The White Paper: what the College wants

Patricia Hewitt, the Secretary of State for Health for England, announced earlier this year that a White Paper on care outside of hospitals in England will be published at the end of 2005 or early in 2006.1 In my view this will be a landmark document that will affect all of our futures — public, patients and health professionals. I predict that its impact will be felt quickly in 2006 and it has the potential to transform the landscape of primary care.

The White Paper will be about community health and care services and it will be a combined health and social care paper. The consultation process by which this White Paper is being developed is ‘deliberative’ involving regional and national events with the public entitled ‘Your Health Your Care Your Say’.2 In addition a number of stakeholder policy task forces have been set up by the Department of Health.

In order to influence and shape the White Paper, the RCGP has created a ‘White Paper team’. The process has included: a ‘call for ideas’3 from members and faculties, a public consultation event to discuss aspirations for future GP services, identifying key papers and policies and discussions within the College community. A programme of practice visits has also been devised for MPs and senior officials who want to gain a better understanding of general practice. In this editorial I want to report some emerging findings and the key recommendations that we will be making to the Secretary of State for Health.

The findings of the Department of Health’s deliberative events show that patients value general practice but want more responsive and coordinated services. There was also a plea for better access and preventative care. In our own public event, the delegates stated that they liked general practice and wanted more of it. There was again a wish for more preventative care, more consistent quality, an expanded range of services and better access. The public did not want to see fragmentation of the services and stated that the special relationship between a patient and a GP must be retained in any future developments.

Ideas put forward by members and faculties included: the need to preserve practice-based registration; to avoid fragmentation of care through better integration and coordination; to maintain the practice as the basic unit of care; concerted primary care development with more local services and expanded but integrated primary healthcare teams; support for community facilities that house diagnostics and support services; a national premises building programme particularly to house teaching and training functions; measures to tackle health inequalities; the importance of being able to book appointments in advance; concerns about quality and safety of accessing care from multiple providers and closer ties between generalists and specialists.

It is clear from this and other evidence that patients, doctors and policy makers all want improvements in access, standards and services. The key question is how to achieve this. The College will urge the Secretary of State to promote policies that build on the strengths and values of general practice and to show confidence in primary healthcare teams’ ability to deliver a progressive patient-centred agenda. There is a substantial research base to support the preservation of primary care based on registration with GP practices (R Jones and A Kendrick, unpublished data, 2005). Registration has brought with it personal and organisational continuity of care, comprehensiveness (including medical generalism and the multiple functions of the primary healthcare team) and coordination of care particularly for patients with comorbidity. Primary care has a crucial role in narrowing health inequalities particularly in patients with comorbidity.4

The College will also urge the Department of Health to tackle fragmentation of care by better coordination and integration of care across the interfaces.5 Policies that break up services into ‘disease categories’ that different providers can compete for should be avoided. Patients expect their GPs to coordinate and orchestrate their care, to be their navigator through an increasingly complex NHS with its multiple providers, points of entry and choice. Navigation is more than simply providing information; it is a complex and skilled function that requires shared decision-making6 with patients, particularly those with comorbidity, in guiding them to obtain care that best meets their needs. There is a continuing need to raise the quality and safety of the patient experience through schemes such as practice accreditation (‘kite-marking’).

The White Paper will be an important leadership challenge. It is important that the profession is not seen as complacent. GPs should continue to be seen as dynamic, creative and concerned for peoples’ wellbeing and to be at the forefront of innovation and service development. Current Department policies on choice, contestability and diversity of provision concern many GPs. Enhanced services, chronic disease management, new specialised services, akin to ambulatory care in the US, are all in the ‘melting pot’ and there should be no automatic assumption that GPs will be the preferred providers. Under the new arrangements a range of providers such as foundation trusts and private companies could tender. One test for potential providers will be value for money. Pitched against these professional business organisations with their large staff, resources and expertise in planning, individual GP practices could struggle. It is essential that GPs engage with this in a robust way and rise to the challenge. If they do not, then it could lead to a declining GP profession at the mercy of diverse service providers. Instead, I would like to see the profession presenting its own ideas for improving primary care. After all GPs are among the most innovative groups in the NHS. Unity and collaboration between practices is essential. This will allow them to maximise opportunities in any new arrangements and respond to contestability. At a national level I am arguing that there must be a level playing
Developing an evidence base for intermediate care delivered by GPs with a special interest

Although the delivery of specialised skills from GPs is not new, the NHS Plan formalised the role of the GP with a special interest (GPwSI) as part of a radical programme to reconfigure the healthcare workforce. This development was part of a broader policy agenda to shift the balance of care towards the primary care sector, in order to deliver more patient-centred services and reduce waiting times and avoidable admissions to secondary care. However, against a background of increasing demands on limited resources and the need to maximise the benefits of additional health service investment, the focus has shifted to cost-effectiveness.

Building on these developments, national frameworks were developed to define skills, competencies and governance but primary care organisations were encouraged to develop innovations in service delivery based on local need. However, despite the policy rhetoric, the initiative has developed considerable momentum without any evidence base. The randomised controlled trial by Baker et al in this month’s Journal (page 912) showing no differences in clinical outcomes between orthopaedic hospital and practice-based clinics reflects an early and developing evidence base of the effectiveness of GPwSIs. With the shift in emphasis to decision making at a local level, a key question is how the evidence base can be developed to support policy decisions in a way that is relevant to local health economies.

The evaluation of public policy is set across a spectrum of approaches.

RATIONAL DECISION MAKING

The dominant analytical framework for health policy research reflected in Baker et al’s study is known as a rational approach. In its broadest sense, this demands an explicit statement of objectives and values, and an examination of the costs and consequences of competing alternatives in order to provide a rigorous and generalisable evidence base. These demands present a formidable challenge to health service researchers.

A rational approach needs the purpose of investment in GPwSIs to be clear from the outset: whether GPwSIs are intended to be additional to and working in cooperation with existing secondary care services (increasing health care outputs more...