

From patient advocate to gatekeeper:

understanding the effects of the NHS reforms

For over two decades GPs have been encouraged to engage in the financial, as well as clinical responsibilities of health care. While it makes sense for GPs to be involved in health planning, such as expanding the number or location of surgeries and services, acquisition of new technology, and so forth, it does not make sense for GPs to spend their time negotiating contracts with other doctors, managers, and hospitals, and even less to bear financial risk for their expensively ill patients. Firstly it turns GPs into rationers of care and away from their professional role as patient advocates. Secondly, it does not save money. Experience with managed care in the US shows that it increases the need for administrators and managers. Finally, putting clinicians at financial risk does not improve quality.¹

Clinical commissioning groups (CCGs) are similar to North American health maintenance organisations (HMOs), with the UK government allocating resources to CCGs based on the number of enrollees (patients registered with constituent practices), from which secondary care services will be bought. Originally conceived as a way to pre-pay for preventive care in addition to acute and hospital care, not-for-profit HMOs were introduced in the 1970s.² Despite their progressive origins, they were rapidly transformed in the 1990s into for-profit corporations.

HMOs profited by avoiding sick patients in increasingly deceptive ways; for example, by cherry-picking the healthy, dumping high-cost patients from their plans (known as 'recession'), and limiting referrals and treatments on financial rather than clinical grounds. This new breed of HMOs created opportunities to control medical care *before* it was delivered, diverting 20–30% of revenues to overhead and profits along the way.³

HMOs, as with CCGs, will create perverse incentives, as well as placing barriers to joint working between primary and secondary care practitioners.

PROFIT-LED ORGANISATION

While primary care physicians are put at financial risk to reduce care, specialists (in hospitals, any-qualified providers, and third sector specialists) will be dependent on the number of patients and intensity of services (treatments, imaging, hospital days) for

their funding, not, as with the system pre-NHS market reforms, on grants from the national purse. Thus, as in the US, specialists will have an incentive to increase activity, inevitably leading to over treatment and over investigation in an attempt to increase revenue and pay their overheads (including staff wages).

Thus, primary care physicians will be pitted against hospitals and other secondary care providers in a market-based scheme that diverts funding from clinical care to overheads and profits. The complexity of putting restrictions in place on who, where, when, and why patients can be referred; the implementation of referral management and gatekeeping systems; performance management and utilisation review; and even firing of practitioners with more than the expected number of expensively-ill patients, along with the many other functions that will be required of CCGs, will come at a high price. In practice, CCGs will have to hire new firms (the giant insurers from the US are already in line) to manage such a complex array of tasks, and based on the US experience, they may be expected to consume 20–30% of funds for their services.

CCGs, as with HMOs, will implement risk-stratification systems, identifying potential high-cost patients and high utilisers of health services, whose care will be outsourced to third parties, such as disease management companies. Patients with complex comorbidities may find their care being managed by a multiplicity of disease management systems, all designed, not to improve their care, but to increase the management firm's profits. Care to the patient will be fragmented⁴ and continuity compromised due to the perverse funding arrangements. Mergers between different CCGs will be inevitable, as the unpredictability of ill-health (for example, small numbers of patients requiring high-cost treatment) takes its toll

on the budgets of smaller CCGs, or worse still, CCGs will become bankrupt. GPs will become corporate employees, expected to perform according to rules dictated by the CCG hierarchy.

SELECTIVE PATIENT LISTS

CCGs will inevitably impose different schemes on participating practices and patients, with the move towards personal health budgets (vouchers for year-of-life care) and away from budgets based on geographical populations facilitating this. Fit, healthy, and younger patients will be targeted in the hope that their cost utilisations will be less, leaving more profit for the CCG, either to reinvest in clinical services, or as is currently proposed with the Health and Social Care Bill, to provide financial reward to the participating clinicians. As the new Act is removing Parliament's duty to provide a comprehensive health service, CCGs will be able to determine what services they provide as standard (that is, free-at the point of use), with other specialist services dependent on co-payments despite their disastrous consequences for care.

Evidence from the US shows that co-payments reduce access to necessary care as much an unnecessary care, and, in the only randomised study in this area ever performed, disproportionately increased death rates among the poor and chronically ill.⁵ Furthermore, they increase bureaucracy and don't save money: the US has the highest cost-sharing in the world and also the highest healthcare costs.

The NHS works. It produces some of the best health outcomes of any modern health system. It is a universal service, with risk pooling across the entire population. GPs are paid according to capitation, and financial incentives, where they exist, are to keep patients well. Before the market reforms of the 1980s, hospitals were paid a grant to cover their budgets, with no

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incentives to increase activity or maximise costs by up-coding or gaming. Rather than trying to implement the US’s failed market-based model and put corporate profits and bureaucrats at the centre of our health system, the UK government should improve and protect the NHS and its achievements in providing health and security to our nation by ending the experiment with market-based care and focus on what matters to patients: continuity, access, caring, and coordination.

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