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DATELINE 2013 AD: THE DYSTOPIAN FUTURE OF COMMISSIONING IN THE NEWLY LIBERATED NHS?

The *Judge Dredd* film and comic book character combines the powers of police, judge, jury, and executioner within the same individual. The new NHS white paper thrusts a similarly poisoned chalice of conflicting interests upon GPs, with little detail as to how they can be resolved.[1]

Scenario 1: In the morning, Dr A sees an obese patient requesting referral to a structured weight-loss service. The patient has borderline eligibility for an oversubscribed and financially constrained local diet and exercise programme. The GP's duty of care clearly dictates that he should refer her to the service.

In the afternoon, he sits on a practice-based commissioning (PBC) consortium committee making decisions on commissioning weight-loss programmes in the area. A local authority public health doctor explains that while all weight-loss services are under-resourced, the greatest gap in local provision is actually for bariatric surgery. There is no extra money for weight-loss services overall: the only way to fund extension of bariatric surgery provision is by reallocating resources from services on lower tiers of the weight-loss referral pathway. This could be achieved by tightening the eligibility criteria for the structured diet and exercise programme, such that Dr A's patient would clearly fail to meet the criteria. Dr A is asked his opinion on the proposed changes.

Scenario 2: Dr B is involved in a large PBC consortium spanning a population with areas of both high and low levels of socioeconomic deprivation. In her PBC role she commissions services for the whole consortium area. As a GP, she works in a practice based in a wealthy part of town. She is aware that many of the proposed providers in her consortium (a range of new GPwSI services, an urgent care facility, and a new family planning clinic) are likely to use locations convenient to her patients, to the detriment of practices based in poorer parts of town. She regrets this, but sees herself as a GP who works in a commissioning role, rather than as a public health doctor; indeed, she took on the PBC role precisely because it represented an effective opportunity for her to represent her patients' interests.

Scenario 3: In the newly-liberated NHS, PBC consortia have responsibility for making local prescribing decisions; NICE has been de-fanged. Dr C gets involved in his consortium's prescribing committee. He has a much-loved patient on his list with the rare chronic condition 'obscuromatosis'. Long-term use of the budget-crushingly expensive drug 'costlimab' provides some relief from the symptoms. His patient is really quite keen that the drug be approved for use within the consortium, and repeatedly reminds Dr C of this.

In its existing guise, the PBC process sidesteps these conflicts of interest, because primary care trusts (PCTs) have the final say in approving practices' commissioning plans. But when PCTs have been abolished and ultimate responsibility for commissioning shifts to the PBC consortia, it is unclear who will provide this arbitration. Public health functions are likely to move into local authorities, but this is envisaged as a support function, rather than an oversight function.

Current PBC guidelines tend to focus on financial probity: clearly, it is a conflict of interest for GPs to commission services in which they have a financial stake.[2] They also suggest that doctors must still refer patients to the most clinically appropriate service, regardless of any involvement in that service's commissioning or provision. This uncontroversial advice is in keeping with well-established Hippocratic principles, and the profession will do well to be alert to the dangers.

But the scenarios outlined above describe subtler pressures that GPs linked to a practice may struggle to avoid. They are intrinsic to the different roles of general practice and public health, and represent a strong argument for maintaining 'clear water' between these functions in the new NHS structures. While exchange of people and ideas between disciplines should be encouraged, and this communication has perhaps been neglected in the past, combining these roles without clear governance mechanisms will leave GPs fatally exposed to future criticism.

GP-led commissioning does hold the promise of more responsive health services better tailored to local communities, but it does not guarantee more equitable ones. Designing services that operate fairly and efficiently at the community level requires not just support, but arbitration, from professionals whose primary responsibilities lie at the community level. GPs cannot be police, judge, and jury when it comes to local health service provision.

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REFERENCES

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