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GP commissioning: whose service is it anyway?

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“The structural changes proposed in the new Health Bill raise important questions about the advisability of frequent reorganisation, particularly when money is tight. Important though they are, such questions are distractions from the Bill’s key aims: correcting the traditional misalignment of NHS incentives, specifically at its general practice ‘front end’.

Until 1990, hospitals (where most NHS money is spent) were paid directly by their local health authorities, although their activity was largely driven by GPs (without any formal health authority connections) making patient referrals. It was (and remains) the GPs who invoked most NHS expenditure, and the traditional mechanisms meant that there were few ‘brakes’ in the system; it didn’t matter to GPs whether or not they made referrals, except that sending ‘difficult’ patients to hospitals reduced the stress of running long surgeries.

Put another way, there was no GP ‘ownership’ of referrals; spending other people’s money is always different from spending one’s own, and because GPs spending health authority money didn’t ‘own’ it, they sometimes felt less responsibility for it, so that they may have occasionally referred too many patients, perhaps whimsically.

Fundholding, introduced by the last Conservative Government, was intended to engender GP ownership by giving practices control of some of the funds spent on hospital services, effectively making it ‘their’ money, so that they might spend it more sensibly, whilst continuing to coordinate community medical services. The scheme had problems, mainly associated with its high fixed costs and perceived inequities, but it definitely raised the ‘ownership’ felt by GPs, and it is this *zeitgeist* that the new Bill is aiming to recreate.

Giving GPs (in groups large enough to mitigate clinical and financial risks) control of what happens across the healthcare system is intended to produce two key outcomes: care delivered in a ‘joined up’ manner across the primary/secondary care interface, and where the resources are spent sensibly and hopefully frugally.

There are two major obstacles, one practical and one philosophical: the practical one is persuading GPs to take up the responsibilities that must accompany their new powers. The more challenging problem is that GP consortia are expected to consider population risks as well as individual patient needs, two functions that are often mutually contradictory. The most likely solution here is the re-invention of an intermediate organisational tier to manage population risks, a structural preoccupation that once again risks distracting us from the positive benefits of aligning risk and reward in the NHS.