

What is the future of Dermatology; hospital versus office based, NHS versus private?

Introduction

In recent years, dermatology services in the UK have evolved in line with new NHS care models, to tackle the challenges of a rising demand and limited resources. These care models are likely to result in an increase in office-based dermatological practice and thus, an increase in private provision of dermatology services within the NHS. The first part of this essay discusses why a shift to office-based practice is likely in the UK and explores how this may impact secondary care. The second part of this essay highlights the implications that an increase in private provision within the NHS may have on dermatology as a speciality and discusses why private sector practice outside of the NHS may increase.

Hospital versus Office-based

Most dermatological practice is now outpatient-based and suitable for an office-based setting. This is evident in America where the number of dermatologists in office-based practice approximately doubled from 1974 to 2000, despite the most prevalent diagnoses staying the same over this period (Stern, 2004). Perhaps, office-based practice is appropriate for dermatology because diagnosis has a strong reliance on clinical skills and does not usually require complex equipment, unlike other specialities where there is a heavy dependence on imaging. There is also little need for most dermatological surgical procedures to be performed in a hospital, demonstrated by Kantor (2018) who found 90% of surgical procedures were performed in an office in America. Therefore, it makes sense for

the UK to follow the trend of shifting dermatology practice from a hospital setting to an office-based setting, in order to be more accessible and cost-effective.

However, dermatologists have a key role in secondary care and this is not likely to change. It is important that dedicated dermatology beds are available for emergencies such as skin failure; the British Association of Dermatologists (BAD) recommend a minimum of 2 dedicated dermatology beds per 100,000 population (Eedy et al., 2008). The need for this is supported by a study which concluded that inpatient treatment for dermatology conditions improves quality of life and is clinically effective (Helbing et al., 2002). However, Helbing et al. (2002) also found that admissions could have been avoided in over 25% of patients in this study. This is because treatments for dermatological diseases that would have historically required hospital admission, such as phototherapy, are now possible using day treatment facilities. Although there now exists fewer circumstances where inpatient admission for dermatological patients is required, dermatologists have a much broader responsibility in hospitals. They work closely with multiple other specialities in combined clinics and on-call services, as well as play an active role in teaching. Furthermore, specialised dermatology clinics for rare skin diseases in tertiary centres require a multi-disciplinary team and are therefore, only possible in a hospital setting. This suggests that even if a large amount of dermatological practice can be moved to an office-based setting, there will always be a requirement for dermatologists in a hospital setting.

The shift of specialist dermatology care from the hospital setting to a community setting in accordance with the Care Closer to Home policy of 2007, has resulted in more office-based dermatology practice in intermediate specialist services (RCP, 2012). These

services are delivered by GPs with special interest (GPwSIs), specialist doctors and specialist nurses and are usually located in community hospitals and GP surgeries, rather than the acute hospital setting. Theoretically, this strategy would reduce the workload of dermatologists in secondary care and would provide cheaper, more accessible care for patients without compromising on quality of care. In practice, the success of this policy is debatable as although it is more accessible with similar clinical outcomes to hospital care (Salisbury et al., 2005), it resulted in a 67% increase in referrals to secondary care (Levell et al., 2012) and may be more expensive than hospital outpatient care (Coast et al., 2005). Quality frameworks have since given recommendations to resolve these issues, but there still exists little evidence to prove that dermatological practice in the community is more effective than in hospitals (Edwards and Imison, 2015). Despite concerns being raised about their effectiveness, the future is likely to see more intermediate specialist services.

Private provision within the NHS

The reconstruction of the NHS in recent years has obscured the distinction between public and private sectors because NHS services can now be commissioned to a range of private providers, as long as they meet national standards. Several commissioners hold the view that dermatology services can be successfully shifted to the community using private providers. Therefore, the near future is likely to see dermatology being disproportionately affected by the third of contracts that go to the private sector (The King's Fund, 2019).

This has huge implications for the future of dermatology as private provision is highly controversial. An example of this controversy is shown by the commissioning of

dermatology services in Nottingham. An inadequate risk assessment was completed by commissioners when deciding that an Independent Sector Treatment Centre (ISTC) should deliver dermatology outpatient services which had previously been provided by Nottingham University Hospitals NHS Trust. Although it was expected that NHS dermatologists would continue with their roles, only 3 of 11 consultants opted to transfer to the private provider, due to concerns about training and research opportunities (Clough, 2015). There was also the concern of 'cherry-picking' as the private provider may have been more likely to take on large volume, easy work rewarded by the Payment by Results scheme (NHS, 2013). This would leave the hospital with more difficult, expensive work and would divert much needed investment from secondary care. The result of this commissioning decision was the collapse of the dermatology service in Nottingham; specialist inpatient care for dermatological emergencies has been transferred to Leicester and teaching and research opportunities have been lost. To avoid this happening again in the future, commissioners should be more alert of the consequences that their decisions can have.

Private provision outside of the NHS

Private dermatological practice is also becoming increasingly common outside of the NHS. Dermatology was amongst 16 of the specialities that accounted for 86% of total admissions and 75% of total revenue at 215 UK private hospitals in 2011 (CMA, 2014). The laxity of regulations, coupled with the fact that people suffering with skin conditions have a high level of willingness to pay for treatments (Seidler et al., 2012) is likely to increase private sector use further. Patients are now able to get private treatment from a consultant or specialist without being referred by their GP, although this is not recommended by the

BMA (NHS, 2019). Additionally, dermatologists are now free to advertise their services on the internet and other public spaces, as long as both the standards of the General Medical Council and the Advertising Standards Authority are met. Although this is allowed, BAD advises its members not to advertise directly to the public as it encourages patients to bypass the step of being referred to a specialist by a GP (BAD, 2015).

Rising expectations of skin, hair and nail appearance in society is likely to increase the demand for private dermatologists. A Scottish study by Benton et al. (2008) showed that patients seen privately were more likely to have acne, rosacea and viral warts and less likely to have psoriasis and eczema. This could mean that patients are more likely to seek private dermatological care for skin conditions that lead to cosmetic concerns. Concerns about the cosmetic appearance of benign naevi, skin tags, subclinical acne and hirtuism are likely to require treatment that is not available on the NHS, so private care is the only option for these conditions (NHS, 2015). Furthermore, cosmetic procedures such as chemical peels, botulinum toxin injections and the use of filler substances are more popular than ever to combat ageing, improve skin quality and enhance facial structure (Bennett and Henderson, 2003). However, a barrier to accessing these is the high expense of private medical care in the UK compared to other countries (The King's Fund, 2014).

Conclusion

It is certain that the NHS albeit increasingly privatised, will remain the main provider of healthcare in the UK. Though not a serious contender, private sector practice may increase in line with societal expectations of appearance, so strict regulations may need to

be implemented to ensure safe practice. Additionally, more office-based dermatological practice commissioned to the private sector is likely to be seen in the future, but this does not have to be to the detriment of hospitals. Secondary and tertiary services in dermatology have been developed over many years to provide sustainable care, training and research so dermatology services in the community should supplement this. Services should work together as part of an integrated dermatologist led multi-disciplinary team, to ensure that the best quality of care is given, wherever it is given and whoever it is given by, in the most cost-effective manner. To achieve this, commissioning decisions should be made in conjunction with secondary care clinicians and on a wider scale, government policy should reflect the concerns of dermatologists.

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