

Fund-holding general practices and old age psychiatry

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In a retrospective study, referrals to a community old age psychiatry service were obtained for local practices a year before and a year subsequent to the introduction of prospective general practitioner (GP) fund-holding. Although overall patterns of referral were the same, there was a significant reduction in domiciliary consultations requested by fund-holding GPs which was not balanced by a rise in other referrals. The findings suggest a shortfall in the number of referrals to old age psychiatry services in the light of GP fund-holding, prompting speculation as to the fate of those who would otherwise have been referred.

The domiciliary consultation service was established to enable GPs to obtain advice on the management of patients in the community (DHSS, 1981). Consultant psychiatrists, with knowledge of both their own and other disciplines, play a pivotal role in assessing the medical needs and also what other agencies could offer. Critics suggest that assessment by other team members gives similar information, but fail to appreciate that a domiciliary consultation (DC) is not entirely an information-gathering exercise. It is a response to an immediate need, providing professional input into what may be an emergency situation requiring on the spot assessment as well as management decisions.

The extra cost of DCs has previously been met by health authorities and was not of immediate concern to GPs. With the advent of GP fund-holding, fund-holders (FHs) are billed directly and may need to offset this cost against other services.

Our aim was to examine the impact of GP budgeting on the pattern of referrals to a community-based old age psychiatry service. If the move towards purchaser/provider status has affected GP management of psychogeriatric patients, this should be reflected in the pattern of referrals. Thus we would expect a reduction in requests for DCs to be balanced by an increase in requests to other team members or referrals to out-patient clinics.

The study

South and East Clwyd contain approximately 50,000 patients over 65 in a rural area with small

centres of population. Practices wishing to become fund-holding since April 1992 have been submitting budget returns and obtaining feedback, enabling them to plan care provision prior to actual fund-holding.

We identified periods of 12 months before and after the start of budgeting by prospective fund-holders (FH). We collected the number of DCs and out-patient referrals of new patients during these periods for each practice from department records. Both community teams keep books of referrals and since April 1992 many of the records have been on computer. Data concerning direct (GP) and indirect (carers, relatives, etc.) referrals to the team were listed by practice. We excluded referrals from other team members or hospital wards.

All practices taking part in the FH exercise became fund-holding on or about 1 April 1993. We divided data into FH or non-fund-holding (NFH), pre-fund-holding (April 1991–March 1992) or fund-holding (April 1992 to March 1993) years.

Yates' correction for continuity was applied to the χ^2 analyses.

Findings

We collected data for 185 GPs, of whom 88 became FH.

In the first year of the study, 482 referrals were received, half for DCs, 38% to the community team (23% direct and 15% indirect) and 12% to out-patients. During the prospective fund-holding year, 682 referrals were made, an increase of nearly 30%. Of these, 48% were DC requests, 39% to the team (23% direct, 16% indirect) and 13% to out-patients (see Table 1).

Despite constant rates of referral, the proportion of FH DC requests fell from 41% of the total to 22%, a significant finding in its own right ($\chi^2=4.31$, d.f.=1, $P<0.05$). In the context of a 79% rise in NFH DC requests, which should have been reflected as a similar rise in FH DC requests, the net reduction is 98% ($\chi^2=23.4$, d.f.=1, $P<0.001$). There was no difference in the number of out-patient or direct team referrals. Indirect

referrals of patients from FH practices increased significantly ($\chi^2=4.17$, d.f.=1, $P<0.05$) but taken in conjunction with the rise in indirect referrals of patients from NFH practices, this increase failed to reach significance. The rise in actual numbers of indirect referrals is insufficient to account for the shortfall in overall referrals to the service.

Comment

In our study, the impact of budgeting by proposed GP fund-holders resulted in a significant fall in DC requests. Despite this, a predicted rise in referrals to out-patients or multidisciplinary team members did not occur. This suggests, initially, that FH GPs reduced their DC requests by 27 over a year, referring ten patients to out-patient clinics and leaving a shortfall of 17 who were not referred to the local service. Extrapolation of the figures based on the substantial rise in referrals to all services from NFH practices suggests a shortfall of over 100.

Under the purchaser/provider system, FH practices have the right to refer their patients to other services. Thus the shortfall could represent referrals to other facilities organised by GPs in the light of their new conditions. Discussion with GP colleagues suggests that they have not, as yet, found alternative facilities for their patients. In addition, it should be remembered that the figures collected were for a year of prospective fund-holding with the facility for referral and direct payment by GPs to other trusts not yet in place.

Some decisions not to refer may reflect a tightening of criteria for requesting a specialist opinion and thus raise questions about the perceived value, for GPs, of DCs.

Anecdotally, a proportion of referrals are inappropriate and better dealt with by other professionals or the GPs themselves. It seems unlikely, however, that inappropriate referrals would comprise over 20%. An obvious concern is that GPs feel constrained by cost and, although this may reduce inappropriate referrals, some patients requiring specialist care may suffer as a result. Keeley (1993) suggests that GPs may find other, less costly, routes of approach to care for these patients.

The cost of a DC by a consultant is almost twice that of a similar assessment by a CPN. Team assessments thus constitute a less expensive form of psychogeriatric assessment and provide a 'back door' to consultant opinion, since referrals requiring medical input are passed on to the consultant. Whether this results in equivalent, better, or worse quality assessments has been a matter for debate and depends considerably on the experience of individual teams and

Table 1. Number (%) of referrals to the old age psychiatry service from prospective fund-holding (FH) and non-fund-holding (NFH) practices, April 1991 to March 1993

| Period of study | Domiciliary consultations | | Out-patient referrals | | Community team referrals by general practitioners | | Community team referrals by other agencies | | Total | |
|-------------------|---------------------------|----------|-----------------------|---------|---|----------|--|---------|-------|-----|
| | FH | NFH | FH | NFH | FH | NFH | FH | NFH | FH | NFH |
| April 91-March 92 | 98 (41) | 142 (59) | 15 (28) | 39 (72) | 28 (25) | 84 (75) | 19 (22) | 57 (78) | 76 | 76 |
| April 92-March 93 | 71 (22) | 254 (78) | 25 (28) | 65 (72) | 27 (17) | 129 (83) | 35 (32) | 76 (68) | 111 | 111 |

the quality of working relationships between the different disciplines within them.

Colligan and colleagues (1993) found no significant difference between psychiatrists and other team members in their diagnosis of mental illness. Although cost was not considered, they suggest that assessment by a doctor is not necessary in many cases, saving money and the time of 'specialist' doctors for other matters. On the other hand, confining clinicians within a 'Guy's' model to a supervisory role serves only to distribute their time into non-clinical matters. Their clinical functions are then pushed onto other team members whose own disciplines may suffer as a consequence (Jolley, 1993).

A further approach would be for consultants to be fully integrated with their community teams and to require all assessments requested to be sent to the team with allocation to the most appropriate discipline. Jolley (1993) argues that this approach does not sufficiently allow for the fact that some GPs may expect a medical opinion when referring their patients.

The crucial functions of DCs is in urgent assessment, best fulfilled by one individual with key skills and a knowledge of other disciplines' working. Sutherby reported finding that one four-session consultant had assessed twice as many patients on DCs in a six month period as the combined assessments of six full-time professionals from other disciplines (Sutherby *et al.* 1992).

Whatever the cause, the reduction in requests from FH for specialist psychogeriatric assistance suggests that an increasing strain will be placed upon carers since only a limited range of services are available directly to GPs. The rise in indirect referrals may reflect an attempt to obtain specialist help in cases where this had not been forthcoming from the GP. This trend was more marked in the FH group and requires further investigation. Perhaps it will be possible for FH practices to 'buy' services direct and without recourse to specialist consideration. Such a provision could easily prove more costly and might lead to poorer quality care.

Conclusion

Our results suggest a trend away from referral for specialist psychogeriatric opinion from FH practices. The reduction in DCs has not been balanced by a rise in other forms of direct referral, and there has been a rise in the number of

indirect referrals. This leaves a shortfall in the total number of patients referred to the service.

Another issue concerns the fragmentation of essential community services with the advent of multiple purchasers who can dictate where their patients receive care. Ultimately, with referral to any number of alternative services and hospital trusts, the community care system is likely to collapse due to the impossibility of maintaining adequate community follow-up of patients spread over a wide geographical area. This could influence the placement of patients away from their home areas and the fragmentation of support systems.

Our study looks at the pattern of referrals to two community old age psychiatry teams during the period of prospective fund-holding and may not be a reliable reflection of what will happen when the GPs concerned actually begin managing their own budgets. We are collecting data for the first year of fundholding to examine the effect on referrals now that many practices hold their own funds.

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