Diabetes care and the White Paper— Will it work for patients?

Diabetes mellitus is a major and growing cause of chronic ill-health and early death in Britain and in all industrial societies. More than ever, the need to develop services and to improve methods to protect the health of the diabetic patient concerns those responsible for health care provision. Elsewhere in this issue we review some of the strategies that have evolved in this country to improve the management of people with diabetes; we give particular attention to newer methods of organising care provision aimed at reducing the huge personal, social and economic toll of the long-term complications of the disease.

Notions of what constitutes adequate diabetes care have broadened substantially over the past decade. Anticipatory management, early detection of complications and intervention against them, and much more active patient participation have become highly desirable, virtually crucial, components; careful control of blood glucose concentrations remains necessary but is clearly not sufficient. Wider concerns with diet, self-monitoring, regular systematic screening, patient education and collaboration with community agencies, as well as the increasing complexity of techniques and emerging opportunities for protective and therapeutic interventions, have become central and demanding issues in diabetes care. Together they have dramatically highlighted the inadequacies of the traditional, once a week, diabetic clinic with admission to a general bed as a fallback to deal with problems. Good diabetes care has become a demanding, relatively labour intensive, fairly specialised team activity, crossing the divide between hospital and community agencies of health care, at its best when each of these agencies takes a planned share in a treatment programme individually constructed to meet the special needs of each patient. Cooperation, organisation and evaluation pay dividends in any health care system, not least in fashioning modern, responsive and proactive care for individuals with diabetes.

The importance of district diabetes centres as the focus for this emerging pattern of activity is indicated by their establishment in increasing numbers at a time of general retrenchment and resource restriction. Some funding has come from health authorities but much has been raised by local appeals; the British Diabetic Association made substantial contributions to establish the first pilot centres. Patients, nurses and doctors who use them are enthusiastic supporters. Motivation has been greatly improved both for patients and for staff.

The impact of the White Paper 'Working for patients' and its supporting documents on the care of the diabetic is difficult to assess. Indeed, it makes no provision for the care structures that have evolved, and it offers nothing in their place. Those concerned with the care of patients with many other chronic disorders share the uncertainties and apprehensions that the White Paper has engendered in diabetes care. It will have to be the obligation of the district health authority (or the commissioning authority, as it may become) to ensure the provision of care for its local diabetic population. How it will meet that obligation poses a major question. With the many demands that will be made upon its limited resources, the authority will wish to meet this obligation as 'economically' as possible and will doubtless consider competing bids from a number of providers. Those who set the lowest cost for providing diabetes care are likely to get the contract. Employment of specialist trained nursing and paramedical staff, the provision and maintenance of special facilities such as diabetes centres, the use of relatively more expensive equipment like injection pens, pumps and monitors, research and development, audit and regular detailed screenings will all add to costs, with little obvious short-term benefit. The hospital competing for the contract is likely to opt for the minimal acceptable standards, and thus the least costly service, or even to decline diabetes care altogether to optimise its competitive position. Downward pressures on costs will prevail. It will not be easy to argue 'value for money' for the leg not amputated, the eye not blind, the stroke not suffered, in the face of the need for the independent hospital to show an attractive annual balance sheet. The long-term advantage of something not happening will be difficult to sustain against the need for short-term profitability. Some authorities may even be persuaded that relatively expensive special hospital provision for diabetes is not really necessary and that, at much lower cost, the general practitioner can be the major provider of care for diabetes, allowing for the use of the hospital by appropriate contractual arrangement only when a 'hospital type' problem such as ketoacidosis, the appearance of gangrene, a visual event or some other catastrophe occurs. The horrible truth may be that it is more cost-effective for a hospital to earn a substantial contractual surgical sum for amputating a leg than to make the costly investment in its preservation.

The authority clearly will not be qualified to pass informed judgement on the quality of diabetes care, and it is doubtful whether, in many cases, it will be able to call upon sufficient instructed local expertise to advise it adequately. The role of the British Diabetic Association is likely to assume a new importance here.

It may well fall to the BDA (and like organisations for other conditions) to stand like a watchdog in the market, raising vigorous objection to erosions of existing standards of care, and setting national standards of quality which commissioning authorities will be expected to meet. The BDA has the advantage of a countrywide network of local branches, made up of 'consumers' who will be encouraged to react promptly to shortcomings in local services and to suggest ways in which they can be met.

The existence of the BDA and the personal involvement of its lay and professional members can provide some safeguard against the fragmentation of diabetes services and the erosion of quality which could well result from the imposition of the White Paper directives as they stand at present. The BDA and its members may help to hold the collaborative links between hospital and general practitioner services which could find themselves in a competitive confrontation. By making a combined stand they may preserve the extremely valuable but economically vulnerable special services and trained personnel for which we have fought. More positively, the further development of resource management and audit (both process and outcome) is greatly to be welcomed—so long as adequate provision is made for them and they are not installed at the expense of patient care.

It has been suggested that the structure of diabetes care could best be preserved by making it a 'core service'; however, the Minister's definition of core services as those for which there is local need but no local alternative provider could well not be applicable, and he has steadfastly refused to list any particular patient or diagnostic group, preferring to leave this to local *ad hoc* decision. This is of particular concern if hospitals that opt out of management by the authority do not provide diabetes services on the grounds of non-profitability. If diabetes does not qualify as a core service, it might be sensible to establish a category of 'protected' services, defined as those that the authority is compelled to establish, arbitrarily if necessary, at a hospital considered to be appropriate, whether or not the hospital accepts. How this would affect the freedom of the patient and the doctor to choose whichever hospital they wish remains uncertain. Another way to meet the threat to diabetes services could be to establish a 'diabetes budget' for each authority's district, to be managed by the district diabetologist who would buy services from whatever agency he or she thought most suitable, creating further recruitment to the army of accountants upon whom efficient running of transactional medicine will depend.

We make no apology for expressing our deep concern that much of what has been patiently—sometimes painfully—built up over the years will be put at risk by the imposition of the White Paper directives. Nor do we apologise for feeling a sense of affront that those of us concerned with the care of patients—and the patients themselves—were not consulted during the concoction of a vague plan that seems more concerned with the application of economic theory than the health and welfare of multitudes of citizens. We are little reassured by expressions of good intent uttered by politicians; we suspect that, in a health service driven by market forces, the care of the person with a complex and demanding disorder like diabetes is particularly at risk.

We would prefer to see new and untried methods for the administration of health care subjected to the same careful research and controlled trial that doctors themselves apply before introducing new methods of health care, the more so when we see the distortions and damage to health care services in other societies where profitability, whether private or corporate, is a major incentive.

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