WHITE PAPER **Polly Toynbee**

GPs have reasons not to be so cheerful over commissioning plans

It is a mystery how the hundreds of proposed consortia are to work better than the current system

General practitioners are the masters now, running the whole shebang with £80bn to spend as they please. Some enthusiasts can't wait. But many wise GPs will look this gift horse in the mouth with considerable circumspection. How exactly are they to do it?

Divided into 500-600 consortia, GPs will do all the purchasing that the abolished primary care trusts did with 45% less cash for management costs. They will do it alongside the day job they chose—general practice, not NHS management. Once 303 primary care trusts did the job, but the shortage of finance directors and chief executives forced their reduction down to 150. Now all PCTs and the 10 special health authorities are to be abolished, with their staff cast to the four winds. In yet another game of NHS managers' musical chairs, how will they be spread thin across 500 GP consortia? As happens with each turbulent reorganisation, many of the best will walk away. Civitas—a government friendly think tank—warns that this great disruption will yet again set back NHS progress by one to three years.

Observers agree that PCTs, supposed to be turbo drivers of the internal NHS market, were often the weak link in the chain: top managers preferred the glamour of running hospitals to the pen pushing bureaucracy of PCT purchasing offices. Nonetheless, those same NHS observers were this week shocked at the idea that the entire cadre of commissioners would be fired, and GPs left to set up completely new entities. In times of plenty, money might rescue disasters along the way—but this happens as a massive £20bn of "efficiency savings" is to be cut from the service, with management costs nearly halved and the NHS about to enter a period of greater stringency than it has ever known, according to the Institute for Fiscal Studies. Forget "ring fenced" and "protected," this will be a tighter squeeze than those crises that precipitated Margaret Thatcher and Tony Blair into their radical reforms. The cost of much social care will also be piled on to GP commissioners. The mystery is how these hundreds of consortia are to work better, needing many more staff on much less money. The Nuffield Trust suggests that the consortia will cost £1.2bn more, a conservative estimate.

Another reason for GPs to pause: if they think they can commission whatever local hospitals and services they choose, they should think again. The prime duty of Monitor, the independent regulator of NHS foundation trusts, will be to act as an economic regulator, ensuring a level playing field in a competitive marketplace. That means EU laws apply and every tender must be fairly open to all bidders from home and abroad, contestable in court if bidders feel discriminated against. GPs will not be allowed to favour services and providers they already know and trust. Once the Pandora's box of the market is open, the lid can never be put back on. This will not be the familiar NHS but a random and shifting collection of best bidders from all over the world. Powerful US companies may well begin with loss-leading bids that would be hard to prove unfair. If some GP consortia don't want to put in the management time, these companies will bid to do the consortia's purchasing too, so then who runs the NHS?

Another reason for GPs to worry: a consortium will have power to run the GP practices in its zone with a rod of iron. Managing its budget will depend on GPs' spending behaviour and those who "overspend" will not be tolerated. GPs will not have the same independence. Consortia will have "powerful incentives" to hit their commissioning targets, so you can bet every GP will feel that incentive on their back as never before. Good, perhaps, if all have to perform as well as the best—bad if all have to prescribe the cheapest of everything, regardless.

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A deeper ethical dilemma should grip GPs as they consider how all this changes their role as intermediaries between patient and NHS rationing. Whose side are they on—the patient's, the state's, or their own bank balances'? Once they hold the budget each patient becomes a unit of rationing or possibly a business prospect, if GPs set up their own treatment centres. True, GPs are already small businesses, but their business is conducted through contracts with the government, at which they have been clever on Labour's watch. This has intervened very little in their direct relationship with their patients. But now a patient would be right to wonder if a doctor's decision is guided by how much money the practice has left that year for hospital or expensive drug treatments. If a GP recommends consultant X or drug Y, is it the cheapest or the best? Certainly good doctors should always have concern for the always limited resources of the NHS—but it spells the end of trust if a patient ever suspects a personal financial incentive to offer the cheapest.

Right now the power to say no rests with GPs. So when the BMA negotiates the new GP contract, politicians should remember the doctors have the upper hand. The BMA would be right to refuse anything that risks breaking the trust between patient and doctor or breaking the non-commercial spirit of the much loved NHS.

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LIFE AND DEATH **Iona Heath**

What do we want to die from?

Continuing to fight all causes of mortality offers no hope of success

Successive governments have been committed to reducing mortality, and the recent white paper shows that the current coalition government is no exception (*BMJ* 2010;341:c3796). The problem with such a commitment begins with the word: mortality means both the number of deaths in any given context but also the condition of being mortal and subject to death. We must all die, and so we must all die from something. The mortality rate for the population as a whole will always be 100%; so to what profile of causes of death should we aspire? If we continue to fight all causes of mortality, particularly in extreme old age, we have no hope of success, and we will consume an ever increasing proportion of healthcare resources for ever diminishing returns.

The World Health Organization's 2008-2013 action plan for the prevention and control of non-communicable diseases states that these diseases, mainly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, "represent a leading threat to human health and development. These four diseases are the world's biggest killers, causing an estimated 35 million deaths each year—60% of all deaths globally" (http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf). Yet surely this is, in many ways, a cause for celebration: millions of people are no longer dying from acute infections and malnutrition in childhood and are living long enough to develop the whole array of chronic non-communicable diseases. But WHO also informs us that of the 35 million people who died from chronic disease in 2005 half were aged under 70, and these are the deaths that should demand our attention—globally and nationally.

If healthcare services are ever to do anything serious about health inequalities they will need to find the courage to concentrate their efforts on premature mortality and to resist the inevitable but inappropriate accusations of ageism. Those who die early suffer the most tragic loss of life years. Mortality among under 5s in the United Kingdom is the highest in western Europe, and rates of child mortality in poor countries are a continuing testament to the failure of global economic and social justice.

Death in extreme old age is often timely. When the ageing body begins to fail, diseases are like Shakespeare's sorrows: "they come not single spies, but in battalions." All clinicians caring for older people have the experience of treating one disease process, only for another to take its place; and the more diseases that coexist, the greater the hazards of overtreatment and polypharmacy, and the more the challenges of daily life become a struggle. We continue to prescribe statins to those aged over 70 despite evidence that although this reduces deaths from cardiovascular disease it does not reduce overall mortality and increases rates of diagnosis of cancer and dementia (*BMJ* 2007;335:285-7). When one cause of death is curtailed, others must inevitably come forward to fill the gap. Everyone is obliged to die from something. If we close off all the alternative exit strategies, more and more older people will face the prospect of dementia.

Indeed the contemporary management of dementia in high income countries perhaps demonstrates the nub of the problem. The natural history of dementia offers the failing body and mind a way out: eventually the swallowing mechanism begins to fail, causing aspiration pneumonia and the possibility of dying. Yet now when swallowing becomes problematic health services provide percutaneous endoscopic gastrostomy (PEG) tubes and expensive enteral nutrition. And if pneumonia does supervene, healthcare professionals all too often banish "the old man's friend" with antibiotics. A study of the care of patients with either advanced cancer or advanced dementia dying in an acute hospital in the United States showed that for 24% of both groups cardiopulmonary resuscitation was attempted and that 55% of those with dementia died with feeding tubes in place (*Archives of Internal Medicine* 1996;156:2094-100). Is this what we want for ourselves or for those we love—or indeed for anyone?

"The public health dream of a long and healthy life followed by a rapid and easy death grows ever more elusive"

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WHO publishes profiles of causes of death for countries with different levels of economic resources (www.who.int/chp/chronic_disease_report/part1/en/index2.html). Predictably, high income countries have the highest proportion of deaths from non-communicable diseases; low income countries have a higher absolute number of such deaths, but an even higher number and a greater proportion of deaths are still caused by infections, maternal and perinatal conditions, and malnutrition. Which profile is the one to which societies should aspire? Healthcare professionals, politicians, and journalists have a responsibility to begin to think about these issues. All too often in global statistics it is difficult to unravel total mortality from premature mortality, and we urgently need to see profiles for the causes of premature death. And again, what sort of profile should we be aiming for?

A long life almost inevitably culminates in some form of non-communicable disease. Total life expectancy now exceeds healthy life expectancy by about two decades, and this gap seems to be widening with the ever earlier diagnosis of chronic disease. The public health dream of a long and healthy life followed by a rapid and easy death grows ever more elusive. Non-communicable diseases are here to stay. Memento mori.

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