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What is the future of dermatology; hospital versus office-based; NHS versus private?

Annually, 54% of the UK population face skin problems, making it the most common presentation to general practice (GP).[1] Whilst there are thousands of skin diseases, eight of them constitute 80% of GP consultations, most of which can be managed with self-management or in primary care.[2] However, dermatology referrals to secondary services have risen, particularly for diagnosis.[3] This reflects increasing demands on the National Health Service (NHS) and shortcomings of the structure. This essay will explore the current structure of the dermatology service and how this may evolve in the future.

Hospital versus office-based

Predominately an outpatient service, hospital dermatology deals with over 716,830 referrals each year in England.[4] Consultant dermatologist-led teams manage majority of skin diseases and train medical students, doctors and contribute to the training of nurses and pharmacists. Hospital-based services allow interaction between multi-disciplinary teams prompting a more rounded approach to care. This integrated nature of hospital-based dermatology supports the optimum management of patients with acute and complex presentations.

Since most conditions can be treated within primary care or self-managed, patient care should be retained within the community when possible. However, the current model of gatekeeping and referral has proven a challenge, primarily because of the inadequate dermatology training for GPs. With an average of six days of dermatology training in total, it is not surprising that the Membership of the Royal College of GPs exam highlights

dermatology as an area that needs addressing.[1,5] Ineffective management at primary care level and increasing referrals to hospital have strained services.

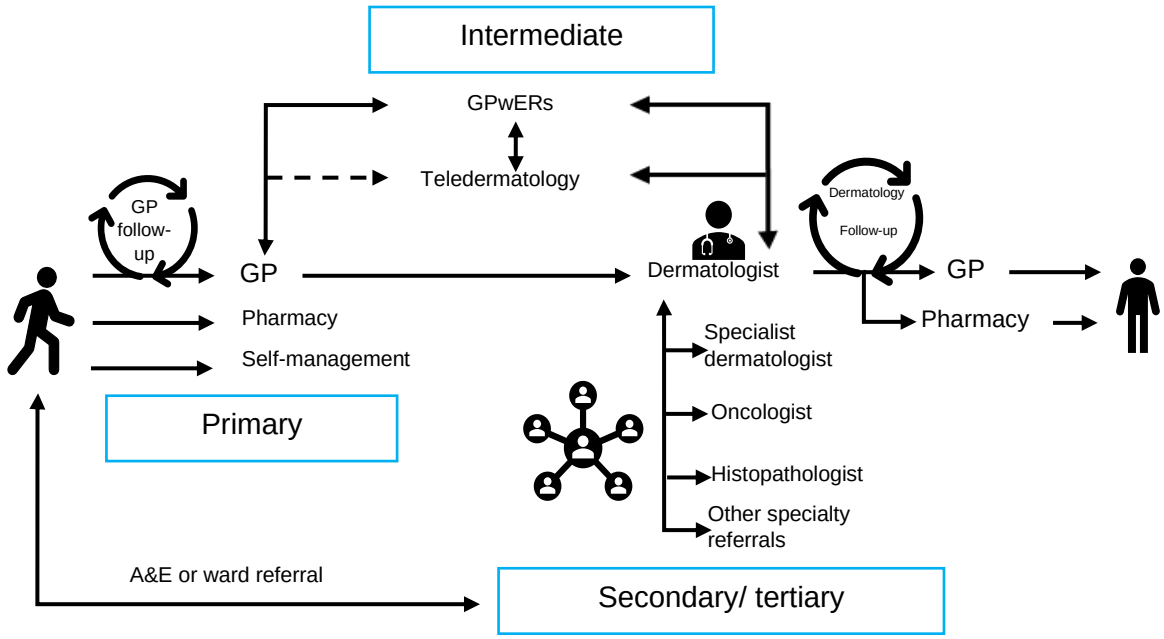

Figure 1 - Diagram representing the patient journey through the current structure of care in dermatology

GPs with extended roles (GPwERs) have supplemented their role as generalists with dermatology training to address the 'medical care gap' between primary and secondary care.[6] However, evidence illustrates that GPwERs have increased referrals, costs and may de-skill other GPs in dermatology.[4]

The growing prevalence of skin conditions, advanced treatments, ageing population and changing attitudes are a few of the growing demands on dermatology. Yet nationally, the service is lacking 250 consultants leading to uneven distribution of dermatologists.[7] The disparity in services has resulted in increased waiting times and in some areas a collapse of

services. Furthermore, prolonged waiting times can have adverse outcomes to the patient's condition and psychosocial wellbeing.

The multitude of stressors combined with the shortfalls of hospital-based dermatology has prompted the consideration of an office-based dermatology model.

Office dermatology

Office dermatology is the practice of dermatology in independent centres run primarily with consultant dermatologists, growing in popularity in the United States of America and across Europe.[8,9]

An office-based system would allow for patients to seek the care of dermatologists and thus bypass the need to see a GP. Patients would thereby have greater autonomy in their health. However, in comparison to hospital dermatologists, office-based care lacks a multi-specialist approach; further fragmenting the service and de-skilling GPs.

Future

The presence of serious dermatological conditions means that dermatology should ideally remain in the hospital setting. However, measures must be taken to sustain hospital services.

At a community level, patients should be empowered in managing their own chronic skin conditions through education and support groups. The Care Closer to Home agenda attempted to address this.[10] While the agenda had limited success in 2007, future schemes could build on this work. Improving training for both GPs and pharmacists is essential.

Introduction of the UK Medical Licensing Assessment in 2024 should standardise undergraduate dermatology teaching across the UK for physicians.[11]

The emergence of Teledermatology services could provide a tool for triage, advice and guidance, thus minimising avoidable appointments, waiting times and addressing the disparity of dermatology services in rural areas.[4] GPs could also be empowered in their decision making through liaison with dermatologist-led teams via Teledermatology.[12] However, care must be taken to ensure it is not used as an alternative to face-to-face consultations.

Within the hospital, the limited workforce can be best used by centralising services. Data from the Getting It Right First Time (GIRFT) project, designed to tackle unwarranted variations in service delivery can be used to implement future changes.[13]

Incorporating office dermatology as an intermediary service allows bridging between primary and secondary care and a diminished need for GPwERs. Additionally, a consultant-led One Stop clinic where patients are assessed, diagnosed and treated on the same day may be ideal for simple cases, evidenced by the success of the spot clinic in Lincolnshire.[14]

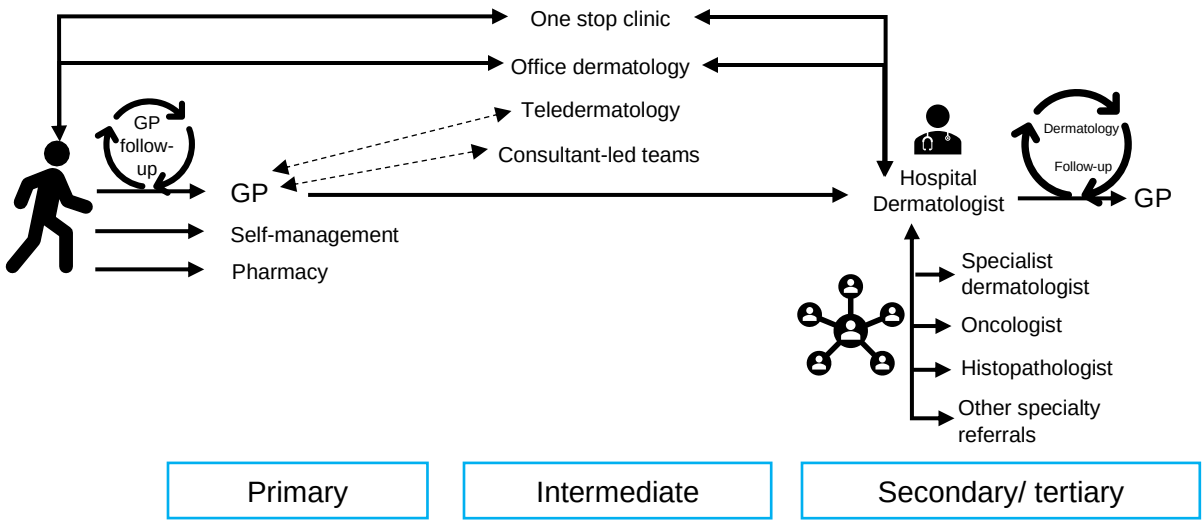

Figure 2 - Patient journey through dermatology services in the future

NHS versus private

The publicly funded NHS recently celebrated its 70th anniversary marking its proud heritage within the UK. However, growing challenges to the system have placed its future in dispute. Introduction of the 2012 Health and Social Care Act (HSCA) adopted a more markets-based approach to commissioning which increased competitive tendering of NHS contracts, thus increasing private providers of NHS services.[15] With a rise in tendering of dermatology services, the line between NHS and private delivery of dermatology services has become ever more distorted. Outsourcing of NHS services to private sectors indicates functional challenges within the NHS.

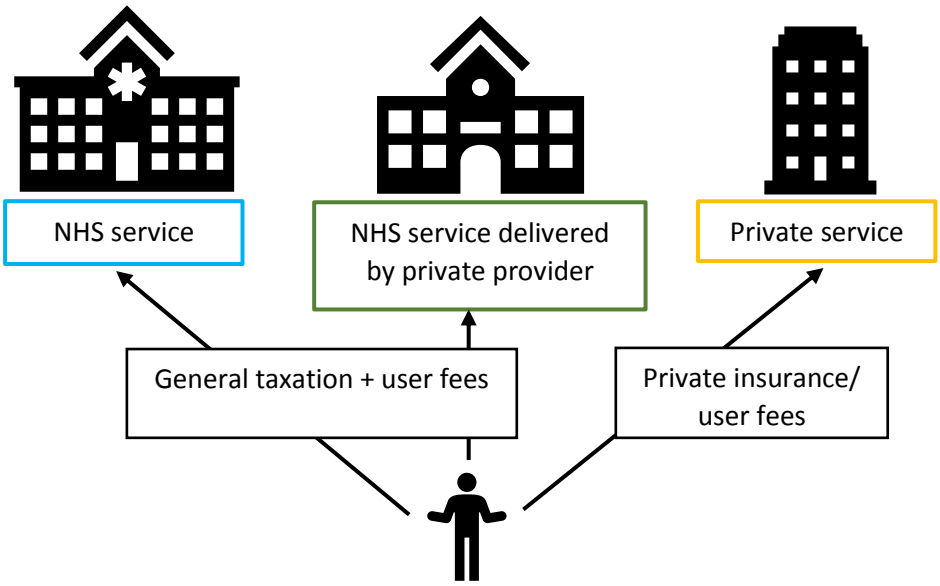

Figure 3 - Diagram of dermatology care providers

Working in the independent sector affords dermatologists the option to augment NHS income with private work. Opting for private care reduces waiting times for patients and offers procedures that would otherwise be unavailable on the NHS. Furthermore, competitive tendering for dermatologist services may ensure maximal efficiency and facilitates greater patient choice.[16]

Nonetheless, privatisation of the NHS brings a host of concerns. Last year, £9.2 billion was spent on non-NHS services thus drawing away funding that was needed within the NHS.[17] Non-NHS private services have no central governing body which raises concerns on the ability to run clinical governance. Doctors working within these services have greater medical indemnity costs and lack an NHS pension. Meanwhile, costs to patients are sometimes more than monetary; the RAND health insurance experiment demonstrated that people paying for private health insurance and user fees are less likely to seek healthcare which can ultimately lead to late presentations for skin conditions.[18] The near collapse of

dermatology services in Nottingham provides insight into the catastrophic impacts of careless commissioning of private services.[19]

For years, Nottingham University Hospital Trust (NUH) had been a ‘centre of excellence’ for dermatology. In 2007, the independent sector treatment centre (ISTC) programme initiated construction of the Nottingham Treatment Centre to reduce waiting times and increase capacity for elective procedures. Despite several warnings from staff, the contract was awarded to a private provider, Circle, with the assumption that staff working under the NUH dermatology outpatient department would TUPE (transfer of undertakings under present employment) to Circle employment. However, out of eleven consultants, only one remained under Circle, leading to a shortfall in the consultant workforce. While a few were ineligible to TUPE, majority of consultants refused to transfer, choosing instead to seek NHS employment elsewhere. To meet the demands, Circle hired European dermatologists, costing approximately £300,000 per annum, considerably more expensive than an NHS consultant salary. Training of students and trainees also suffered. According to David Eedy, president of the British Association of Dermatologists at the time, this collapse was a ‘foreseeable and avoidable’ incident.[20]

While Circle was not in itself a problem; evidenced by the positive feedback from both patients and doctors within the service, the inappropriate introduction of a non-NHS service with poor risk management was devastating to a previously excellent dermatology service.

Future

The introduction of the Long-Term Plan shows good promise for a sustainable NHS service. Continuing care within the NHS in the future would allow a more cohesive system essential

for the management of acute and complex dermatology cases. By allowing private services to adopt small-scale services and fill gaps in care, independent providers can complement NHS services forming a more cohesive service. For instance, Touch Psoriasis aim to fill a gap in primary care through patient education.[21] The disastrous impacts of commissioning demonstrated by the Nottingham case highlight the need for adequate education of commissioners.

Conclusion

With roughly 4000 patients a year dying from skin disease, it is essential that any change to healthcare is made in the best interest of patient safety.[22] The current system must evolve in order to continue providing high standards of care whilst maintaining cost effectiveness. While any one system may struggle to face the growing demands of dermatology, a system that incorporates and maximises the benefit of each model; whether it be hospital, office, NHS or private would be ideal for the formation of a cohesive healthcare structure capable of meeting the dermatology needs of a diverse society.

Word count: 1496

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