INTRODUCTION

In many ways, general practitioners (GPs) have been able to remain the most independent practitioners within the NHS since its inception in 1948, when Aneurin Bevan negotiated their co-operation by allowing them to remain as small businesses contracted for specific service provision. Because of this independent status, GPs have managed to remain detached from the reorganisations of the 1970s and early 1980s and were largely untouched by the managerial culture being fostered in the rest of the health service during this time. Ironically, it is through being awarded extended opportunities for enhanced power, control and prestige in the health service that they have been drawn into a pivotal role in the ‘new’ NHS of the 1990s and hence have become more accountable than ever before.

The introduction of an internal NHS market has led to substantive changes in the working arrangements of GPs. To begin with, changes in their contracts have offered them a key role in the delivery of health promotion services by giving them the responsibility to ensure that certain targets are met in screening and immunisation. This has quickly been followed by the implementation of Working for Patients (DoH, 1989a) and the introduction of the internal health care market, also described as the purchaser/provider split, which provides GPs with the opportunity to drive the commissioning of health care through the fundholding scheme.
Fundholding is a scheme whereby eligible GPs are allocated funds to refer their patients to hospitals of their choice. This has meant that hospital providers have had to compete for GP custom. In order to do this they have had to demonstrate the nature of the services offered and the costs of individual treatments so that GP fundholders can make informed choices about the services on offer. In addition, since April 1994, fundholding GPs have been able to purchase community nursing services from community providers and have been able to influence community nursing and health visiting services. The extent to which they have been able to do this will be discussed later.

While many GPs have welcomed the opportunities offered by fundholding to expand and develop the services offered to their patients, a substantial number have vehemently opposed the notion of extending doctors' involvement in economic decision-making, including small and single-handed practices that are ineligible for the scheme and those who prefer the status quo. Some non-fundholding GPs have argued that the introduction of the internal market has led to a two-tier service with the most vulnerable sections of the community (that is those patients most likely to be registered with single-handed GPs) disadvantaged in the competitive market.

At present there is little evidence that fundholding has changed the focus of secondary health care provision in any major way; however, the impact of fundholding on such a large and complex organisation as the NHS is unlikely to be fully realised for some time.

It is important to understand the philosophy behind the health care reforms. In many ways the changes have come about in response to the growing recognition of the value of the 'new' public health by changing the orientation of the NHS from a technology-driven and medically-led service towards an organisation based on health care needs led by those working in primary care. One of the most significant ideas to emerge from the newly-defined health service is the increasing awareness of the need to ensure that all treatments provided by the health service are effective. Many people would be horrified if they realised how few of the treatments currently used by practitioners were based on research which had evaluated their effectiveness. Day (1995) describes how health service commissioners are making increasing use of such evidence to make purchasing decisions. The Cochrane Centre in Oxford is dedicated to collecting systematic reviews of the literature which will help clinicians and purchasers make decisions about treatment