A new direction for community-based health services

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The paper by Roger Jones, 'Expanding community-based health services'[1] is based on the recently published White Paper, *Our health, our care, our say: a new direction for community services*.[2] A theme of the new White Paper is that general practice is 'the best point of contact for routine and continuing care', and it establishes 'plans to bring many services currently provided by hospitals into the community'.[3] However, Jones questions the assumption that a shift of services to the community will prove to be cost effective and asks whether this recommendation is evidence based.

Jones discusses the move of services into primary care – the largest potential change proposed in the White Paper. Chronic disease would be managed in the community by GPs with Special Interests (GPwSIs) in intermediate clinics funded by Primary Care Organisations (PCOs). This has implications for secondary care budgets since contracts might be moved from hospital-based clinics to fund these changes. Diabetes is a good example. GPwSIs do not have the skills or expertise to manage some of the complications of diabetes, for example patients with advanced nephropathy or patients needing skilled control of their diabetes during pregnancy. Jones cites evidence that such clinics may be more expensive than the currently available hospital clinics and there is also the challenge of taking consultants away from their base hospital and moving them into the community when these clinics cannot solely be run by GPwSIs. Although the proposed reforms are intended to reduce the NHS budget through increased 'productivity', GPwSIs may prove more expensive than hospital specialists. Unfortunately, the White Paper does not address the primary–secondary care interface.

The ethos of the White Paper is concerned with an increase in community services. However, as Jewell, Editor of the *British Journal of General Practice*, wrote:

> *there is a curiously Utopian air to the whole White Paper. There is an acknowledgment that some of these developments will cost real money, but no indication where the additional resources will come from.*[4]

Jewell went on to argue that the aims of the White Paper will be difficult to achieve given the 'astonishing deficits' of NHS trusts and PCOs. Where will the finance come from to fund other proposals in the White Paper such as extending GP surgery hours and allowing patients to register with a GP practice near their workplace as well as their home? Jones is realistic, however, and argues that these reforms will ultimately need to reduce the NHS budget through increased productivity.

The major implication of the changes proposed by the White Paper are what Jones refers to as the 'paradigm shift' which will be required in the way medical students are prepared for clinical practice. Currently most of their training is in secondary care, but as more care moves into the community, will medical education need to reflect this change? Will primary care have the facilities, resources, time and trained medical teachers to provide for the changing learning needs? The General Medical Conference is encouraging more of the undergraduate curriculum to be delivered in the community following its publication *Tomorrow's doctors*,[5] but this needs to be planned in a way which takes into account the burden on the primary care teachers, as postgraduate training is also increasing rapidly in the community, as well as increases in the patient service load.

On 1 April 2004, GPs voted overwhelmingly to accept a 'new contract' part of which allowed them to opt out of 24-hour cover for their patients. GPs thereby forfeited their monopoly over primary healthcare provision[6] and the door was opened for competition from commercial providers and PCOs to franchise primary care services. Jones hints at how this ultimately has the potential to fragment primary care and its coordination with secondary care under the original gatekeeper – the GP. A similar franchising model will apply to services during working hours as well and so further accelerate this fragmentation. GPs remain independent contractors so that, as well as providing NHS services, their practices are also businesses. General practice will no longer be a 'closed market' according to the White Paper and GP practices and other members of the primary healthcare team will need to work much more closely together, coordinate their activities better and develop a 'corporate' approach. It is inevitable, however, that the continuity of care provided by GPs will be further reduced with the increased competition in primary care to provide healthcare.

Jones describes how patients are likely to see a greater range of primary care practitioners, including

non-clinical professionals, rather than simply a general practitioner. This could be a healthcare assistant, a practice nurse, a nurse practitioner or one of many other healthcare practitioners. Some have argued that this could be the end of the continuity of care and the traditional doctor–patient relationship. This process has been accelerated by GPs ending out-of-hours care. Some have argued, however, that this will create the environment for GPs to become consultants in primary care or generalist community-based physicians. Other members of the team will provide care for patients who are acutely ill with self-limiting illnesses and provide services such as contraception and vaccinations. GPs will manage more complex medical conditions such as epilepsy, the complications of diabetes and multiple sclerosis.

With the new GP contract came the need to meet targets, in particular, chronic disease management targets through the Quality and Outcomes Framework (QOF) and accountability that can be measured.[7] If any services are franchised, this will be a threat to small practices and similarly will be an incentive to create 'super surgeries' where a wide range of services and increased patient choice may be available. Competition will increase and as the new 'directed enhanced service' of 'Choose and Book' illustrates, patients will become 'healthcare consumers' not just healthcare users.

If the White Paper suggests new directions, Jones rightly recommends that many questions need to be addressed first before the proposed major changes can be successfully implemented.

References

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