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GP Budget Holding: Lessons from Across the Pond and from the NHS

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Executive summary

GP budget holding is likely to be one of the flagship policies of the new government. This paper draws on evidence from the U.S. as well as on previous experience in the NHS of GP commissioning in different forms, to identify lessons for policy makers as they take this policy forward. While the government is on the right lines in promoting GP budget holding, the paper suggests that there is a need for caution in promoting budget holding as a universal solution without regard to the capabilities of practices to manage a budget and the safeguards that need to be put in place to avoid the downside risks. Evidence from the U.S. and previous NHS experience point to seven key implications:

- the size and scope of budget holding need careful thought and it is unlikely that one size will fit all needs. Budget holding should be implemented for both smaller and larger groupings with the scope of budgets being adjusted accordingly
- GP leadership and management expertise are critical to the success of budget holding. Policy makers need to be flexible in the way that cuts in management costs are implemented to ensure that adequate resources are available
- budgets need to be adjusted for the risks of the populations served and they must be set in a way that is both rigorous and fair
- stop-loss insurance needs to be built in to budget holding to provide safeguards against random fluctuations in demand for rare, costly treatments
- the quality of care delivered by budget holders needs to be measured to ensure that financial incentives do not lead to under diagnosis and under treatment of patients
- budget holders will need to work in partnership with PCTs e.g. in negotiating contracts with tertiary and secondary care providers and in managing the demand for and use of services
- budget holding may stimulate the emergence of new provider organisations that include hospital based specialists and the term 'budget holding' may not be the right one to use to describe these organisations

As these issues are worked through, further thought needs to be given to the incentives that are required to motivate GPs to become involved in budget holding and whether GPs would be expected to take on real risk. The fear of knavish behaviour on the part of GPs may blunt the willingness of policy makers to offer GPs hard budgets with the prospect of personal gains and losses. If this is the case, then the potential of budget holding to release resources and improve care may not be realised.

The Back Story

Policy makers in England have experimented with different ways of involving general practitioners (GPs) in the commissioning of health services in the last twenty years. Beginning with GP fund holding in the 1990s, policy has migrated through the total purchasing pilots to primary care groups and trusts, and most recently to practice based commissioning. A consistent theme in these different initiatives has been a concern to use the expertise of GPs in determining how resources are used with the aim of improving both allocative and technical efficiency.

By basing commissioning decisions on the knowledge that GPs and primary care teams have of the patients they serve and their needs, policy makers have sought to improve access to care, deliver more services closer to home, and reduce the inappropriate use of hospitals. They have also attempted to create incentives for a key group of NHS decision makers to use resources more effectively, for example by enabling GPs to redeploy budgetary savings for the benefit of patients. An important motivation on the part of policy makers has been to use GP commissioning in its different forms to link clinical decisions with financial responsibility in the belief that this will help drive improvements in performance.

This motivation takes on added force at a time when NHS funding will be tightly constrained for a number of years. With cash releasing efficiency savings of between £15bn and £20bn required between 2011 and 2014, and with savings in management costs likely to contribute only a small proportion of these savings, it is increasingly recognised that tackling variations in clinical practice needs to be at the heart of efforts to use resources more efficiently. These variations include the length of time patients spend in hospital, admissions to hospital for ambulatory care sensitive conditions, and the cost of drugs prescribed by GPs.

Although some variations in clinical practice result from decisions taken in hospitals, others derive from the decisions of GPs and primary care teams, for example on prescribing and whether to refer patients to hospital for diagnostic tests and appointments. Advocates of GP commissioning argue that these decisions are likely to be influenced not only by the professional judgement of doctors but also by awareness of the costs of their decisions and opportunities to use resources differently. It is this that lies behind the promotion of practice based commissioning by Labour politicians and GP budget holding by their Conservative counterparts.

Studies of GP commissioning in its many guises over the last twenty years indicate that linking clinical decisions with financial responsibility has indeed delivered some improvements in performance. Examples include:

- the provision of more services out of hospital, for example the deployment of additional nurses and allied health professionals in practices
- improvements in access to care through reduced waiting time for specialist appointments
- reductions in the costs of prescribing
- increased capacity to manage demand for emergency care in some practices, and
- reductions in lengths of stay and delayed transfers of care

At the same time, it is clear that the willingness of GPs to be involved in commissioning is variable, and taken as a whole the results of their efforts are more modest than hoped for.

If GP budget holding is one of the flagship policies of the new government, what should policy makers be doing to increase its impact and to secure the more widespread engagement of GPs? To answer this question, this paper draws on evidence from the United States (U.S.) where groups of doctors in many states have taken on hard budgets with the aim of managing care for their patients and in the process controlling costs and improving quality. While there are important differences between health care in the U.S. and in England, there are sufficient similarities in this area of health policy to suggest a number of pointers that will need to be heeded by policy makers in the next iteration of GP budget holding. This paper updates previous studies that have drawn on U.S. evidence to identify lessons for the NHS[1, 2, 3, 4]. The final section of the paper summarises the implications for policy makers.

Capitation and risk contracting in the United States

From the mid-1980s until the late 1990s, capitation and risk contracting (see box for an explanation of terms) became increasingly prevalent in the U.S. as part of the development of managed care.[5] Most commonly, health insurance plans paid individual primary care physicians (PCPs) capitation for their primary care services, while paying specialists fee-for-service. In some cases, health plans withheld a percentage (often 20%) of these capitation payments and transferred all or part of the withheld funds to the individual PCPs in proportion to the extent to which the costs of specialist and/or hospital care for the PCP's patients were higher or lower than anticipated. In many areas of the country, especially but not exclusively California, health plans contracted with large groups of doctors. These groups took two forms: large medical groups and independent practice associations (IPAs).[6]

Large medical groups commonly had between 100 and several hundred or more physicians who worked in multiple practice sites but were part of a single organization with a single bottom line.[7] IPAs by contrast were networks of hundreds of physicians in smaller practices, including solo practices, who banded together into an IPA for purposes of contracting with health plans, but remained in their own independently owned practices. IPAs – and many large medical groups – were created to gain negotiating leverage and obtain higher payment rates from health plans and to have the size to engage in more extensive risk contracting than individual physicians or small practices could prudently accept.

The scope of capitation

When contracting with large medical groups and IPAs, health plans typically paid the group or IPA via monthly capitation payments intended to cover both primary care and specialist physician services, and often outpatient, laboratory and imaging services as well. Most groups and IPAs then capitated their PCPs and paid their specialists via fee-for-service, and withheld 10-20% of payments to cover possible excess spending on specialist, laboratory, and imaging services. Health plans typically

Capitation is the payment of a fixed amount of money per month to a physician or provider organization for each person for whom the physician or organization is responsible. The amount is usually adjusted for the age and sex of the person, and sometimes is "risk-adjusted" to account for chronic illnesses and other characteristics that the patient may have that may affect the costs of caring for that patient. At one extreme, capitated payments may be intended to cover only the services provided by an individual primary care physician to his or her patients. At the other extreme, "global capitation" is intended to cover all of the medical services – physician, hospital, and others services such as diagnostic tests – that patients may need.

Capitation is sometimes referred to as "risk contracting" but there are important forms of risk contracting that do not involve capitation. For example, a payor may pay a physician or group of physicians on a fee-for-service basis, but may provide the physicians with a bonus if the costs of patient care for the year are lower than anticipated. A payor may pay physicians fee-for-service but withhold a certain percentage of each payment, and give this money to physicians at the end of the year only to the extent that the costs of their patients' care has not exceeded the targeted amount. These forms of risk contracting may involve a substantial percentage of the physicians' potential income, yet fall far short of full capitation.

paid hospitals via a per diem rate. The plans also created a "risk pool" for each large medical group or IPA, from which funds were drawn to pay for hospital and other services not included in the plan's capitation payments to the group or IPA.

If funds remained in the risk pool at the end of the year, they were shared between the medical group or IPA and the health plan according to a pre-negotiated formula. If costs exceeded the amount in the risk pool, the health plans sometimes sought to recover the difference in a variety of ways e.g. from the following year's capitation payments. Many medical groups and IPAs operated their own prior authorization programmes intended to control the utilization of specialty physician, laboratory, emergency department, and imaging services, and required prior authorization for non-emergency hospital admissions.[8] Health plans operated case management programmes intended to get patients discharged from the hospital as quickly as possible, and some medical groups and IPAs had their own parallel case management programmes aimed at the same objective.

In some cases, medical groups and IPAs negotiated "global capitation" contracts (also called "full risk" contracts) with health plans. The health plan paid the medical groups and IPAs a per patient per month capitation fee intended to cover virtually all services – physician, hospital, ancillary services, and sometimes pharmaceutical costs (rare, very high cost services such as transplants were excluded). Some globally capitated medical groups and IPAs took responsibility for paying all claims to other providers (e.g. hospitals and laboratories) and sometimes for negotiating contracts with them as well.

The impact of capitation

Initially, many capitated medical groups and IPAs, particularly but not solely in California, were quite successful.[7, 9] Generally speaking, they aimed to break even on professional capitation, but to profit from savings generated by reducing the number and duration of hospitalizations. The most effective medical groups and IPAs reduced hospital days per thousand patients per year by as much as two-thirds, generating large profits for themselves and for health plans, albeit at the expense of hospitals.

The decrease in days per thousand resulted primarily from the groups' and IPAs' utilization management programmes that aimed to prevent admissions of patients who did not really need hospitalization and to provide care as efficiently as possible for patients who did, resulting in earlier discharges. The capitated model, involving substantial or even global risk, appeared so successful that many commentators believed that it would soon become the prevalent model in the U.S. Accordingly, physicians and associated hospitals throughout the country took steps to prepare for it.[10]

In practice, between the early 1990s and 2000, the model ran into difficulties.[11] Successfully managing global capitation required groups and IPAs to track and manage the utilization of physician, hospital, and ancillary services, to accurately calculate the actuarial risk of the population of patients for whom they were assuming financial risk, and to actuarially and expeditiously pay specialist, hospital, and ancillary service claims. Many groups and IPAs lacked the data systems, experienced executives, care management infrastructure, and financial reserves to succeed in a heavily capitated environment. Some groups and IPAs went bankrupt, leaving health plans to pay millions of dollars of claims to physicians, hospitals, and ancillary service providers outside the groups.[12, 13] State regulators in California and other states began to create much stricter requirements for groups and IPAs that wanted to assume substantial financial risk for providing medical services.[14, 15]

Even the largest, best capitalized, and most competent medical groups and IPAs discovered an unanticipated problem with capitation.[9, 16] The groups and IPAs found, for example, that it was much easier to reduce annual hospital days per thousand for commercially insured (under 65 year old) patients from over 500 per year to 150 per year than it was to move from 150 days per year to 130. Initially, the groups and IPAs were able to pick the "low hanging fruit" e.g. to reduce utilization by not hospitalizing patients with severe low back pain, not hospitalizing people a day before elective surgery, etc. Once these comparatively easy gains had been made, it became much more difficult to further reduce utilization.

The backlash

Early on, capitation rates and hospital risk pools were generous, based on the high utilization of services in the pre-capitation years. However, as the groups and IPAs successfully reduced utilization, health plans' funding of capitation and of risk pools became much less generous. The end game for this process was that the funds available to medical groups and IPAs to care for patients more or less equalled the projected cost of caring for these patients, given the much lower rates of utilization that had been achieved.

In effect, this left the groups and IPAs holding pure insurance risk, rather than, as intended, the "service risk" related to the volume of unnecessary services provided. The medical groups and IPAs were much smaller and less actuarially competent than insurance companies and therefore not appropriate to take insurance risk. Chance variation and/or attracting an unusually ill population of patients (capitation rates and hospital risk pools were adjusted for patients' age and sex, but not for their co-morbidities) could and did cause severe financial difficulties for even relatively competent groups and IPAs.

There was also a national popular backlash against capitation from patients and physicians.[11] Health plans that used capitation required that patients choose a primary care physician. In theory this physician would serve as a coordinator of care, but patients and specialists perceived primary physicians as gatekeepers whose job was to say "no" rather than as facilitators of care.[17]

Physicians and patients disliked prior authorization requirements for specialist and hospital services, regardless of whether the requirements came from the health plan or from their own medical group or IPA. Physicians and patients perceived that capitation gave physicians a strong incentive to engage in limiting care and in cream-skimming i.e. in withholding care and in avoiding sicker patients. The lack of risk adjustment and absence of incentives for providing high quality care and high quality patient experience lent plausibility to these concerns.

The position today

Capitated contracting – and risk contracting more generally - has continued to decline in the U.S,[18] though it still exists in California and other pockets of the U.S.[19] Recent surveys suggest that U.S. medical groups with 20 or more physicians accept capitation for primary care services for less than 20% of their patients, for specialty services for less than 20% of their patients, and for hospital services for less than 15% of their services. For all three categories of capitation, IPAs take capitation for higher percentages of patients than large medical groups and groups with 1-19 physicians take capitation for lower percentages of patients.

The relentless rise of health care costs in the U.S. is however leading to renewed interest in capitation and in risk contracting more generally. The thinking is that if structured correctly, with adequate risk adjustment and with rewards for high quality and patient experience, risk contracting might be able to achieve improvements in performance. For example, a Massachusetts Special Commission recently recommended that "global payments" become the norm in Massachusetts within five years, and the large Massachusetts health insurer Blue Cross Blue Shield recently began using an "Alternative Quality Contract" with selected provider organizations.[20] This contract puts provider income at risk for both quality and costs, but is not full capitation.

The rapid growth of interest in the U.S. in Accountable Care Organizations – provider organizations that agree to be held accountable for the quality and cost of care for their population of patients - is a further indication of the continuing interest in capitation.[21, 22] It is important to note that this interest is in risk contracting with large provider organizations, not with small physician practices. It is also worth noting recent evidence from California indicating that medical groups and IPAs have used their negotiating leverage to drive up the costs of care in what amounts to an interesting reversal of the original intention of the move to capitation and managed care[23].

Capitation and physicians

Despite capitation's colourful history, there is relatively little data on its effectiveness. The evidence suggests that capitation initially led to decreased provision of services and lower costs, but there is limited information about its effects on the quality of care and of patient experience.

From the perspective of physicians, capitation can be attractive because it provides up-front, guaranteed cash flow, can make it possible for physicians to decide on the best mix of services for their patients without considering which services are paid for and which aren't, can reduce the administrative costs of billing and of dealing with payor attempts to control utilization (e.g. through "prior authorization" programmes), and can make it possible to earn substantial additional income if the costs of providing care are less than the amount of the capitation payments. Also, by banding together in medical groups and IPAs, physicians may be able to increase their leverage in negotiations with health plans.

On the other hand, capitation can be unattractive to physicians if it is not combined with incentives to improve the quality of care (i.e. if it appears to be primarily a means for cost-reduction), and if the financial risk assumed is larger than the physician organization can reasonably assume. Difficulties can also arise if risk-adjustment is inadequate, if timely data on costs of care incurred are not available from the payor, if the physician organization does not have the capabilities required to "manage" care, and if the capitation includes medical services for which the physicians cannot reasonably be held responsible. As already indicated, there are major challenges if the payments are structured in such a way that the physicians are taking "insurance risk" – i.e. risk for random fluctuations in patients' costs – rather than "service risk" – i.e. risk for reducing the volume of unnecessary services.

Summarising the evidence

Table 1 provides a framework for thinking about the types of financial risk that may be taken and suggests the kinds of organization that may be most capable of taking different types of risk. The Table assumes that the organization is taking substantial risk for the services covered either because it is capitated for these services or because, under risk contracting, it will be subject to a large retrospective bonus or penalty paid on the basis of the costs and/or quality of the service in that category for the patients for whom the organization is responsible.

The larger the organization and the more types of providers it includes – primary physicians, specialty physicians, and hospitals – the more risk it may be able to reasonably assume. There are many reasons for this. First, the law of large numbers means that the more patients for whom the organization is taking risk, the more likely it is that the overall costs of care required by its patients will not greatly exceed the capitated amount.

Second, large organizations are more likely to have access to the capital required if they incur significant losses on capitation. Third, large organizations may have economies of scale in terms of employing physician and non-physician staff who are responsible for the organized processes the organization uses to control the costs and improve the quality of care. Fourth, the more patients for whom an organization is responsible, the more robust the quality measures that can be used to balance the incentive capitation gives to restrict services.

Another consideration is that primary care physicians need some degree of cooperation from specialists and from hospitals in order to control the overall costs and quality of care. It is therefore unwise for primary physicians to assume substantial financial risk for specialist and hospital services unless the specialists and hospitals share in the potential risks and rewards, or unless the primary physicians have some other way of gaining cooperation.

Definitive data on how large groups need to be does not exist, but some experts estimate that the organization should have at least 100,000 patients if it is going to take global capitation.[24] Others believe that lower numbers – perhaps 25,000 patients – could be adequate. Certainly, smaller groups are able to work on a capitated basis if risk sharing is negotiated with health plans and other payors on the basis of the ability of groups to assume a proportion of risk i.e. less than 100%. Smaller groups are also able to take on less than full global capitation, provided that they have the resources and expertise to do so.

Implications for policy makers

What lessons can be drawn from the evidence summarised in this paper, acknowledging important differences between health care in the U.S. and England? While it is clear from the above review that budget holding by medical groups and IPAs has had an impact on the use of resources and health services, it is also apparent that there have been unintended and unwanted consequences. Alongside progress in controlling costs by reducing hospital utilisation, budget holding led to a backlash among patients and some doctors, as well as causing bankruptcies and failures where too much risk was assumed, or too little control was exercised.

Table 1. Financial Risk and Organizational Form

	PCP risk	PCP and specialist risk	Hospital risk	Diagnostic and other risk	Pharmaceutical risk
Organization					
Solo or small PCP practice	++	+	0	+	+
Medium-sized PCP practice (10-19 PCPs)	+++	++	+	++	+
Large PCP practice (20+ PCPs)	++++	++	++	+++	++
Medium-sized multispecialty practice (20-49 MDs)	++++	+++	++	+++	++
Large multispecialty practice (50+ MDs)	++++	++++	+++	++++	+++
Hospital and large multispecialty group practice	++++	++++	++++	++++	++++

The number of plus signs suggests the ability of the organization to take the risk and the amount of risk that it can plausibly take.

There is also the recent evidence from California that the negotiating leverage of medical groups and IPAs has contributed to increases in costs, contrary to the original expectations of the advocates of managed care.

Despite this, there is a renewed interest in how capitation and risk contracting can play a part in improving performance in future, suggesting that policy makers in England are on the right track in seeking to promote GP budget holding in the next phase of NHS reform. At the same time, even a cursory reading of U.S experience indicates the need for caution in promoting GP budget holding as a universal solution without regard to the capabilities of practices to manage a budget and the safeguards that need to be put in place to avoid the downside risks. In this final part of the paper, we draw out seven key implications that policy makers need to take into account in the next phase of NHS reform.

Size and scope matter - but in which direction?

Accepting that there is little 'science' on the size and scope of budget holding, the risks of catastrophic failure (e.g. bankruptcies or large overspends) may be managed more easily in larger groupings of GPs. A population range of 25,000-100,000 is indicated by the evidence reviewed here, suggesting that networks or federations of practices may offer more promise as the building block of GP budget holding than individual practices (except those that have very large registered populations). This range is similar to the minimum (30,000) and maximum (100,000) population sizes suggested in earlier analyses of GP commissioning in the NHS[25, 26].

Population size is closely related to the scope of budget holding, in terms of the range of services included in the budget. If GPs are to take on total or near total global capitation, then large groupings are likely to be needed in order to manage risks. In addition, random variations in demand can be managed for populations at the bottom of the indicated population range by allowing GP budget holders to carry forward over and under spending between years. This would require greater flexibility in NHS accounting practices than has often been the case.

Having made these points, previous studies of GP commissioning in the NHS, especially total purchasing, suggest that larger groupings of GPs find it more difficult to bring about changes in services. This is because of the time it takes to negotiate changes within larger groupings and the ability, by contrast, for smaller groupings to implement improvements in care rapidly when they have decided what needs to be done. It has been suggested that this may be because larger groupings of practices find it more difficult to create strong incentives for individual GPs and practices to change their decisions and are vulnerable to the 'free rider' problem[27].

As these comments suggest, there are trade-offs to be made in the design of GP budget holding between:

- larger groupings able to take total or near total global capitation but less well placed to introduce change quickly, and
- smaller groupings that may be better able to make change happen but across a narrower scope of services because of the risks involved in devolving full budgets for smaller populations

In practice, it may be appropriate to implement GP budget holding for both smaller and larger groupings with the scope of budgets being adjusted accordingly: one size is unlikely to fit all needs. It is also important to not focus on size and scope to the exclusion of other factors that may be of equal or greater importance.

GP leadership and management expertise are critical

Related to size and scope is the availability of management expertise and information. The success of GP budget holding will depend critically on the engagement of GPs and the leadership they provide. GP budget holders also need access to skilled managers and information to enable them to use their resources effectively and avoid over spending. While some of the expertise needed may be supplied by PCTs working on behalf of a number of budget holding organisations, evidence from the U.S suggests that much of it needs to be embedded in and 'owned' by the groups themselves.

The importance of GP budget holders having access to management expertise is reinforced by previous studies of GP commissioning, and especially total purchasing, that have shown a relationship between the level of management costs and achievement of objectives[28]. Also comparisons between the U.S. and the U.K have highlighted the much higher level of resources and expertise available across the pond and have argued that NHS commissioners are at a disadvantage by comparison[4]. The difficulty this creates is the expense of employing managers with the range of skills required at a time when there is a drive to reduce management costs by one third, always assuming that the requisite skills are available.

If policy makers wish to make GP budget holding a flagship of their NHS reform strategy, then they will need to be flexible in the way in which cuts in management costs are implemented.

Risk adjustment is essential

Failure to adequately adjust budgets for risk was one of the reasons for the backlash against managed care in the U.S. in the 1990s. Risk adjustment typically uses claims data from the prior year to predict costs in the current year; it should include consideration of patients' age, sex, and co-morbidities, and possibly socio-demographic characteristics as well. Risk adjustment is not very accurate for individual patients or small numbers, but as the number of patients grows larger the ability to predict costs in the current year based on patients' characteristics improves.

This underlines the argument for basing GP budget holding on larger populations where random fluctuations can more easily be accommodated. Detailed discussions of risk adjustment are plentiful[29, 30-32] and work for the Department of Health by the Nuffield Trust provides a basis for this to be done more successfully in the NHS[33]. Even so, experience in Europe suggests that there are continuing challenges in risk adjusting individual patients[34].

Related to risk adjustment is the method used to set budgets. Difficulties have arisen with practice based commissioning, and in the past with total purchasing, because of concerns that PCTs have not always used transparent or appropriate methods in

deciding on the size of the budgets to be controlled by GPs. It will be important that these difficulties are avoided in future e.g. by the adoption of a risk adjustment funding formula that is both rigorous and fair.

Stop-loss insurance is a pre-requisite

U.S. experience shows that as long as budgets are set at a level that assumes that the costs of care could be significantly lower (via reducing inappropriate services and by keeping patients healthier), provider organizations will be taking primarily service risk. If budgets are set at a low level – one which is close to the minimum cost of providing appropriate services to patients - then the provider organizations being paid at this rate would be primarily taking insurance risk. Providers should be protected against insurance risk through stop-loss insurance.

Stop-loss insurance – also called reinsurance – means that providers are not held accountable for costs above a predefined limit, or are held accountable for only a small fraction of costs.[35, 29] Stop-loss insurance may apply to the costs of individual patients and/or to the aggregate costs of all of a provider organization's patients. This approach was used in the early days of GP fund holding as well as in total purchasing and will be important in taking budget holding forward. One of the functions of stop-loss insurance is to enable smaller groupings of practices to manage risk.

Quality measures must be built in

While risk adjustment and stop-loss insurance offer some protection against the failures experienced in the U.S., quality safeguards must also be built in. Managed care in the 1990s ran into the ground in large part because it focused mainly on managing costs with insufficient attention paid to the impact on quality of care. This gave rise to concerns that medical groups and IPAs were withholding or delaying appropriate care and that quality of care was suffering as a consequence.

Although the evidence on this is either lacking or incomplete, the suspicion that doctors may be skimping on what is best for patients because of the financial incentives under which they are operating means that measures of quality are needed to assess how in practice GP budget holding influences doctors' decisions. These measures should include patient experience as well as access to care and outcomes e.g. PROMs. PCTs as strategic commissioners will have a critical part to play in this process.

Partnership with PCTs is necessary

Leading on from this, experience from the U.S. indicates that payors (health plans and public funders) often work in partnership with medical groups and IPAs. For example, in Massachusetts the big health plans take the lead in negotiating payment rates and quality standards with major tertiary and secondary care providers, and medical groups utilise the services of providers on the basis of these rates and standards. Health plans also provide real time information to medical groups on their use of services and performance against budgets.

In Massachusetts and some other states, health plans may also use their medical and other expertise e.g. in utilisation review and disease management, to support medical groups in the work they do, especially in the case of smaller groups that may lack the resources to acquire this expertise themselves. One of the functions of health plans in this context is to assess the ability of medical groups to take on capitation and risk. PCTs will need to perform a similar role in the NHS as budget holding is implemented in order to ensure that responsibility for public funds is taken on only by GPs with the skills needed.

Budget holding may stimulate the emergence of new provider organisations

One of the effects of capitation in the U.S was to stimulate the emergence of new alliances and provider organisations. These alliances included multispecialty medical groups and IPAs and hospital-physician alliances. This suggests careful thought should be given to the language used and whether GP budget holding is the right term to adopt if there is an ambition to engage specialists as well as generalists in jointly commissioning and providing services.

Having made this point, the challenges of specialists working effectively alongside GPs to commission and provide care need to be recognised as this was often problematic in the U.S. when hospital-physician alliances were forged. Nevertheless, there is considerable potential to explore the role of integrated models of care led by physicians in the next stage of NHS reform. As the author has argued elsewhere, clinically integrated groups in which federations of practices work with specialists could play a major part in enabling the NHS to meet the challenges that lie ahead[36].

Conclusion

Like many other health policy initiatives, GP budget holding holds promise and is an idea worth taking forward, but the devil is in the detail. It will be important for policy makers to take the idea of GP budget holding from broad concept to detailed implementation and in the process to ensure that the challenges reviewed in this paper have been worked through. In view of the complexities involved, a strong argument can be made for piloting and evaluation in advance of widespread implementation. As this high level summary has shown, there also needs to be careful selection of participating practices and federations to avoid the problems experienced in the U.S. and to ensure that a policy that has considerable potential is able to deliver in practice.

Alongside the seven implications enumerated above, there is also the fundamental question of whether the incentives in GP budget holding will be strong enough to motivate a sufficient number of GPs to become involved to the extent needed for it to make a real difference. The new government has argued that budget holding will be more successful than practice based commissioning because hard budgets will be on offer under the direct control of GPs and that this will make it more attractive to GPs and others in primary care whose support is critical to its success. While the prospect of hard budgets is likely to make a difference to the motivation and engagement of a proportion of GPs, it has to be recognised that the 'offer' to GPs is to manage these budgets at a time of tight

funding constraints. If practice based commissioning has been attractive to only a minority of GPs when the NHS budget has been growing rapidly, there must be doubts as to whether GP budget holding will fare any better when GPs may perceive they are being asked to make cuts in services and take the lead in unpopular rationing or reconfiguration decisions.

One way of countering this would be for policy makers to present GP budget holding as a prize to be offered practices able to demonstrate their preparedness to take on a significant role in the commissioning of care rather than expecting all practices to be involved from the start. Not only is this consistent with the evidence summarised in this paper, but also it would appeal to the natural competitiveness of GPs. Seeing GP budget holding as a reward for proven competence might provide the motivation that has been lacking in GP commissioning in the recent past, and could be linked to an offer to successful budget holders to take on this role for practices unwilling or unable to do so themselves. Starting with practices able to demonstrate competence would also be a prudent approach to take in view of the failures experienced in the U.S.

The other issue on incentives is whether GPs would be taking on real risk, both on the upside and the downside. In the U.S. market based system, medical groups and IPAs did assume real risk with the consequences - positive and negative - outlined above. In a publicly funded health system like the NHS in England, the prospect of GP budget holders generating either profits or losses is much more sensitive and has meant that politicians have been reluctant to allow GPs to use surpluses or under spending of their budgets for personal gain.

The sensitivities on this issue are compounded by underlying concerns that surpluses may result from skimping on care, especially when NHS funding is under pressure. In Le Grand's language[37], the likelihood of knavish behaviour on the part of some GPs may therefore blunt the willingness of policy makers to offer GPs hard budgets with the prospect of personal gains and losses. If this is the case, then the potential of budget holding to release resources and improve care may not be realised. Finding a resolution to this dilemma may hold the key to the impact of GP budget holding in practice.

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