The new NHS: commentaries on the white paper

From specialist services to special groups

This week our commentators look at the impact of the white paper on people in the NHS, both staff and patients. These include patients with cancer, who can expect urgent appointments within two weeks (discussed by Christopher Bunch); the specialists who serve them (Christopher Bunch and Stephen Atherton); minority ethnic groups (Caroline Free and Martin McKee); and all NHS staff (Anne Cockcroft and Siân Williams)

Challenging times for specialist services

Christopher Bunch

The white paper focuses to a large extent on dismantling the internal market and the development of primary care. The provision of specialist services—which investigate and treat the bulk of serious ill health—get scant mention, despite their accounting for about £1.4 billion of NHS expenditure annually.¹

In an almost throw away line, the white paper insists that “everyone with suspected cancer will be able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment.” It is not difficult to understand why cancer has been singled out for this treatment. It is a common and greatly feared disease. Much work has been done around the country following the Calman-Hine report² to set standards for cancer care, define protocols and guidelines, develop multidisciplinary teams, and identify appropriate specialists. It is not unreasonable to suggest that a patient whom a general practitioner thinks is likely to have cancer should see an appropriate professional (usually, but not necessarily, a specialist) without delay. A two week target may seem as arbitrary as a 30 minute wait in outpatients but if achieved will reduce unnecessary anxiety and increase patients’ confidence in the service.

As with much of the white paper, the devil will be in the detail. The wording here is specific, but it is left to the general practitioner to decide if the referral is urgent. A danger therefore exists that anxiety in either the patient or the doctor, rather than the probability of cancer, will be the major determinant of urgency. If this is the case specialist services will probably become overloaded with patients who do not have cancer and will find it difficult to maintain the standard. The appropriateness of referral should therefore be assured by developing tight and clear referral guidelines with the specialist teams. Patient anxiety should be allayed by well informed general practitioners and possibly through better public education. NHS

Direct—the proposed new telephone helpline—may be useful here.

The only other significant reference to specialist services relates to the commissioning of services that are provided to more than one health authority. These include the old “regional specialties,” so called because the old regional health authorities used to be responsible for specifying and funding them, and range from haemophilia (very low numbers, extremely high cost) to coronary intervention (very high numbers, moderately high cost). The smaller specialties felt particularly disadvantaged by the 1989 reforms,³ which made health authorities responsible for purchasing them—because many individual health authorities did not give them high priority or fully understand their requirements.

The Audit Commission recently highlighted these concerns¹ but did not recommend a fundamental change in health authorities’ responsibility for commissioning specialist services. The white paper, however, gives the NHS Executive’s regional offices a clear responsibility for ensuring that effective arrangements for commissioning these services are established in each region. This is welcome and should help to over-

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The white paper is silent on future development of specialist services

come some of the difficulties encountered by specialist providers.

One important issue not covered directly by the white paper is the future development of specialist services, and in particular where, who by, and how much we can afford. Already it is becoming more difficult for smaller district general hospitals to provide some of the commoner specialist services—for example, urology, ear, nose, and throat surgery, and oral surgery. Changes in working patterns, in higher specialist training, and in the availability of staff make it likely that specialist services will in future be provided from fewer hospitals. Specialist care tends also to be associated with high cost interventions: bone marrow transplants, β interferon,

and taxol chemotherapy, for example. The new government promises a year on year increase in NHS spending (as did the last), but rejects the affordability argument and proposes better resource management, use of technology, and a reduction in bureaucracy as ways of countering present financial pressures. Given the focus on developing primary care that is clearly the cornerstone of this nation's healthcare philosophy, one can predict challenging times ahead for the specialties.

- 1 Audit Commission. *Higher purchase: commissioning specialised services in the NHS*. Abingdon: Audit Commission Publications, 1997.
- 2 Calman KC. *Policy framework for commissioning cancer services*. London: Expert Advisory Group on Cancer, Department of Health, 1994.
- 3 Secretary of State for Health. *Working for patients*. London: Department of Health, 1989.

Involving clinical professionals in managing and planning services

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A change of government should bring a new and fresh approach to the problems of the NHS, which in turn will invigorate the service and go some way towards correcting the inequities of the past. It is in this spirit that the new white paper on the NHS has been received by most health professionals.

From the doctors' perspective the important chapters are 4, 5, and 6—those on health authorities, primary care groups, and NHS trusts.

Health authorities will be responsible for assessing the health needs of the population and drawing up strategies (health improvement programmes) to meet those needs in concert with all other agencies concerned, including organisations outside health care. This provides an opportunity to rethink our approach to planning patient care. Assessing needs first and subsequently determining the resources needed to meet those needs is an approach that should be welcomed. Although there is still a cash limited budget for the health service, such an approach would allow us clearly to define the priorities of care and will inform decision making in a way that clearly puts the patients first and should allow all clinical professionals to make their contribution.

Primary care groups, and, ultimately, primary care trusts, are possibly the white paper's most radical feature. The development of these groups has the potential for far reaching change in the provision of health care in Britain. Primary care groups are not optional: all general practitioners will be required to be within a group, and these groups will be answerable to health authorities not only for their financial stewardship but also for their standards of clinical practice. Closer working relationships between general practitioners are an inevitable consequence of this change. Given that general practitioners are not employees but independent contractors to the NHS, it will be interesting to see who will be the accountable officer for a primary care group. Is there potential for an explosion in bureaucracy, with more managers—a chief executive officer, finance director, and, possibly, medical director? All this, of course, runs counter to the white paper's promise to redirect money from bureaucracy to patient care.

For hospital trusts, a major change is the development of clinical governance, which places a new emphasis on the quality of care. This emphasis is welcome, but enormous difficulties exist in measuring the quality of clinical care. Much more work needs to be carried out on outcome measures if we are to determine which health care intervention produces the best outcome. If we are to develop very high quality care we may also discover that there are no efficiency gains and that the cost to the taxpayer may actually increase.

Long term service agreements organised around care groups or disease areas will give hospital clinicians an opportunity to make an important contribution to the future direction of the health service. This approach, together with the development of clinical governance and health improvement programmes, suggests that the government values the contribution of the medical profession in designing the future service and in ensuring its quality. However, there is little in the white paper to give confidence that clinicians will be greatly involved in planning the future health service. Hospital consultants, directors of public health, and general practitioners will have to work together to ensure that the management of the health service takes the role of the clinical professional seriously by involving and encouraging them at all stages of the planning process.

If we are to improve the service that we provide to sick people—and indeed to go further and improve the health of the nation—then we need to develop systems that allow us to take a long term view of the health needs of the population. Only then can we truly plan the resources that are needed to deliver this level of health care. In the past workforce planning has been centralised, done separately for each profession, and of poor quality. We need to look at how to develop integrated workforce plans together with integrated care.

The increased involvement of health care professionals in planning the future NHS is to be welcomed. The professions and the government need to be aware of three major issues: long term health needs, resource implications, and clinical practice that is based on prescribed standards of clinical care.