



# **‘SINS OF COMMISSION?’**

**Response from the UKPHA to the  
‘Commissioning a Patient Led NHS’ Document**



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UKPHA Response to *Commissioning a Patient Led NHS*, July 2005

## Context

The United Kingdom Public Health Association (UKPHA) represents a wide range of individuals and organisations involved in promoting the public's health.

In its role as ‘the voice of the public health movement’, the UKPHA looks to promote the development of healthy public policy at all levels of government and across all sectors.

The Government's latest set of proposals for NHS reform - the 15th since 1974 - are centred on creating a patient-led NHS, giving emphasis to choice, encouraging competition, and transforming Primary Care Trusts (PCTs) into much larger commissioning bodies.

The changes come on top of other recently announced policy developments such as payment by results, practice-based commissioning, and patient choice. Together they amount to the most significant and, in the UKPHA's view, potentially disruptive reorganisation the NHS has ever undergone. At present, the precise details of many of the proposals appear uncertain and in a state of flux, which can only add to the disruption. Such a climate is hardly conducive to getting on with the job of improving the public's health and tackling the considerable health inequalities which persist.

A major concern is that of the incoherence of some of these policy changes which appear to push and pull in different directions, often creating disincentives to promoting public health. In particular, a commitment to tackling public health requires collaborative working. Yet, the Government, in its desire to stimulate efficiency, wants to see competition in the delivery of services - it is the UKPHA's view

that it is not possible to have both competition and collaboration.

Moreover, it is hard to conceive of a system under threat of increasing fragmentation, and whose parts are competing with each other, being capable of functioning as an integrated ‘whole system’ of the type required to tackle the challenges posed by poor public health.

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However, while the NHS and healthcare provision is clearly an important part of delivering good public health, it is by no means the only or even the most critical. Public health straddles all sectors and, for its success, is dependent on a common commitment from all agencies, organisations and individuals to work towards a health promoting environment for all.

As such, the organisation of the NHS itself is not the UKPHA's principal concern. Rather, our chief concern is for the impact of the proposals set out in

Commissioning a Patient-Led NHS and associated developments, on the public's health. Perhaps most striking of all is that the proposals contain little specific reference to public health despite their having far-reaching consequences in this sphere. This is a matter of some concern following the public health white paper and delivery plan - both of which placed public health high on the policy agenda. The UKPHA is pleased however that public health staff below director level and engaged on implementing the Choosing Health agenda are not to be included in management cost reductions. This gives a positive signal that public health concerns have not been entirely overlooked.

In this response to the changes set out in Commissioning a Patient-Led NHS and associated developments, we consider why the structural changes to PCTs in particular could impact negatively on the public health agenda. We then go on to look at how the proposals specifically endanger the ongoing work being done to combat health inequalities. Finally, we propose a way forward for the public health movement to safeguard important policy objectives, and to ensure they are implemented and do not suffer the fate of earlier policy promises as documented by Derek Wanless in his second report for Government.

### Changes to Primary Care Trusts

*Shifting the Balance of Power within the NHS* (DoH 2001) referred to the need to engage effectively with communities and some progress has been made. The latest proposals could push this progress further by turning PCTs into ‘patient-led and community led organisations’. For example, by the community becoming actively involved in formulating a strategy for their area, a range and quality of services that the community need, value and use could be developed. This, in turn, would strengthen social capital, further enhancing and promoting both individual and community health. However, while there are potential advantages to the new PCTs, there are also some potential drawbacks that need to be addressed to ensure that the NHS public health function is not compromised or, as has happened in the past, marginalised by the demands from the acute hospital sector.

### Loss of momentum

Since their creation only a few years ago, many PCTs have contributed significantly to the public health agenda. But, to a considerable degree, progress has been hampered by the dysfunctional aspects of the target culture and its emphasis on downstream acute care issues such as waiting lists, access to hospital beds, and balancing the books. However, PCTs, by forging good working relationships with local individuals, organisations and agencies, have begun to make a real impact. But building these relationships and establishing good

practices has taken time, and only recently have PCTs begun to emerge as truly effective partners in promoting public health within the community.

Although arguably, some PCTs were too small to collaborate sensibly with local government, many were evolving into larger entities through a process of incremental and locally determined change. The UKPHA has real concerns that the latest ‘big bang’ restructuring process will give rise once again to a lengthy period of instability and planning blight, diverting attention and energy away from public health issues. The result could be a significant loss of momentum in regard to current and future good work.

There is no easy or right answer to organisational design and although in time county-level partnerships between the health service and other agencies may become stronger, it is feared that locality partnerships may be lost as PCTs cease to operate close to local communities as service providers. These partnerships, with for example District and Borough Councils, have been vital to the success of local community based health promotion and gains at county level must not be achieved at the expense of effective joint working at a sub-county level.

### Co-terminosity - across the board

While the creation of the new PCTs coterminous with local authority boundaries offers the potential for a far more streamlined approach to public health, the proposals leave some areas without a clear PCT to match the local authority. The UKPHA is concerned that unless this change is made consistently throughout the UK, there will continue to be problems caused by differences in agencies’ boundaries. Moreover, it should be acknowledged that co-terminosity is by itself no guarantee of effective partnership working. Attention also needs to be given to the skills required to collaborate and to the high-trust relationships that need to be encouraged.

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## **Directors of Public Health (DsPHs)**

As the PCTs merge to form larger organisations there will be a surplus of DsPHs. While we acknowledge that currently there are vacant DPH posts, senior public health input into the NHS must be safeguarded. There is a risk that non-medical DPHs - whose appointments were an important gain following the creation of PCTs - could lose their director-level posts while clinically qualified DsPHs retain theirs. It is vital that both medical, academic and cross-sectoral public health expertise at director level is retained. One opportunity arising from the increase in co-location could be an increase in jointly held DPH posts between the NHS and local government - something that is already working very well in some areas. In addition, it is vital that the DPH and Medical Director roles are clearly defined so that the DPH has clear accountability for population health.

## **Health visitors, nurses and midwives**

Under these proposals around 250,000 health visitors, school nurses, community nurses and midwives could no longer be employed by PCTs. Instead they may have to become self employed, or work for organisations (both for profit and not for profit) that then 'sell back' their skills to the NHS. At present it is not clear whether this change will happen although PCTs will have the option of divesting themselves of the provider function if they so choose and if the local community supports their plans. However, if it were to happen we would be concerned that by outsourcing this huge number of unsung contributors to community health and well being, the public health workforce will become further fragmented and disillusioned leading to a negative impact on public health.

## **PCTs as commissioning bodies**

To date, where PCTs have been effective in public health they have taken a holistic approach to health promotion, co-ordinating community involvement and developing partnerships to support behaviour change. This has been done through integrating commissioning and providing services.

PCTs that chose to become purely commissioning bodies, and no longer deliver services, are likely to lose this overview of specialised health promotion services. The loss of this unique overview could also have a negative impact on monitoring and combating anti-health forces.

## **Sustainable?**

There is no evidence that the inter-relationship between social economic and environmental issues have been taken into consideration in the planning of the re-organisation which focuses primarily on downstream health care issues. Sustainable development is a vital part of promoting good public health and as such, must not be ignored.

## **Eliminating Health Inequalities**

The eradication of health inequalities can only be achieved through the organised efforts of society as a whole.

Much work has recently been done across all spheres of public health to close the gap between those who are either economically or educationally deprived and those who are fully informed and/or wealthy. Any distraction from, or fragmentation of, established methods and/or relationships that these proposals may have would inevitably cause a loss of momentum to this work.

However, of greater concern is that these proposals could actually widen the gap.

By placing the emphasis on choice rather than quality, through the patient choice agenda and related policy changes, those who have traditionally been on the wrong side of the inequalities gap seem destined to remain so, being left with a Hobson's choice of provider depending on their individual circumstances. At the same time, those who are wealthy, well educated or able to research the full range of providers will be in a far better position to choose a provider that most closely meets their needs or preferences.

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Overall, the policy changes are being driven by a desire to develop a market in health services in the belief that this will drive up quality and improve effectiveness. Yet evidence from the USA suggests that market mechanisms increase rather than decrease inequalities in health and ultimately drive up costs resulting in cost inflation.

Private providers commissioned by the NHS in this new 'health market' may well be driven by financial gain and, instead of public health being given priority when providing services, other factors like profit or turn-around and increasing shareholder value will become all important. It is essential that Local Authorities and the voluntary sector should be encouraged to come forward as providers and that preventative strategies should be commissioned alongside healthcare provision.

As well as compounding the inequalities gap, there is an additional danger that providers might develop their services at the expense of challenging anti-health forces - another key concern of the UKPHA.

### **The way forward for Public Health**

We need a public health system that is strong across the three domains of public health - health protection, health improvement/promotion, and service improvement. The core principles of public health need to be agreed over all three of these

domains and we must work together to implement them.

With regard to NHS reform, public health professionals should be vocal in asking challenging questions about the impact reform will have on public health and inequalities. They also need to be more proactive in keeping these issues on the agenda of ministers and the local NHS where the focus may well be on health care, as opposed to simply reacting to Government policy. In short they need to become advocates for public health.

It is important to remember that in addition to the NHS's role in delivering public health, the role of other agencies, particularly local authorities and regional public health departments, must continue to be developed.

Above all, it is vital to ensure that the public health movement continues to advance to improve public health at all levels by:

- combating health inequalities;
- challenging anti-health forces; and
- promoting sustainable development

so that public health is improved through interventions and policies that not only improve health, but also produce social economic and environmental gain.

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