Reorganisation and cost savings in diabetes care

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The UK's new coalition Government has moved quickly since gaining power, introducing a variety of reforms, with the explicit intention of making expenditure savings, which will reduce the nation's large financial deficit. The Government has promised to ring-fence NHS spending, but their intention to reform welfare benefit and public sector pay and conditions will certainly impact on primary care healthcare professionals. The plans to put GP commissioning at the heart of the NHS changes in England has the potential to radically reform the way in which diabetes care is delivered (Department of Health, 2010).

The three devolved governments outside England will not be immune from cuts and reforms. The Scottish Government would like to maintain healthcare spending (Carrell, 2010). The NHS in Wales and Northern Ireland has barely "bedded in" after a large-scale reorganisation. They are reporting budget shortfalls that are only expected to get worse.

The costs of prescribing in diabetes

The number of people with diabetes is increasing throughout the UK, with the highest prevalence in Wales (4.4%), followed by England (4.1%), Scotland (3.7%) and Northern Ireland (3.3%) (Diabetes UK, 2008). As diabetes prevalence increases, it is inevitable that prescribing costs should also increase.

A recent report from The NHS Information Centre provides statistics for diabetes-related prescribing in primary care in England over the past 5 years (The Information Centre and Prescribing Support and Primary Care Services, 2010). The document shows that just over 35.5 million prescription items were dispensed in England to treat diabetes in 2009/10 at a net ingredient cost of nearly £650 million – an increase of more than 40% over 5 years. The figures represent a 43% increase in items and a 42% increase in net ingredient cost compared with 2004/05, when 24.8 million items were dispensed at a net ingredient cost of £458.6 million. It would appear that prescribing trends are outstripping the prevalence rates – one reason for this could be that QOF payments for achieving performance indicators have encouraged therapy intensification.

This cost of prescribing for diabetes represented 7.7% of the total cost of prescribing in primary care in 2009/10, compared with 5.8% in 2004/05. Prescribing advisors will certainly be scrutinising these costs carefully, but faced with the increasing prevalence of diabetes it is difficult to see how these expenditures could be reduced. New antidiabetes agents are emerging that may be safer and more effective, but may well carry a higher tariff price.

Commissioning

It is apparent, then, that minimal savings in healthcare spending can be made through the prescribing budget. Where else could savings be made? The heart of the English White Paper is the belief that GPs will be effective purchasers of high-quality care (Roland, 2010). It is expected that they will work with other GPs, consortia or private providers to purchase services for their patients.

However, it would appear that primary care trusts have not been effective commissioners and nor have GPs when given practice-based commissioning in 2004 (Smith et al, 2004). Scotland had turned away from commissioning services in this way from the beginning, preferring vertically integrated care. Both Wales and Northern Ireland have commissioning groups but they are very much in preliminary stages.

Conclusion

GPs are motivated to improve the care of their patients – in general and for people with diabetes in particular as they recognise the rising burden of care needed for this group. This person-centred approach should be at the heart of this White Paper. "Reorganization is a splendid method of producing the illusion of progress whilst creating confusion, inefficiency and demoralisation" seems like a quotation for our times, yet it comes from Petronius Arbiter, who was speaking about the Greek Navy in 60 AD – nothing changes! ■

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