GP commissioning and the NHS reforms: what lies behind the hard sell?

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General practitioners (GPs) are divided on the government's proposed changes to the NHS, in which Primary Care Trusts (PCTs) will be replaced by commissioning consortia that promise to allow them a greater role. Some, such as members of the National Association of Primary Care, have been enthusiastic advocates of the government's proposals, at least as set out in the initial Health and Social Care Bill prior to the 'pause'. They see an opportunity to exert greater control over the services to which they refer their patients. Others are highly critical, seeing the changes as portending the break-up of the NHS; according to a recent poll, only a small minority (14%) have confidence in the Health Secretary in respect of the reform.[1] Critics include Clare Gerada, chair of the Royal College of General Practitioners, who has drawn attention to the profound risks to GPs and patients.[2] Here we reflect on some of the practical consequences for GPs if the proposed changes become law.

Commissioning requires time and specialist skills

Although the precise division of responsibilities between the National Commissioning Board and Commissioning Consortia, like much else in the draft legislation, remains unclear, it is already apparent that GPs engaged in commissioning will have to assume considerable additional responsibilities.

It is often forgotten that the system of commissioning healthcare, adopted in the UK to create an internal market within a tax-funded system, is unique. Other countries with tax-based systems, such as Spain and Sweden, have experimented with versions of it on a small scale, as have some American health plans, typically in small-scale local initiatives, but none have implemented it nationally and for all health services. This observation should itself give cause for thought. Where commissioning pilots have been implemented they have struggled to achieve the coordinated packages of care required to respond to an increasing burden of chronic disease.

One reason why commissioning has not been rolled out elsewhere is that it is difficult to do well; indeed the mixed record of commissioning by PCTs lies behind the enthusiasm among some GPs for an alternative. But will they have either the time or the expertise to make this work? Commissioning is potentially very complex, as evidenced by the Department of Health guidance on commissioning roles and responsibilities. If done properly, it requires a combination of skills in assessing needs, designing packages of care, taking an overview of local service provision to ensure that decisions on one service do not undermine the ability to deliver others, and evaluating what is delivered. Then follows the process of negotiating contracts that are affordable and deliver what is wanted,[3] monitoring compliance with them, ensuring cash flow, and keeping spending within budget. Much of the care commissioned will be provided by large private corporations with powerful legal and contracting departments who will seek to sign only those contracts which limit their risks and maximize their profits[4] at the expense of commissioning consortia. The consortia must command sufficient legal expertise to identify all potential risks and losses and negotiate hard to avoid bad deals.

In practice, it is likely that many consortia will subcontract many of these activities to commercial organizations, such as KPMG,[5] and the US health insurance companies Humana and UnitedHealth,

who have acquired a significant presence in NHS commissioning since the launch of the Framework for procuring External Support for Commissioners by the last government. However, this begs the question of how such agencies will deliver a service with greatly reduced resources while extracting sufficient profit, unless they ration patient care to save money. Loss leaders may be appropriate when seeking market entry and the acquisition of 'market share' from NHS providers, but are unsustainable when rolled out in the long term. If commissioning is outsourced, it then becomes unclear whether it is really GPs who will be in control of the commissioning process.

Financial and legal risks

While commissioning consortia may contract out much of their activity, they retain responsibility for what is done in their name. The Bill states explicitly in section 9(3) that:

> 'a commissioning consortium has responsibility for persons who are provided with primary medical services by a member of the consortium'

Recent examples in social care should act as a warning. Price-based competition creates a significant risk that care will be provided by less-qualified staff, with lower pay, working longer hours,[6] a situation exemplified by the now-defunct care home Winterbourne View and its two sister homes where similar problems have since emerged. This situation is likely to result in more clinical errors, as pointed out by a clinical negligence QC.[6] Recent debate on the NHS reforms has tended to obscure the fact that only those services paid for according to tariff will be protected from price-based competition. This leaves 40% of hospital care and the entire mental health and community budgets[7] to be selected based on price competition.

The risks are especially great in relation to providers failing, as is more likely within the new system,[8] which explicitly expects provider failure,[9,10] as provided by sections 125 and 126 of the Health and Social Care Bill. Consortia will require much greater legal clarity about their liabilities in the event of imminent 'market exit' of a provider due to insolvency. For example, commissioners must apply due diligence and monitor the financial health of providers, and not refer to a provider whose finances they find to be precarious,[9] but should a consortium withdraw patients still under treatment who were referred before problems were detectable? Loss of referrals may hasten the provider's financial failure, providing an incentive for providers to conceal problems from commissioners, thus complicating due diligence.

Commissioning consortia cannot look to the government to bail them out if things go wrong. They are unlikely to be considered 'too large to fail' and the White Paper's section 5.14 makes it clear that they will not be indemnified against financial failure,[3] whether caused by weak budgetary management, errors of commissioning, or by circumstances entirely outside their control. They are required to break even on their budgets.[3] This is similar to the situation in the United States where many consortia went bankrupt,[11] despite (or perhaps because of) spending 15–20% of their total income on technical support for commissioning.[12] The government has not yet stated what will happen when commissioning consortia go bankrupt, and for those keen to be involved, it may be timely to seek some clarification on this question.

To carry out the commissioning role itself, the budgets to be paid to GPs are expected to be far from generous, a matter which has generated some concern in the British Medical Association's General Practice Committee.[13,14] Within the context of a planned 45% cut in NHS management costs, set out in the NHS Operating Framework 2011–2012, this is perhaps to be expected.

Impact on patients

Involvement by GPs in commissioning creates many potential conflicts of interest.[15] No measures are yet in place to limit the ability to contract with providers in whom GPs, their families and business associates have a financial interest. If such contracts are set up, there is a real risk of supplier-induced demand, as in the US health system,[16] and of accusations thereof by patients. There is simultaneously an incentive to build up budget surpluses (or reduce deficits) by reducing or delaying necessary referrals, something the British Medical Association has warned about.[17]

This problem is likely to be exacerbated by the proposed 'quality premiums'.[3,18]

Consortia faced with budget deficits have already started to ration care. NHS South West Essex has circulated a list of 213 treatments for which general practitioners can no longer refer. These include hip replacements, cataracts and hysterectomies. Overall 8% of GP referrals have been rejected outright by the 'referral gateway' run by Fortis Healthcare on behalf of NHS South-West Essex, which took this measure because the savings expected from the new commissioning system failed to materialize. Their expectation is that this rationing of NHS care will save them £1.9 million this year.[19] Health insurers are already gearing up to provide top-up insurance to cover procedures no longer covered under the NHS;[20] this strategy is likely to result in both higher costs and an increase in inequality.[21]

Patients unable to access procedures which have previously been routine are likely to be distressed when they discover they will now have to fund their own treatment. It is possible that they will 'shoot the messenger' and blame their GP, especially those who can neither afford nor borrow the money for an operation they need to relieve chronic pain or disability.

Finally, the removal of practice boundaries will have major implications for patients. An obvious example is out-of-hours care, as is already happening in the Netherlands, where the attempts by general practitioners to coordinate patient care are being challenged by the competition authorities.[22] However, looking ahead, this measure threatens to undermine any attempt to create integrated care pathways across providers inside and outside the health sector.

Conclusion

The government's proposals to change the NHS have been seen by some general practitioners as offering an opportunity to steer the delivery of care. Yet, on closer inspection, it poses many threats to participating GPs.

Doctors are still the most respected group in British society. There is a real danger that these changes, many of whose practical ramifications are still far from clear, could trigger a backlash from patients, as well as significant legal and financial risks for those participating in consortia.

Indeed, it is difficult to argue with the proposition that they could easily become the scapegoats for the failings of these ill-conceived changes.[1]

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