rather than classifying it as indeterminate, which we believe would be the correct solution for a substantial number of these reported deaths. There is furthermore the interesting statement regarding the 18 ... cases for which data were available that 'all of them had high risk factors' and by implication the series contains no example of a repeat classic cot death in a low risk family."

Professor Hall's conclusion was that he and others regarded the paper's findings as "seriously misleading" and thought they could have "serious consequences" for child protection.

Competing interests: None declared.

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Summary points

An analysis of sudden infant deaths suggested that almost 90% of second deaths in the same family are natural

Classification of deaths in the study was changed after the death of one of the senior authors

Deaths of indeterminate cause were counted as natural

The study was used as evidence in murder appeals

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- doi 10.1136/bmj.39031.590914.68

Primary care

Does practice based commissioning avoid the problems of fundholding?

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Current changes to primary care are meant to improve services for patients, but history suggests that they may not deliver and could even decrease satisfaction

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BMJ 2006;333:1168-70

By the end of 2006 all general practices in England are expected to be responsible for a budget to purchase secondary care and community health services for their patients.¹ What is remarkable about the practice based commissioning initiative is its similarity to the general practitioner fundholding experiment of the previous decade, which Labour abolished after it came to power in 1997. There is therefore potential to take stock of the lessons from fundholding and to assess the prospects for commissioning in that light.^{2 3}

Fundholding

Fundholding was a cornerstone of the NHS reforms of the 1990s. It allowed general practices to hold budgets to purchase secondary care for their patients on the grounds that it would make general practitioners more aware of the financial implications of their prescriptions and referrals. It was also assumed that it would give general practitioners greater leverage in negotiating those referrals with other health providers, as a clear resource would be attached to their commissioning decisions, and

that services would become more responsive to patients as a result. Practices were also allowed to retain any budgetary surplus to invest in additional patient services or in enhancing practice premises.

There were three varieties of general practitioner commissioning in the 1990s that gradually extended the scope of the scheme: the fundholding scheme itself; total purchasing pilots, which extended the range of services general practitioners purchased with the rationale that their purchasing would be more responsive than that of health authorities; and general practice commissioning pilots, where groups of practices collaborated to exercise a greater collective influence over commissioning to make health authorities more sensitive to local needs.

Evidence on fundholding

Studies show that fundholding increased general practitioners' awareness of the resources involved in referring patients. Both fundholding and total purchasing pilots lowered referral rates for elective

procedures⁴ and led to a more cost sensitive approach to referral. Fundholding also seems to have slowed the rate of growth of drug spending. Practices were able to make savings through prescribing generic drugs, the use of practice formularies, and by making better use of prescribing information. However, some evidence shows that once these strategies had been implemented the rate of growth of prescribing costs reverted to that among non-fundholders.⁵

Both fundholding and total purchasing pilots seem to have reduced waiting times for non-emergency treatment.⁶ The potential threat of moving to an alternative provider seems to have been successful in improving responsiveness. However, the scheme also caused problems.

Firstly, patient satisfaction was significantly reduced.⁷ This suggests that the additional managerial responsibility of fundholding might have distracted general practitioners' efforts away from patient care or that patients experienced the gains in economy as a reduction in service. Secondly, the management and transaction costs of general practices increased because of the need to set up, maintain, and monitor contracts.⁸ Finally, fundholding may also have resulted in inequities of access. The gains in responsiveness experienced by patients of fundholders seem to have occurred at the expense of practices that continued to rely on health authorities to purchase their care.^{9 10}

Thus for every achievement of the reforms there seems to be a downside. Giving general practices purchasing budgets can improve the use of resources, but this gain is subject to limits. Making general practitioners responsible for commissioning does reduce waiting times for non-emergency treatment but can lead to a two tier service. And the extra administrative responsibility and transaction costs can distract general practitioners' attention from patient care and so potentially reduce patient satisfaction. So will practice based commissioning avoid these pitfalls?

Prospects for practice based commissioning

Practice based commissioning has many similarities to fundholding. Under both schemes general practitioners are given budgets to purchase care on behalf of their patients with the aim of making doctors more aware of costs and increasing service responsiveness for patients. The reforms are part of a commitment to move care from secondary to primary settings and also

occur in a context where the mantra of "money following the patient" is becoming a reality through payment by results.

General practices now have a greater potential to influence secondary care through referrals as a result of the introduction of payment by results (box). However, fundholding showed that individual practices often struggle to change service provision in secondary care because of the small scale of the purchasing. It is hard to see how changes in secondary care can be achieved without considerable coordination between practices, moving us back towards the model of primary care purchasing that Labour encouraged in 1997. However, working in primary care trusts may have made general practitioners more aware of the need to collaborate.

Commissioning practices are portrayed as care entrepreneurs, providing new services for their local communities through their ability to reinvest surpluses in improving patient care. But practices may not have the time and space to plan and create new services.¹¹ The greatest potential for providing new services comes from cooperation and planning between practices, as well as with social services. Cooperation also offers the best chance of achieving the shift of capacity from secondary to primary care, but this raises questions about the financial viability of secondary providers that lose these services and the payments that follow them.

Another concern is that commissioning practices will have greater management and transaction costs. Practices will have to employ new financial managers or retrain existing administration staff to be more financially aware. Practice size is clearly important in determining whether the additional costs that commissioning imposes can be absorbed, with larger practices having greater potential to be able to afford the additional staff. The choose and book referral system may also increase practice costs because of the time it takes to navigate through the menus and book care for patients. Appointment times may have to be extended if general practitioners do the booking or new staff

Potential effects of practice based commissioning

Benefits

- Lower elective referral and admission rates
- Reduced emergency related occupied bed days
- Lower waiting times for non-emergency treatment
- Improved coordination of primary, intermediate, and community support services
- Improvements in financial risk management
- Better collaboration between practices
- Reductions in the growth in prescribing costs
- Engagement of clinicians in the commissioning process

Drawbacks

- Reduced patient satisfaction
- Increased management and transaction costs
- Inequities of access
- Little effect on organisation and delivery of hospital care

Summary points

Practice based commissioning shares many similarities to the fundholding reforms of the 1990s

Fundholding had both positive and negative effects, offering valuable lessons for commissioning

Practice based commissioning does not seem to overcome many of the problems of fundholding

The deficiencies seem to lead us back to the primary care groups model, originally introduced to tackle the failings of fundholding

employed for the task. The second option, however, may decrease patient satisfaction because patients would have to wait to see a doctor and then to book an appointment through an adviser.

Finally, there is the problem of inequity that occurred between fundholding and non-fundholding practices. If all practices have to take on commissioning, we might expect the problem to disappear, but this may not be the case. Large practices will have considerable advantages in commissioning over their smaller counterparts, as well as having greater potential to offer new services. There is therefore the potential for inequity based on the size of practice.

Conclusion

Policy makers do not seem to have learnt the lessons from fundholding. Commissioning practices can expect increased management and transaction costs, and the size of the practices will matter in terms of their ability to be able to absorb these. General practitioners can also expect patients to be less than happy when they perceive a service reduction to be due to economic rather than clinical priorities. This may result in patients changing practices when they do not get what they want, creating the paradox for practices that to invest money in new services they must generate surpluses but to generate surpluses they might have to find ways of economising on patient care. Ironically, these problems seem to lead us back to the logic of practices combining to overcome them, returning to the primary care group model that Labour introduced in 1997.¹² Securing collaboration between practices is surely a desirable and valuable way forward. We must find an approach to organising primary care that allows responsive commissioning with sufficient impact to drive service improvements in both primary and secondary care.

This work was in part funded by the Department of Health as part of a core programme of work at the Centre for Health Economics, University of York. We are grateful for its support, as well as for the comments of the external reviewer, Kieran Sweeney.

Contributors and sources: The authors have published widely in the areas of health policy and management and both have roles

in academic centres at the forefront of policy analysis in the United Kingdom. The article draws on a review performed by RM carried out in 2005 for the Department of Health and was extended by IG to consider implications for new policy.

Competing interests: None declared.

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(Accepted 29 September 2006)

doi: 10.1136/bmj.39022.486921.94

Corrections and clarifications

How to measure renal function in clinical practice

Formulas, like URLs and email addresses, are often danger areas, where one tiny error can matter. In figure 2 in this clinical review by Jamie Traynor and colleagues (*BMJ* 2006;333:733-7, 7 Oct, doi: 10.1136/bmj.38975.390370.7C), the formula for the 6-variable MDRD (modification of diet in renal disease) contained an error: the serum albumin concentration should have been divided, not multiplied, by 10.

ABC of obesity: Management: Part III—Surgery

It's surprising how the omission of one small, vital word can escape the notice of a technical editor, an author, a series editor, a proofreader, and a duty editor during what we thought was a rigorous production process. At the bottom of page 902 in this article by John G Kral (*BMJ* 2006;333:900-3, 28 Oct, doi: 10.1136/bmj.333.7574.900), a box carries the unlikely title "Conditions improved or prevented by obesity"—if you hadn't guessed, the word "surgery" is missing from the end.

Resuscitation using albumin in critically ill patients: Research in patients at high risk of complications is now needed

The author of this editorial, J L Vincent (*BMJ* 2006;333:1029-30, 18 Nov, doi: 10.1136/bmj.39029.490081.80), declared no competing interests in his submitted article. A day after the *BMJ* went to press the author declared the following competing interests. Professor Vincent and his department "have received unrestricted grants from Baxter, Braun, Fresenius, and PPTA [Plasma Protein Therapeutics Association]."

We have already published these corrections on bmj.com.