

The Commissioning Chame(r)leon

Healthcare commissioning is what the Health & Social Care Bill is all about. The driving force from the civil servants in the Department of Health has been to constrain NHS expenditure, and then to apportion either credit or blame, when this bureaucratic Heath Robinson “invention” either succeeds or fails, on the doctors.

The notion that GPs could at a stroke take over the commissioning role of the PCTs and the PCT budget holders, the SHAs, without reemploying most of those bureaucrats, was as cockeyed as the previous notion that PCTs and SHAs could control budgets and equitably deliver care without a substantial input from the medical profession. By turning this process on its head one has merely exposed a different underbelly to public scrutiny and criticism.

What the politicians have missed, or deliberately ignored, is the fact that if the majority of the decision makers on this commissioning board are practising GPs, then they will have at least two conflicts of interest. Firstly, there will be their desire to deliver all possible assistance to their own patients’ specific needs. Secondly, there will be an agenda to keep as much as possible of the budget in Primary Care and keep the begging bowl of the NHS Hospital Service at arm’s length. Furthermore, with GPs restraining hospital spending that would facilitate the demise of a substantial proportion of the smaller hospitals in the inner cities – the not so secret agenda of the top healthcare bureaucrats and David Nicholson in particular. At least Stephen Dorrell would appear to have recognised some of the inconsistencies generated by the creation of “GP Consortia”.

If the Health Select Committee think that they can re-launch this flawed bill by changing the name of “GP Consortia” to “NHS Commissioning Authorities” then they have missed a fundamental point, namely that these bodies must eliminate any suspicion of conflict of interest from the members sitting on these “Commissioning Authorities”. Loading these “Consortia/Commissioning Authorities” with baggage from local governmental “stake-holders” just makes these “Consortia/Commissioning Authorities” more cumbersome and unwieldy. If the other political agenda is to make these commissioning bodies more robust, more locally accountable and less expensive to run than the bodies that they would be replacing, then where is the evidence upon which these theories have been based? Interestingly, after devolution in 2003, the Scottish commissioning system replaced the English Purchaser/Provider system with Health Boards which have been

shown to achieve somewhat better healthcare gains with less bureaucratic confusion and expense than their English counterparts, although there is scant medical representation amongst the members on these Boards.

Since the bureaucrats in the Department of Health, who have been weaving this complex shroud over the past decade, have clearly got it wrong, surely they and their advisors should be the first to be offered alternative employment – hopefully outside the NHS. They should be replaced by those with medical expertise and accumulated wisdom. Likewise, the redefined “GP Consortia” should receive their advice from a similar source. Where are you likely to find such a pool of unbiased opinion, lacking the temptation of empire-building or financial self-gratification? Surely it must be amongst the ranks of the recently retired medical workforce who today, unlike their medical predecessors, have a life expectancy of many years in healthy retirement. If these doctors were called upon to serve in a strictly honorary capacity on these “Commissioning Authorities” they would at the very least negate the growing opinion in the community that doctors have become a bunch of money-grubbing clock-watchers.

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