Practice-based commissioning: Responsibilities that GPs cannot shirk

Peter Stott

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Peter Stott is a GP, Tadworth, and Medical Director, Epsom Downs Integrated Care Services (EDICS), Surrey.

Practice-based commissioning (PBC) is founded upon the experience of fundholding, Personal Medical Services (PMS) and the total purchasing pilots (TPPs) of the 1990s, which showed that groups of GPs working together could make cost-efficiency savings by reducing referrals and by improving the interface between primary and secondary care – areas over which GPs have direct control (Smith and Goodwin, 2002).

Practices that take on PBC will be obliged to take on all services covered by the national tariff under payment by results (hospital referrals and admissions) as well as prescribing. After that they can opt to include other areas such as community nursing, mental health, accident and emergency, and diagnostic tests. Indicative budgets will be calculated from historic activity, current formulae for prescribing, weighted capitation and an uplift to meet agreed additional activity. A Directed Enhanced Services payment of £0.95 per patient has been suggested, with a further £0.95 if savings are achieved (British Medical Association, 2006). There is a lot of necessary work (Department of Health [DoH], 2006) and many practices will wish to group so as to share these management costs.

Cost implications

PBC is not the same as fundholding and total purchasing, in which the budget was real and the practice was able to keep the savings. In PBC, the budget is indicative. And practices do not have the automatic right to keep the savings. While the guidance suggests that resources which are 'freed-up' from the indicative budget may be split 70–30 between the practice and the primary care trust (PCT), and that practices will have the right to make recommendations about reallocation of these resources, PCTs will have a prior right to use any savings to pay off their overspend (DoH, 2006). In 2005, in a written parliamentary answer, Patricia Hewitt, the Secretary of State for Health, admitted that 72 PCTs were more than £1 million overspent (United Kingdom Parliament, 2005). So it is likely that in year 1, at least, PCTs will have a major claim to any savings.

A cynic would say that PBC is a cost-saving measure designed to lure altruistic GPs into making savings on an indicative budget – just as indicative prescribing budgets were. This may be possible in year 1, when PCTs will have first call on the savings. But if the experience of PMS plus (which encompassed aspects of traditional secondary care) and the TPPs is anything to go by, then there is a risk that the indicative budget will reduce year on year until further savings become impossible.

Impact of diabetes

As regards diabetes, there are economies to be made by transferring the care of patients currently attending hospital back into the community. This will involve training primary care staff to assess complex diabetes risk and to manage the care of stable insulin-treated patients. In my own locality, new referrals to the hospital diabetes clinic are rare – fewer than 50 per year for a population of 121 000. So it is only by repatriating hospital patients at the national tariff price that PBC will make realistic savings. There will be consequences for the prescribing budget too. Only 3–4% of the population has diabetes, but the condition is associated with a disproportionate amount of spending (Currie et al, 1997) and its prevalence is increasing rapidly.

Conclusion

PBC is voluntary, but if practices do not join, the PCTs will administer an indicative scheme on their behalf. PBC is a way of controlling the spiralling costs of healthcare and, as its most important consumers, GPs cannot shirk the responsibilities. ■