The Economist

The National Health Service

The power game

Family doctors are being asked to get a grip on hospital spending. It is a tough battle

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EVER since the National Health Service was founded almost 60 years ago, hospitals have had the upper hand in terms of prestige and resources. In Sheffield the power of the teaching-hospitals trust is as palpable as the steel for which the city in South Yorkshire was once renowned. It occupies two sites, one to the north of the town, the other close to the centre near the university, where a 20-storey tower block has specialist units clustered round it.

Compared with the grandees working in hospitals as consultants, general practitioners (GPs) —the main contact for patients—have been the junior partners in the NHS. At the Avenue practice in the south of Sheffield, six GPs and three nurses look after 8,700 patients in what is a bigger surgery than many. Yet it is a modest enterprise compared with the teaching-hospitals trust, whose 13,000 staff make it the city's second-biggest employer.

Now David is taking on Goliath. GPs in England are beginning to play a crucial part in restraining hospital spending. Unlike family doctors in most other advanced countries, GPs in the NHS have long acted as “gatekeepers”, controlling patients' access to expensive hospital care through their referrals for treatment. Now this insurer-like role is being widened and made more explicit as they become responsible for clinical budgets covering hospital care as well as some of their own costs.

In Sheffield the Avenue has joined forces with 15 other practices to form a consortium with a patient population of over 90,000. Altogether there are eight consortia in the city looking after a budget of more than £300m ($588m). Of this a quarter pays for the drugs GPs prescribe while the remainder goes towards the cost of acute care in hospital.

The budget has been devolved to the GPs by the primary-care trust (PCT) in Sheffield, one of 152 which purchase most of the health care in England. The trust still pays the bills covered by the budget. However, the reform aims to add some clinical muscle to PCTs, which until now have been rather weak buyers of medical care. That task has become pressing as the NHS has slid into deficit.

More cost-effective purchasing has become essential because other policy changes have loosened restraints on the supply of costly hospital services. Twenty miles down the motorway from Sheffield, for example, is the Barlborough treatment centre, which carries out orthopaedic operations. Run by the Partnership Health Group, it is one of several private clinics that sprang into existence after the government put a slice of elective care out to tender in order to challenge the monopoly of state-owned hospitals.

The government has also sought to unleash greater enterprise among existing NHS hospitals by letting more of them have a freer financial hand in running their affairs. Sheffield's teaching-hospitals trust was among the first 20 to win this cherished "foundation" status in 2004. Now 54 acute-care trusts—nearly a third of those in England—have achieved it, and the goal is that eventually all will do so.

Most important, the government has shaken up the way that hospitals are paid. Under previous arrangements, hospitals got the bulk of their income through "block contracts" which largely reflected past budgets. Now most of it comes from activity-based payments: the more work hospitals do, the more money they get. Neil Priestley, the finance director of Sheffield's teaching-hospitals trust, welcomes the clarity: "The old fudge has gone. If you do something, you get paid."

Strengthening the buyers

But if providers now have keener incentives to do more, purchasers must be stronger in order to control costs. As Tony Blair's health-policy adviser in 2004 and 2005, Julian Le Grand of the London School of Economics spotted the danger: "I was worried that the primary-care trusts were too weak; too often they got walked over by the hospital trusts."

One step has been to rationalise the primary-care trusts. When they were originally set up in 2002 there were around 300 of them, but since October the number has been halved. The change has been especially marked in Sheffield, where four smallish PCTs have been merged into one. The reorganisation so soon after they were first established was an unwelcome distraction. However, Mike Curtis of the Yorkshire and Humber strategic health authority, which oversees the PCT, says that "the new organisation will have more clout".

But the reform that matters is the one that Mr Le Grand urged when advising Mr Blair: to make purchasing more cost-effective by mobilising GPs. "Practice-based commissioning" in fact resurrects the Tories' policy of the 1990s when GPs held their own budgets for prescribing and elective care. Research at York University suggests that this did help to restrain demand. About half of GPs had become "fund-holders" before the Conservatives lost power in 1997. Among these practices, referral rates for elective care were 3% lower than they would have been if they had carried on as before.

Labour's policy is more ambitious since it covers all family doctors. Their budgets include emergency hospital care and will be extended in a month's time to mental health. In Sheffield Chris Ratcliffe, deputy director of commissioning at the PCT, expects the reform will help to close the trust's deficit. The budget controlled by the GPs should contribute half the savings the PCT is hoping to make in 2006-07.

The consortium to which the Avenue practice belongs is currently concentrating its efforts on reducing unnecessary referrals to hospitals. While the PCT is in deficit, the GPs are not expecting to keep any savings for themselves, says St.John Livesey, who leads the consortium. But in the longer term, family doctors have a clear incentive to be involved in commissioning. Practices will retain 70% of any savings (the PCT will keep the rest), provided that they are ploughed back into better services.

One potential drawback is that GPs' revived role in purchasing may stymie competition in the primary care they provide. The reform could put off potential competitors with new ideas about integrating care across the traditional boundary between GP practice and hospital. Family doctors, for their part, may worry that they will get the flak for containing costs. Another finding from the research at York University about the 1990s was that patients of fund-holders were less satisfied with their GPs.

Practice-based commissioning is reinventing GPs' historic “gatekeeper” role in a more market-based health service. Whether or not it works may determine the NHS's ability to survive less generous funding from the spring of 2008.

From the print edition: Britain