Regime change

'If I'd listened to my customers I'd have just ended up designing a faster horse.' (Henry Ford)

It's easy to design faster horses — practices that work harder, deliver more, employ more nurses. But when faced with the disruptive innovations of the 21st century, horses that are merely faster will remain forever unfit for purpose. Recently the new regime of contestability and competition took a large step forward with the Department of Health's announcement of a single national procurement process to provide hundreds of new general practices across 30 under-doctored PCTs. GPs, like the lamp lighters of Henry Ford's time, are in danger of walking gently into history, a quaint footnote to the behemoths of bioscience and late capitalism.

So the issue that faces us is not what kind of general practice we want, not whether continuity of care is important, not whether nurses can do the same job as GPs. The issue, in short, is not what sort of horse we need. What we need to be thinking about — even at this late stage in the day — is the nature of 21st century medicine in the community. And whether we want to be a part of creating it. We can spend our time designing faster horses — or we can get on with building the future.

The medicine that is emerging will be:
- technically complex;
- rapidly changing;
- delivered by highly skilled multidisciplinary teams;
- neither primary care nor secondary care but a new synthesis of both;
- capital intensive; and
- information intensive.

It will be delivered to people who:
- know more and demand to be involved;
- want a personalised service;
- are happy to be co-producers of services;
- have relatively few family to be carers; and
- want all the personal and therapeutic advantages of current general practice.

Our communities will be:
- more demographically stretched;
- more environmentally stressed;
- more connected to the wider world, less connected locally; and
- information rich.

Measured against this agenda the limitations of our 10 000 under-capitalised general practices become very clear.

Happily, by chance or design, in England the policy, legal and technical context in which to develop new forms of 21st century medicine in the community, has never been more favourable. Practice-based commissioning is forcing practices to work together in larger units. Payment by results — at least in principle — provides the economic engine by which to shift significant funds into primary care and Connecting for Health is building the IT platform that will both glue new services together and allow us to unbundle services from old forms of delivery. With imagination and vision we can use all this to our advantage and create the entirely new forms of care that our patients will expect of us.

So what might be the characteristics of 21st medicine in the community? The core of what is coming is the ability to deliver much more technically advanced medicine in community settings. To exploit this requires a set of doctors who are able to synthesise aspects of primary and secondary care into new forms of medicine. This new regime, like all great dialectic resolutions, will involve blending the traditions of both into something quite new. The key technical tasks of the new regime will include:

- better gate keeping
- integration of advanced diagnostics into this process; and
- more advanced therapeutics and interventions.

Let's start with gate keeping. At present this is viewed through the prism of managing demand. But more generically the heart of good gate keeping — and of cost-effective medicine — is the ability to differentiate between the population of patients with a low prevalence of a particular disease (who should not be subjected to high octane diagnostics because the predictive value of a positive result is so low) from those with a high prevalence who will benefit.

Currently we do this by saying 'I don't know what's wrong with you, so I'll send you to that big black box over there called the hospital'. But in the 21st century we should be able to do better than this. Organisations looking after populations of tens of thousands of people and linked by a single electronic record could create accurate figures for the predictive value of common symptom complexes relatively easily by logging everyone who presents with say, rectal bleeding, whether they were referred, and the outcome. We would then have real data to share with people — 'the chances of a 43-year-old man like you with rectal bleeding having cancer are less than 1%. These are the options — what would do you want to do?' Such data would hone our ability to differentiate low prevalence populations into something approaching a respectable science while allowing us to carry on conversations with individual patients that legitimate subsequent management decisions. Along the way we would have created a partial answer to the ecological fallacy. And a very significant commercial asset.

Science-based gate keeping also creates the platform for integrating advanced diagnostics into the new medicine. Not only would we in principle be able to find out which tests were most discriminating for our community population of men with rectal bleeding, our new colleagues who have migrated from secondary care, could use the community-based predictive values that we had generated to recalibrate their own hunch-based use of tests to the lower prevalence of disease that they will encounter in community settings.

At the same time it will become clear that an increasing number of advanced therapeutic procedures are best delivered

in community settings. Consultant colleagues will be employed by PBC consortia (or UnitedHealthcare next door) to deliver this improved, cheaper care. New forms of collegial relationship will emerge and over time all distinction between primary and secondary care could be lost.

Services will be delivered via organisations that look after >50 000 people. These will no doubt contain semi-autonomous units that are accessible to their populations and that represent the symbiotic endpoint of current general practices. Such symbionts may well retain their status as profit centres together with a large measure of independence. But they will willingly cede sovereignty to the larger organisations over many aspects of clinical care and management in order to access things that will protect them from the pressures of inadequate size and isolation.

Prime among these will be access to capital. Currently we are entwined in a love–hate relationship with PCTs whom, one way or another, we expect to provide for us. One side effect of this dysfunctional dependence is that we have become like anorexics in relation to capital — we look in the financial mirror and think we are reasonably well off when in reality we are, in terms of investment, grossly malnourished. Happily, new ways to raise capital and share financial risks using limited liability partnerships (LLPs) are emerging just in time.

Larger consortia will force us to develop new forms of governance. Newer legal vehicles, such as LLPs, are likely to offer competitive advantages — not least by offering ways to make the whole organisation transparent, flexible and fair to all staff groups. The more enlightened consortia will find that the highly skilled, multidisciplinary teams on which they depend can only be guaranteed by transparent and fair rules for sharing surpluses and deciding strategic direction. Large pay differentials will continue to exist in such organisations but nursing colleagues will no longer feel that they are an exploited and colonised tribe.

Thinking about the shape of 21st century medicine in the community is both inspiring and frightening. It moves us on from tired old debates and frees us to really think about how we might combine the latest medical advances with new ways of practicing medicine that provide world-class care for our patients. Along the way those old nags of 'GP' and 'consultant' will be put out to grass. In their place we will have a body of doctors who are great community diagnosticians, enthusiastic and skilled in delivery of advanced therapeutics and dedicated navigators of the complex archipelago of services and meanings that will face our patients. The Iron Curtain between primary and secondary care will have disappeared — and we will have reinvented ourselves. The new horse-less carriages will be multiprofessional organisations that can grasp the opportunities of high bioscience and late capitalism while preserving the best of 20th century general practice for our patients. Of course we may fail — but the real danger is that we are too addicted to our well-paid comfort zone to allow ourselves to be inspired.

Paul Hodgkin

Disclaimer

The views expressed here are entirely personal.

Neville Goodman

MONEY MATTERS

I have in front of me two newspaper articles. The headlines tell it all. Nick Cohen asked us to, 'Just imagine what the NHS could do with the £20bn wasted on sick IT.' (*Observer* 4 June, 2006). The *Guardian*'s health correspondents (13 June, 2006) wrote, 'Doctors fight to save drug guidance from government axe.' Cohen's story is not just of the runaway costs of the government's determination to bring in a comprehensively computerised NHS, but of the large amounts of money paid to management consultants. These are the people to whom our elected representatives turn for advice, to avoid asking anyone who knows about the subject. They charge enormous fees, add on enormous expenses, and suggest systems that don't work. I have only Cohen's word for it, but '26-year-olds can charge an NHS trust £3000 a day for their services'.

Unlike *Drug and Therapeutics Bulletin*, the *Guardian*'s subject, the IT programme does not strike as good value for money. Anyone familiar with even small computer programs knows that it's best to go for simplicity. When you have as many different institutions needing to use the systems as the NHS has, the best bet would be a core with easily followed specifications, so that locally sourced programs could interlink with it.

Set against the IT costs, £1.4m providing a paper copy and online access to the *DTB* for all doctors is negligible. It is impossible not to think that the *DTB*'s stance on, for example, drugs for multiple sclerosis and dementias, upset someone, a someone with a lever on the Department of Health. The *DTB* did not need to pull any punches, so the DoH has decided to stop it punching. NICE does not render all other medical advice redundant. NICE has too many problems with political direction (even if not interference), lobby groups, and Big Pharma. There have been times when NICE has been 'privately furious' with ministers but, as Professor Joe Collier — who was editor of the *DTB* for a long time — pointed out, that is dishonest. And to weigh against *DTB*'s £1.4m, Big Pharma spend £33bn persuading us which drugs to use. Although it wouldn't have to be so much, a drug company spokesman explained, if they were able to advertise directly to patients. The word for this is 'chutzpah', witness another *Guardian* headline (26 June, 2006): 'Kickbacks, cartels and chatrooms: how unscrupulous drug firms woo the public'.

But Patrician Hewitt has more important things on her mind: she has to explain how selling off the commissioning work of the PCTs to BUPA and friends is not privatisation.