the practice to other services but could not be used to supplement GPs' incomes.

The idea for fundholding was based on the US experience of health maintenance organisations (Robinson and Steiner, 1998). By bringing together the responsibility for financial and clinical decision making, it was expected that GPs would have an incentive to make more cost-effective use of limited resources. Moreover, it was felt that GPs, with their direct knowledge of individual patients, would be in a good position to negotiate with providers to secure the provision of timely and appropriate services. They would be well-informed local decision-makers. Furthermore, because their budgets depended on the number of patients registered with them, they had an incentive to offer services that were responsive to consumers' preferences and to thereby extend patient choice.

Although the GP fundholding scheme was very much a 'side-show' at the beginning of the NHS reforms (Glennerster *et al*, 1994), it grew to become a major aspect of the reform programme. As was pointed out above, 303 funds were established in 1991 covering approximately 7 per cent of the population. By 1995, there were 2,221 funds covering 41 per cent of the population. By the time the new Labour government

was elected in May 1997, fundholding covered over half of the patient population.

During this period a number of changes to the original model of fundholding took place (Mays and Dixon, 1996). First, it was adapted to allow smaller practices to take part. Initially, it was restricted to larger practices with 9,000 or more patients. Thereafter the threshold was reduced to 7,000 patients and, from April 1996, practices with lists of 5,000 or more patients were allowed to join. Moreover, a new form of 'community' fundholding was introduced in which practices with 3,000 to 5,000 patients were permitted to purchase non-hospital services included in the standard fundholding budget. Second, the range of services that were included in the fundholding budget was extended. Thus, for example, from April 1996 standard fundholders were able to purchase specialised nursing services (e.g. stoma care and diabetic nursing). Third, a number of arrangements developed—such as consortia and multi-funds—whereby individual fundholding practices worked closely together. By pooling certain managerial facilities, they sought to realise economies of scale and scope without jeopardising the original flexibilities offered by the fundholding scheme. Finally, an experimental extension of fundholding was introduced, known as 'total purchasing'. Through this scheme, selected fundholding practices were allocated budgets with which they could purchase potentially all of the hospital and community health services received by their patients. (A fuller discussion of total purchasing is presented in the next section).

Despite its growth GP fundholding remained a controversial part of the NHS reforms with strong supporters but also strong critics. Even among GPs it had its opponents (Robinson and Hayter, 1995). In fact, because of their opposition, some GPs banded together into rival non-fundholding organisations that became known as GP commissioning groups. These groups sought to bring about change in primary care services by close consultation and collaboration with DHA purchasers rather than as direct purchasers in their own right.

The Labour Party, while in opposition, was hostile to fundholding and, as will be shown later, has abolished it since becoming the government. Perhaps because of the controversy surrounding the scheme, fundholding was the most heavily-researched aspect of the NHS reforms. The evidence from a variety of research studies has most recently been summarised by Goodwin (1999). His review identifies the following areas where there is some consensus among the research community about the impact of fundholding.

The rate of increase in prescribing costs among fundholders was lower than among non-fundholders initially, but the differential appears to have been eroded over time. Fears that fundholders would reduce their referral rates seem to have been unfounded: there was no difference in the rates of increase in referrals between fundholders and non-fundholders. Fundholders took the opportunity to expand the range of practice-based services (e.g. counselling, outreach clinics). Providers (i.e. hospitals, diagnostic services) have been more responsive to the demands of budget-holding fundholders than to non-fundholders. This took a variety of forms including more speedy hospital appointments for fundholding patients, quicker production of test results and generally better communication between hospital specialists and fundholding GPs. Holding a budget appeared to offer fundholders leverage over the hospital sector.

On the downside, the decentralisation of purchasing associated with fundholding led to a heavy management workload and large numbers of small contracts with providers resulted in substantial transactions costs. A two-tier system grew up whereby patients of fundholders received better access to care than those of non-fundholders. There was no evidence to suggest that the degree of patient choice was increased. More seriously, there was no evidence to establish whether or not fundholding led to improvements in the quality of care and better health outcomes.

Despite this mixed picture, however, the Conservative government of 1991 to 1997 remained committed to the principle of a 'primary care-led NHS' and fundholding was central to this commitment (NHS Executive, 1994). As part of this policy-thrust an experimental extension of standard fundholding, total purchasing, was introduced in April 1995.

4. Total purchasing pilot sites

Fifty-three total purchasing pilot sites (TPPs) began a preparatory year in April 1995 and went 'live' in April 1996. These were joined by another 35 'second wave' sites in April 1996. The average first-wave TPP comprised four general practices and 20 GPs. The average patient list size was 31,300 with a range extending from 8,100 to 84,700. The characteristics of the second wave were similar although they included a whole DHA site covering a population of over 300,000 people.

Most TPPs had experience of GP fundholding and saw becoming a total purchaser as an extension of this activity. Unlike GP fundholding, however—which was enshrined in legislation—no official definition of total purchasing was ever specified. One working definition put forward unofficially was:

> *'where either one general practitioner practice, or a consortium of practices, are delegated money by the relevant health authority to purchase potentially all of the community, secondary and tertiary health care not included in standard fundholding for patients on their list'* (TP National Evaluation Team, 1997).

Another contrast between standard fundholding and the TPPs was that the government decided to make total purchasing the subject of a three-year, independent evaluation. Accordingly, a consortium of researchers was brought together with the remit to establish: 'the factors associated with successful set-up and operation of total purchasing; the costs and effectiveness of total purchasing; and the benefits delivered to patients through total purchasing'. (TP National Evaluation Team, 1997).

At the time of writing (July 1999) the final report of the research team is in the final stages of preparation, but a number of earlier reports identified many of the strengths and weaknesses of total purchasing (TP National Evaluation Team, 1998a, b).

The research evidence indicates that there was a strong link between TPP organisational development and their ability to achieve objectives. For the most part, their achievements were incremental, small-scale and locally generated. They included schemes to achieve early discharge for their patients from hospital; the provision of community and continuing care beds as part of integrated care schemes; the provision of improved maternity services; reductions in unnecessary emergency hospital admissions; and the development of an enhanced range of primary care services (Killoran *et al*, 1999).

The TPPs also attracted interest because they appeared to be UK examples of primary care-based, managed care organisations. As in the case of the more highly-developed US managed care organisations, TPPs were starting to use a range of micro-management techniques—such as utilisation review and management—to manage patient care at the primary-secondary care interface (Robinson and Steiner, 1998). Many total purchasers attached high priority to reducing unnecessary hospital admissions and unnecessarily long hospital lengths of stay. To achieve these aims, TPPs set up minor injuries clinics, developed local community hospital facilities, created GP-led emergency assessment facilities and appointed discharge and liaison nurses.

Set against these positive achievements, TPPs were found to add to total health system transactions costs locally. The bulk of these costs were incurred at the practice level (85 per cent) and were particularly associated with the time-costs expended by GPs. Since the TPPs were managed by a few people with high workloads, their sustainability over time and on a wider scale was questionable. Their ability to engage in population-based, strategic activity was also limited. This suggested that if the devolution of purchasing responsibility to primary care-based organisations was to be extended, it needed to be accompanied by public health and other more strategic functions based at a more aggregate level of organisation.

In the event, TPPs proved to be a fixed term experiment. Their lives drew to an end in October 1998. By this time a new government with its own plans for the reform of primary care was in power. These plans focused on the creation of Primary Care Groups (PCGs). The experience of TPPs remains of relevance, however, because they constitute the closest organisational form to PCGs about which there is actual evidence on performance. The plans for PCGs and the lessons that can be drawn from TPP experience are discussed later in this paper, but before then, two

other important developments in the primary care sector that took place during the 1990s are examined. The first of these is the establishment of Personal Medical Services (PMS) pilot sites.

5. Personal medical services pilot sites

As the 1990s progressed, the then Conservative government increased its commitment to a 'primary care-led NHS'. During the first part of 1996, the Minister for Health conducted an extensive listening exercise in which the views of professionals, patients and others were sought on the future of primary care (NHS Executive, 1996). A Paper, *Choice and Opportunity* setting out the proposed future direction for primary care was published shortly afterwards (Department of Health, 1996). Among the proposals contained in the White Paper was the introduction of a salaried option for GPs—rather than their independent, contractual status—and the introduction of practice-based contracts through which health authorities could commission primary care teams directly to provide a specified range of services. These proposals were subsequently developed through the Personal Medical Services (PMS) pilot sites introduced in 1998 as part of the NHS (Primary Care) Act, 1997. They have attracted bi-partisan support with the new Labour government continuing the earlier Conservative government's commitment to the policy.

Eighty-five pilots were established in the first-wave and these have been joined by another 171 in the 1999 second-wave. Schemes vary a good deal. A number involve the recruitment of salaried GPs to work in deprived areas. Others offer the full range of chronic care services on one site, e.g. one-stop diabetes services such as eye screening, chiropody and dietetics and a nurse-led urology service.

The changes being introduced by the PMS pilots have been referred to by some people as the 'quiet revolution'. They have attracted far less comment and debate than more high-profile reforms such as GP fundholding and now primary care groups. But in some ways their potential consequences are far greater. The GP national contract has made it very difficult to plan and manage the provision of primary care services in the way that acute services are planned. Ultimately GPs have been self-employed professionals able to offer services in locations and ways of their own choosing. The introduction of salaried option enables the recruitment of GPs to locations, e.g. inner-cities, where there is currently a shortage of high-quality care. At the same time, the introduction of local contracts enables planning to take place within a co-ordinated framework. Although there has been a good deal of wariness on the part of many GPs about the threat to their independence, the introduction of a salaried option—alongside the more traditional, contractual arrangement—is viewed favourably by many GPs (Moore, 1999).

Another feature worth emphasising about the PMS pilots is that the granting of pilot status has been contingent on a satisfactory system of local evaluation being put in place. In addition, there is a centrally funded programme of national evaluation. The emphasis placed upon evaluation continues the trend of the total purchasing evaluation programme and is in sharp contrast to the lack of official interest in evaluation displayed at the time of the 1991 reforms (Robinson and Le Grand, 1994).

6. Shifting the balance towards primary care

The primary care reforms of the early 1990s placed major emphasis on the purchasing or commissioning role of primary care-based organisations. This was most pronounced in the case of GP fundholding and continued with its extension to total purchasing. But primary care has, of course, always been primarily concerned with the *provision* of services. This became apparent as the focus of both fundholding and total purchasing was extended by GP practices themselves to incorporate the provision of an enhanced range of primary care services. It was also confirmed by the government in various statements that interpreted the primary care-led NHS to mean that services should be provided in locally-accessible, primary care or community settings wherever it was appropriate, safe and cost-effective to do so. This led to a major policy-thrust aimed at shifting the balance of care from acute to primary care settings.

Although there have been many examples of the expansion of primary care services as substitutes, or

part substitutes, for hospital-based services, defining a shift in the balance of care in a way that commands universal acceptance is not as straightforward as it might appear. Practitioners often define services in terms of organisational boundaries or budgets. Others view them in terms of key inputs (e.g. GPs versus specialists) or the location of treatment (primary/community settings versus acute hospitals). Moreover, Evans (1994) has shown that different stakeholders (i.e. GPs, other members of primary care teams, hospital specialists, managers) view the nature and extent of shifts in different ways. Faced with these different perspectives, in a recent study, Godber *et al* (1997) chose to define as a shift towards primary care as having taken place when a service acquired one or more of four key attributes. These were direct access, generalist care, longitudinal care and delivery in a community setting. According to this definition, numerous shifts in the balance that have taken place during the 1990s can be identified.

Most directly, there has been direct substitution of primary care services for hospital based services as GPs have undertaken more minor surgery. Under the 1990 contract there are special payments available for GPs qualified to undertake this work. In terms of substitution, services such as physiotherapy have also been developed in primary care settings. Primary care teams have also assumed a larger role in managing the recuperation of patients after surgery as rates of day surgery have increased. The expansion of primary health care teams has also led to the development of shared care/integrated care programmes for the management of chronic diseases such as diabetes and asthma. Domiciliary and hospital-at-home schemes have expanded as new drugs and other technologies have made it possible for many patients to be treated at home whereas previously they would have required hospital admission. A final example is provided by the massive expansion in primary care-based counselling services as an alternative to hospital referral.

The emphasis placed by the UK government on the development of primary care services is, of course, consistent with the World Health Organisation Alma-Ata declaration on the need to strengthen primary health care (WHO, 1978). As Coulter (1996) points out:

"In the ideal model, primary care teams provide continuous care and preventive care for defined populations, referring on to specialist services only when necessary. The emphasis is on co-ordination and continuity of services, which respect individuals' autonomy while catering for the full range of basic health care needs for local populations. At its best, a strong primary care system should be able to deliver cost-effective health care distributed equitably according to need".

Moreover, as Starfield (1994) has noted, those countries with strong primary care sectors—such as the UK, Denmark and the Netherlands—seem to have been more effective in containing the growth of costs than those countries with relatively weak primary care sectors, such as the USA, Belgium and Germany.

Despite these potential advantages, however, Coulter (1996) questions whether the move towards a primary care-led NHS is actually justified on grounds of clinical and cost-effectiveness. On the question of cost-effectiveness, Godber *et al* (1997) reviewed 23 relevant studies published since 1985. On the surface, the evidence from this literature was encouraging. It suggested that diverse initiatives involving GP's undertaking minor surgery, practice-based physiotherapy, early hospital discharge schemes and shared care were all cost-effective. On closer scrutiny, however, many of the studies displayed serious methodological shortcomings in relation to the measurement of costs and outcomes. The researchers concluded that, contrary to the assumptions made by many policy makers, the cost-effectiveness of shifts in the balance towards primary care is far from proven.

Despite the shaky foundations of the evidence base, however, the current Labour government has continued to emphasise the central role to be played by primary care in the future development of the NHS. This has been especially strong in relation to the formation of primary care groups.

7. Primary care groups

The new Labour government recognised that GP fundholding had led to a number of service improvements but it also felt that it had increased transactions costs, fragmented services and increased

inequality (Department of Health, 1997). In view of this, its own programme for the future of primary care has abolished GP fundholding and its variants and replaced it with a nation-wide set of primary care groups (PCGs).

Four hundred and eighty one PCGs were established on 1 April 1999. Unlike fundholding—which was voluntary—membership of a PCG is compulsory for all GP practices. Each PCG has a governing body comprising between four and seven GPs, one to two nurses, a local social services department representative, a lay member, a health authority representative and the PCG chief executive. They have been formed around local communities with the average PCG covering a population of 100 thousand people, although there are variations around the average ranging from approximately 50 thousand to over 250 thousand people.

The government has set out a range of tasks for PCGs. They are required to commission health services for their populations from NHS trusts. However, to avoid the fragmentation of services, this commissioning is expected to be done within the framework of the local health authority's Health Improvement Programme. Transactions costs are expected to fall as three year service agreements replace annual contracts. PCGs are expected to monitor trust performance in terms of the specifications contained in these service contracts, to ensure quality standards and strive after efficiency gains. Considerable emphasis is placed on collaboration and partnership working in the new NHS and PCGs are expected to contribute to this process by working with health authorities, trusts, local government social services departments, voluntary groups and other organisations in the local health economy.

Recognising that the current state of primary care development varies around the country' the government has adopted a flexible approach to PCG development allowing them to enter the scheme at one of four levels. These are:

Level 1: acting in an advisory capacity to support the health authority in commissioning care for its population.

Level 2: acting as part of the health authority but taking devolved responsibility for managing the budget in the PCG area.

Level 3: becoming a free standing body with a budget for commissioning care, accountable to the health authority.

Level 4: assuming the functions of stage 3, but with the added responsibility for the provision of community health services for the PCG population. This level is known as a primary care trust (PCT).

Thirteen first-wave primary care trusts will be set up in April 2000. These will replace health authorities and each of them will have a budget accounting for about 80 per cent of NHS spending in its area.

Bloor *et al* (1999) have examined some of the main future challenges expected to result from the PCG agenda. These relate to organisational structure, clinical governance, financial accountability and the rationing of services.

On the question of organisational structure, it is important to emphasise the fact that PCGs are considerably larger than any previous models of primary care commissioning in the NHS. This will be an advantage in terms of risk-pooling and may yield some economies of scale. On the other hand, research carried out on the total purchasing sites (which were considerably smaller) showed that progress was slower among the larger sites as they had to confront complex problems of internal management. These problems are likely to be magnified among PCGs as their members are conscripts rather than volunteers. The main challenge for PCGs will be to develop a management infrastructure that enables 50–100 GPs and other primary care professionals to function corporately. The independent contractor status of GPs who work alongside salaried staff either employed by them or by community trusts, will require the development of an appropriate set of incentives and sanctions to ensure effective joint working. Ensuring effective collaboration with other agencies working in the local health care economy will require a similar incentive structure. (Killoran *et al*, 1999).

PCGs will also face considerable challenges in meeting the government's expectations in relation to clinical governance. The current government's policy places heavy emphasis on improving quality standards

in the NHS. The Paper, *A First Class Service: Quality in the new NHS* (Department of Health, 1998) sets out a completely new institutional structure for achieving its quality objectives. This includes a National Institute for Clinical Excellence which will assemble research evidence on clinical and cost effectiveness and produce guidelines for local decision-makers. Initially it is expected that many of the guidelines will relate to pharmaceutical products. GPs will be expected to adhere to these guidelines. Quite how this compliance will be achieved—in view of GPs' independent contractor status—is not yet clear.

More generally, PCGs will have a clear incentive to manage inappropriate variations in clinical activity among their members. Because the PCG receives a cash-limited budget, any excessive referrals to hospitals, or drug prescribing, on the part of some GPs will have implications for other GPs whose budgets will be reduced. Put another way: the opportunity costs arising from each GP's behaviour will be felt within the group. This can be expected to lead to some sensitive intra-group negotiations between GPs, and to the emergence of new forms of peer pressure. (This is, of course, the combination of financial and clinical decision making that US managed care organisations have used to control the growth in their costs [see Robinson and Steiner, 1998]).

Another concern about the emphasis placed upon primary care-led services centres on the role of public health. GPs have traditionally responded to individual patient demands and have not been prominent in population-based, public health programmes. Although the 1990 contract extended the GP's role by offering financial incentives for a range of preventive health activities undertaken on a population basis, e.g. achieving immunisation and screening targets, maintaining registers of patients with hypertension coronary heart disease and stroke, the GP service is still overwhelmingly demand led. As budgets are devolved to GPs, care will need to be taken to ensure that decisions incorporate a public health input that will probably continue to be based at the health authority.

Finally, the need to operate within a cash-limited budget will raise the profile of rationing undertaken by GPs. Opposition to rationing based on financial considerations was one of the main reasons why many GPs were reluctant to join the fundholding scheme. Now all GPs will need to operate within a fixed financial envelope and decisions regarding the relative priority of patients and services will become more sharply focused.

Taken overall, the programme for the development of PCGs raises a number of unresolved issues. The government has clearly tried to continue it's predecessors emphasis on a primary care-led service. To this end, it has decided to place GPs and other primary care professionals at the centre of decision making in terms of the commissioning of secondary care services and in the provision of an enhanced range of primary and community care services. To avoid the perceived inequity and heavy transactions costs of previous models of primary care-led commissioning, it has opted for a compulsory scheme based upon larger population aggregates. But this approach may embody a major inconsistency. The origins of primary care-based commissioning clearly lie with GP fundholding. Fundholders were essentially small-scale organisations (generally based upon a single practice) that had short lines of management and were able to act flexibly to bring about change. These characteristics were continued in the total purchasing experiment, even though these were larger than single fundholder practices. But this feature seems to have disappeared totally in the PCG model. Rather than being lean and flexible organisations, PCGs are large organisations embedded in health authority bureaucracy. This is not the model that delivered the improved performance associated with early examples of the primary care-led NHS and which provides the rationale for the policy in the first place. In short, the government may have fallen between two stools in its plans for the future of primary care.

8. Primary health care in the UK and Japan: some comparative analysis

The proportion of GDP spent on health care in the UK and Japan is very similar (6.7 per cent in the UK, 7.3 per cent in Japan [1993 OECD figures]) and both countries have succeeded in achieving universal access to health care. But, beyond this, the systems are very different.

Japan has a Bismarckian, pluralistic social insurance system—similar to that found in Germany—with mandatory enrollment based on employment or residence, and with premiums proportional to incomes. Funding for health care is provided through premiums paid by employers and employees to numerous company-based plans, patient co-payments, and national and local government subsidies (Ikegami and Campbell, 1995). Finance provided through the national budget represents about 25 per cent of total health care expenditure and patient co-payments represent another 12 per cent (Rapp and Shibuya, 1994). In contrast, approximately 90 per cent of the funding for the UK National Health Service comes from general taxation and—with the exception of pharmaceutical, dental and ophthalmic services—there is little cost sharing.

The ways in which doctors and hospitals are reimbursed also differ quite fundamentally. Under the Japanese Medical Service Law (*Iryou Hou*), doctors certified by the Minister of Health and Welfare are permitted to open clinics or hospitals anywhere in the country and insured individuals can receive primary medical care at any such clinic or hospital. This system has led to an abundant supply of medical care. The number of medical doctors more than doubled from 103,131 in 1960 to 211,797 in 1990, although the proportion of clinic-based doctors fell from 44.8 per cent to 30.5 per cent (Rapp and Shibuya, 1994). Doctors providing primary care from their own offices or clinics are paid on a fee-for-service basis after submitting claims to the Social Insurance Medical Reimbursement Fund (*Shakai Hoken Shinryou Houshuu Shiharai Kikin*). There is a national fee schedule which specifies all procedures and products that can be paid for through health insurance and sets their prices. Since all doctors receive the same payments under the fee schedule, the incentive for doctors to specialise is weaker in Japan than in many other countries. A review process is used to regulate the volume of care provided under the national fee schedule in order to make sure that it is not excessive. Despite this safeguard, however, there are claims that primary care doctors in Japan maximise their revenues by seeing as many patients as possible, performing large numbers of tests and prescribing large quantities of pharmaceuticals. It is also claimed that primary care doctors are reluctant to refer patients to hospital specialists (who are paid on a salaried basis) because it is feared that patients will prefer to remain with hospital specialists on an out-patient basis rather than return for clinic care. (Rapp and Shibuya, 1994).

The reimbursement fee schedule in Japan also encourages the widespread use of advanced medical technologies in clinics as well as hospitals. For example, 70 per cent of clinics have electro-cardiographs, 60 per cent have X-ray equipment and 26 per cent have ultrasonic image testing equipment (Rapp and Shibuya, 1994).

The UK payment system offers a very different set of incentives to those found in the Japan. Although a greater element of fee-for-service payment has been introduced for GPs in the NHS since 1990, the predominant capitation system does not provide any incentive to maximise services. Quite the reverse: if anything there is an incentive to under-treat, because once a patient has registered, a GP receives a payment irrespective of the level of care actually provided. Also the financial incentive to become a hospital specialist is stronger in the UK because senior hospital doctors (i.e. consultants) generally receive higher incomes than their GP counterparts. Hospital doctors can also boost their incomes through private work, whereas GPs rarely have this opportunity. As far as medical technology is concerned, a tight planning system has operated in the NHS for many years with the result that practically all but very basic diagnostic equipment is located in hospitals. Hardly any GPs in the UK, for example, have X-ray equipment at their surgeries.

There are also differences between the UK and Japan in terms of patient choice. Patients in Japan are free to choose any primary care doctor who works under the social insurance system. Although freedom of choice is generally considered to be a desirable feature of a health care system, the way that it works in Japan appears to pose some problems. Both small clinics and large hospitals provide primary care services and compete with each other for patients. As there is no differentiation in charges, many patients choose to visit large, especially university, hospitals for primary care consultations because they believe that the quality of care is better. The result has been severe

overcrowding, queuing and short consultation times of typically less than five minutes. There is a common saying in Japan that "you wait for three hours to see the doctor for three minutes".

In contrast, although many of the health care reforms that took place in the UK during the 1990s were supposed to increase patient choice, there is little evidence that they did so. Changing GPs for reasons other than a change of residential location is unusual. Moreover, the single payer system means that there is no choice of insurance plans and no demand-side competition for enrollees. Moreover, unlike the Japanese system, GPs are accepted as legitimate gatekeepers to hospital care by most people and there is little demand for direct access to hospital-based doctors. On the other hand, primary care consultations are not dramatically longer in the UK compared with those found in Japan (eight minutes versus five minutes). In both countries it seems that there is a degree of deference on the part of patients to doctors; certainly patients seem less demanding than they are in, say, the United States.

The traditional Japanese model of medicine did not separate the roles of pharmacist and doctor. Doctors carried medicine boxes when visiting patients and dispensed medicines. The basic elements of this system continue to this day with Japanese doctors and hospitals dispensing most prescription drugs. Patients tend to visit doctors for drugs and doctors—who derive 25 to 30 per cent of their incomes from drug prescriptions—often prefer drug treatments to other forms of therapy. Drugs are covered by the national fee schedule but doctors frequently prescribe newer, more expensive drugs than older, cheaper ones. Patients only pay 10–30 per cent of the costs of medicines in the form of co-payments. The combined result of all of these factors has been that Japan has an extremely high per capita rate of pharmaceutical consumption. In 1996 Japan accounted for 19.5 per cent of the global pharmaceutical market compared with 32.6 per cent for the US (which has twice the population of Japan) and 6.9 per cent for Germany (Ikegami, Ikeda, Kawai, 1998).

The earlier discussion of the UK described how rising pharmaceutical costs are seen as a problem too. However, the separation of the prescribing and dispensing roles in all but a minority of cases means that GPs do not have a personal financial incentive to prescribe. To the extent that there is an incentive, it is to substitute drug prescriptions (that have traditionally been paid for by the government and therefore been a free good as far as GPs are concerned) for alternative, time-consuming consultation time. Efforts to combat this perverse incentive have taken the form of overall cash limits on drugs budgets and initiatives designed to make GPs aware of the financial implications of their prescribing behaviour (e.g. GP fundholding).

9. Conclusions: primary health care policy in the UK and Japan

This review of primary health care policy and practice in the UK and Japan has revealed a number of interesting similarities and contrasts.

At the macro-level, both countries have succeeded in controlling the growth in health expenditures and do not, therefore, face the major challenge confronting many advanced countries. Interestingly, though, they have achieved this objective through different approaches to the fundamental equation: Expenditure (E) = Price (P) *times* Quantity (Q). In the UK reliance has been placed on overall cash-limited budgets (i.e. controlling E). In Japan, reliance has been placed on controlling P (through the national fee schedule) and, to a lesser extent, regulating Q.

It is, however, at the micro-level that the differences are most pronounced. Most notably, the 1990s have been a period of unprecedented health reform in the UK, whereas in Japan—despite some notable changes—the situation has been far more stable. Why is this the case?

One of the main reasons for this difference would appear to be the fact that the health system in Japan (along with accompanying factors associated with diet and lifestyle) has succeeded in achieving levels of health status that are probably the best in the industrialised world. Data on life expectancy, infant mortality and death rates from major diseases such as heart disease and cancer are all better in Japan than in the UK. Moreover, the Japanese have achieved these results at levels of spending that are as low as those in the UK. In the light of these results the adage "if it ain't

broke, don't fix it" would seem to apply!

More generally, the thrust for health reform in the UK must been seen as one aspect of a wider move for socio-economic reform during the 1980s and 1990s. The 1980s were a period when a radical, market-oriented government under the leadership of Margaret Thatcher unleashed a series of reform initiatives. The NHS was a rather late entrant to this process, but the White Paper, *Working for Patients*, published in 1989 set out an agenda for reform that derived as much from a general ideological preference for market-based systems as from the needs of the NHS. Subsequent changes built on this platform until the election of a radical new Labour government in 1997 has, once again, set a direction of change that is informed by ideological preferences as well as technical considerations. Without these great surges of political change, the Japanese health care system would appear to have operated in a more stable overall, political environment.

Notwithstanding these explanations for the different perspectives on health reform in the two countries, from the point of view of a health policy analyst, there do seem to be certain features of the UK reforms that may hold some lessons for Japan. These centre on the relationship between the primary and secondary care sectors. The brief review of the Japanese system described above points to a number of perverse incentives that lead to, *inter alia*, excessive use of secondary care facilities for primary care purposes, over-investment in new medical technologies in primary care, heavy doctor workloads and excessively short patient consultation times, and very high levels of drug prescribing. These are all examples of an inefficient allocation of resources. Many of them represent an inefficient allocation between primary and secondary care.

Faced with its own inefficiencies, the way that the UK has sought to deal with the problem is by devolving budgetary responsibility to primary care doctors so that they become responsible for the allocation of resources. This approach brings together financial and clinical decision-making. It focuses on the interface between primary and secondary care where co-ordination is notoriously bad. The idea is derived from the US experience of managed care but is designed to deal with problems other than cost-containment. Rather, it seeks to encourage the use of a range of techniques for the micro-management of clinical activities—bearing in mind their financial consequences—in order to improve the quality of care. The term 'integrated care' is being used increasingly in a number of countries to describe this approach (Robinson, 1998).

Clearly, building elements an integrated care approach into the Japanese system would be difficult given the current payments systems covering doctors and hospitals, and the dispersed nature of primary care. However, if there is sufficient recognition of the deficiencies of the present system, there may be scope for pilot projects to pioneer alternative approaches and for evaluations to assess their performance. Many different forms of pilot model are possible, as the UK experience has demonstrated. Ultimately, though, international experience of health care reform suggests that they will only be successful if there is general support for them among doctors, hospitals, patients, insurers and politicians.

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