NEW COMMISSIONING FORMULA

Dismissing patients’ past healthcare cost seems premature

Hendrik J Beerstecher  GP principal
Canterbury Road Surgery, Sittingbourne, Kent ME10 4JA, UK

The models for health expenditure at practice level presented by Dixon and colleagues have impressive predictive power. The approach and selection of variables seems to be logical and sensible. However, the authors exclude historic healthcare cost, a powerful predictor of individual future healthcare cost, on the basis that its inclusion would either be a perverse incentive for supplier induced demand or reflect supply instead of need. This reasoning seems illogical: past healthcare cost has not determined practice budgets and therefore precedes supplier induced demand. Arguably, including historic expenditure could reward practices for frivolously using resources. However, this argument assumes that patients are recruited more or less randomly from the local population. Anecdotally, reception staff actively screened patients in both practices where I was partner. Additional adverse selection through practice boundaries was a policy in one practice and is still commonplace. Its widespread existence was shown by O’Reilly and Steele.

Even if practices did not select patients, patients would affect the population profile through self selection. Patients who attend frequently will have much stronger incentives to re-register at high performing practices, which may be accumulating a population with high health needs. Individual health usage will determine cost at practice level but is not reflected in area deprivation or age-sex profiles. Beale et al describe a more accurate way to determine socioeconomic deprivation at patient level. To discount past cost at patient level seems premature. In the wrong hands, inaccurate budget setting tools will lead to practices being blamed for the cost of healthcare of their registered population. The way forward requires a model to more accurately predict the healthcare cost of individual patients to predict practice expenditure.

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hendrick.beerstecher@nhs.net