# Goodbye (and good riddance?) to PCTs

As England's primary care trusts give way to clinical commissioning groups, **Richard Vize** pens their obituary. Did PCTs seize power from providers for patients?

Did primary care trusts improve healthcare? It took just 13 years for them to be created, merged, clustered, and abolished. During that time they were responsible for about 80% of the NHS budget in England.

The original 303 PCTs across England began taking over from district health authorities and primary care groups in 2000. In 2006 they were merged to form 152 organisations and instructed to begin withdrawing from running community services—known in the artless syntax of Whitehall as "separating out their provider arm"—to focus on commissioning. As the local "system leader" they were charged with driving up quality, improving public health, and reducing inequalities.

In 2010 the health select committee delivered a devastating critique of their commissioning performance, condemning them for failing to tackle quality issues such as variations in clinical practice. It attributed their weaknesses to their "lack of skills, notably poor analysis of data, lack of clinical knowledge, and the poor quality of much PCT management." All this was exacerbated by the Department of Health's imposition of constant reorganisation, it added.

## Lack of power

One of the myths of commissioning is that commissioners wield considerable power. The macho rhetoric of the Department of Health gave the impression that the relationship between commissioners and providers was increasingly one of equals as PCTs ramped up their skills and confidence, fired by the hyperbole strewn world class commissioning development programme.

The reality is that the providers have always been in charge. While in theory PCTs could strip poorly performing services of their contracts and award the work elsewhere, in practice commissioners were generally faced with few palatable options beyond making the existing service work as best they could, and even then there was little they could do to compel improvements or changes.

As the health select committee pointed out: "Commissioners do not have adequate levers to enable them to motivate providers."

The solution the MPs offered—rigid, enforceable quality and efficiency measures written into all contracts—missed the point that improving services is almost always about time, effort, and relationships.

But PCTs often failed to build the strong, effective relationships with clinicians in both primary and secondary care that were needed to make improvements happen.

In theory, clinicians were well represented on the commissioning side. The professional executive committee provided a voice for GPs and other clinicians in the area while medical, nursing, and public health directors were generally influential figures on the PCT board.

But too often there was a distant, or even antagonistic, relationship between local GPs and PCT management. This failure to bring an authentic clinical voice to PCT strategies made it more difficult for commissioners to engage clinical staff in the trusts. An NHS Confederation study to be published this month exploring the legacy of PCTs and the implications for clinical commissioning groups highlights the problem.

"Did the frontline of clinicians feel ownership of the commissioning agenda? No they didn't. The opportunity for the CCGs is to get genuine frontline ownership of what they do," says David Stout, former chief executive of Newham PCT.

## Reconfiguration

The push for safer, higher quality care accelerated the need to "reconfigure" services, often by focusing work on fewer, more specialist sites. The sharp improvements in London in reducing deaths and serious disability from stroke is one of the most celebrated examples.

But major services changes almost invariably drew in the strategic health authority, and national politics began to interfere. As Robert Creighton, chief executive of Ealing PCT, puts it: "Over 10 years we tried three times to address those issues and each time we were unsuccessful. The government's ambition for us as commissioners was to be bold and change the system, but when push came to shove those attempts got derailed because politically they were not supported."

Other changes focused on shutting hospital services and opening community ones. Again, there were successes in areas as diverse as Hertfordshire and Manchester, but progress was excruciatingly slow. PCTs learnt harsh lessons about the difficulty of prising the fingers of the public off the gates of their beloved hospitals.

While this was always going to be difficult, commissioners made life tougher for themselves by repeatedly presenting closure plans to the public and asking what they thought, rather than involving them from the beginning in shaping a new service. There is clear evidence that when PCTs talked with the public and developed trusting relationships with key opinion formers such as councillors and MPs, progress could be made. For example, the Delivering Quality Healthcare for Hertfordshire plan unveiled in 2007 to reconfigure hospital services in the county was led by clinicians, with a consultation exercise that included meetings in 32 towns and villages, the distribution of more than 400 000 leaflets, 120 events for NHS staff, and the close involvement of MPs and councillors. The NHS team developed a strong relationship with the county council's health scrutiny committee, explaining in detail the rationale for the complex proposals and providing evidence for why services needed to change.

PCTs largely failed to rein in the growth in demand for hospital services—although this was a much lower priority during the years of Labour largess. They could never have succeeded. The payment by results system served as a conveyor belt to carry the sharply increasing NHS budget from the Treasury to the acute trusts. The hospitals played their part in slashing waiting times and waiting lists, but the system incentivised them to keep doing more.

There were some modest victories. When funding for emergency admissions was capped PCTs, GPs, hospital consultants, and community care clinicians often managed to cut admissions. But the underlying problem of the funding system remains.

## Quality of care

In some areas tension between GPs and PCTs were increased by the fraught, time consuming, and difficult work commissioners undertook to unseat substandard local doctors. In many

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areas the PCT's biggest success was making primary care safer. The move was driven both by contractual changes and the murders by GP Harold Shipman. The introduction of personal medical services contracts in 1997 allowed local commissioners to negotiate on service specifications. This was followed in 2003 by the ending of GPs' monopoly in primary care; PCTs could now commission anyone.[1]

Meanwhile the conviction of Shipman in 2000 exposed risks and concerns around clinical governance in general practice.

In the NHS Confederation study Stout says: "There are some extraordinary stories about the frankly dangerous and appalling quality of general practice . . . It was incredibly time consuming taking action, to some extent against the will of the GP leadership—they certainly didn't get behind it even though they knew it needed doing."

It could take two years to persuade a GP, often working alone, that it was time to go. Buckinghamshire GP Johnny Marshall, who is now also the confederation's policy director, could see why it was so hard: "It needed a greater partnership between local GP communities and PCTs, and in some areas that simply didn't exist . . . In many it was quite an adversarial, contractual relationship."

PCT leaders are adamant that general practice is now much safer. As Sophia Christie, who was chief executive of Birmingham East and North PCT, puts it: "There are a small number of PCT medical directors . . . who have spent 10 years of their lives putting huge personal and emotional commitment into trying to protect patients from dangerous practice."

One of the great hopes for PCTs was that they would finally begin to reduce the inequalities in health between wealthy and poor people. The idea was that, working with their local authority, PCTs would not only be able to commission services to meet clinical needs but also begin to work with other local services to address wider determinants such as housing, health education, sexual health, and exercise.

There were some successes, such as Liverpool leading the country in smoke-free public places and work in east London to tackle tuberculosis. But taken together, the immense amount of effort thrown at inequalities made virtually no discernible difference to the national picture of a profound deficit in life expectancy and years of healthy life in the most deprived areas.

**The legacy**

Overall, it is easy to come to a critical judgment on the record of PCTs, but that is to belie the adversities they faced and the successes.

They played their part in improving the quality and safety of services, including driving through the virtual wiping out of waiting lists. Their share of the credit for these and other improvements, such as the sharp reduction in hospital acquired infections, now has to be balanced against the wider failures that have been exposed in the quality of basic care. CCGs will find that, with the imposition of tight running cost limits, they are likely to be even more dependent than PCTs on hospital trusts supply-

ing reliable data on issues such as dignity and nutrition if they are to avert serious failures.

Local successes in addressing aspects of health inequality add up to a national failure. This highlights the profound difficulties the health service faces in addressing lifestyle and poverty related diseases. And 13 years is simply not long enough to build and sustain improvements that will show in the figures.

Under the new system commissioners have been stripped of responsibility for primary care and most specialist services, which go to the NHS Commissioning Board, while public health has gone to councils. This leaves CCGs with the £60bn part of the NHS budget that is most difficult to control—general acute care.

The PCT legacy to CCGs includes a greater understanding of the health needs of the local area, a firmer grasp of what commissioning involves, and often strong relationships with the local authority. Generous NHS funding settlements allowed them to expand services in deprived areas. The high performing PCTs leave good foundations for further improving care.

But it is inescapable that after 22 years of the purchaser-provider split in the NHS, commissioners have been unable to seize power from the providers on behalf of patients. Will clinical commissioners fare better? If they can use insights from individual patient consultations to drive strategic improvements in services, and build a shared understanding between primary and acute clinicians of what needs to change, then they have a chance.

But the obstacles that PCTs endured, and the imbalance between effort and achievement, expose the extraordinary difficulties commissioners face in making a difference to patients' outcomes. And that was when there was plenty of money.

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Cite this as: *BMJ* 2013;346:f2039

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# DOCTORS AND THE ALCOHOL INDUSTRY: AN UNHEALTHY MIX?

**Jonathan Gornall** reports on an ideological schism over working alongside the alcohol industry that is dividing the public health community



Over two days in October last year, key figures in the international alcohol industry gathered in Washington, DC, to take stock of how the business had responded to the World Health Organization's Global Strategy to Reduce the Harmful Use of Alcohol, endorsed by the World Health Assembly 28 months earlier.[1]

For an industry well aware that it was in danger of following tobacco down the road to pariah status, the conference on global initiatives to reduce harmful drinking was an opportunity to show off what it had accomplished as a corporate good neighbour who could be trusted to self regulate.

On the final day of the conference, "in response to the call by WHO," the chief executives of 13 of the world's leading alcohol companies announced "a collective commitment to 10 targeted actions in five areas over the next five years." The five areas they picked were "reducing under-age drinking; strengthening and expanding marketing codes of practice; providing consumer information and responsible product innovation; reducing drinking and driving [and] enlisting the support of retailers to reduce harmful drinking."[2]

On the surface, it seemed like a positive development. The commitment built on what the signatory companies called their "longstanding efforts to reduce the harmful use of alcohol." Furthermore, it showed that they supported WHO's global strategy and welcomed "the positive role it identifies for producers, distributors, marketers, and sellers of beer, wine, and spirits."

Yet for a sizeable proportion of the international public health community the announcement served as a red rag to a bull.

An ad hoc group of public health professionals, health scientists, and representatives of non-governmental organisations, brought together under the auspices of the Global Alcohol Policy Alliance (a network of organisations and individuals working in public health) drafted a statement of concern, condemning the industry's commitments as "weak, rarely evidence-based," and "unlikely to reduce harmful alcohol use."

The 16 page document, bearing over 500 signatures from 60 countries, was presented to WHO this week and suggests that the 13 chief executives are "misrepresenting their roles with respect to the implementation of the WHO Global Strategy." The strategy, it says, had given the industry "no authority to engage in public health activities on behalf of WHO or in support of the public health community."

For the record, the industry says the charge of misrepresentation is nonsense and quotes paragraph 45(d) of the WHO alcohol strategy, which states that the producers, distributors, and sellers of alcohol, "are especially encouraged to consider effective ways to prevent and reduce harmful use of alcohol within their core roles mentioned above, including self-regulatory actions and initiatives."

In fact, says Marcus Grant, president of the International Center for Alcohol Policies, the industry's mouthpiece in much of its dialogue with WHO and the scientific and public health communities, it was that paragraph that led the companies to make the commitments. "They were meticulous," he says, "about making sure they weren't promising to do anything that wasn't encompassed by the role that was given to them by WHO."

It remains to be seen how, if at all, WHO will respond to the statement of concern. But perhaps the true value of the document lies in the spotlight it has thrown on the ideological schism that is dividing the public health community, between those who are prepared to work alongside the industry in the effort to reduce alcohol harm and those who are not.

### Divided opinion

To some extent, the statement echoes the concerns expressed by the BMA and five other UK bodies (the Royal College of Physicians, Alcohol Concern, the British Association for the Study of the Liver, the British Liver Trust, and the Institute of Alcohol Studies) in 2011, when they walked out of the government's public health "responsibility deal." They claimed that the deal focused on voluntary interventions by the industry that lacked evidence for effectiveness while failing to tackle issues such as availability and the promotion of alcohol.

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**POACHER TURNED GAMEKEEPER**

It might come as a surprise to some working in public health—although he makes no secret of it himself—to learn that Marcus Grant (right), who founded the industry funded International Center for Alcohol Policies, is a gamekeeper turned poacher.

Between 1973 and 1983 he ran the Alcohol Education Centre at the Maudsley Psychiatric Hospital in London, offering training programmes for health and social staff dealing with alcohol problems. He was then recruited by WHO and, after spells in Copenhagen and Manila, spent 10 years at its headquarters in Geneva, where he was chief of global activities on the prevention of substance misuse, including alcohol.

In 1993, after addressing an alcohol industry conference on public health issues, he resigned from WHO to set up the International Center for Alcohol Policies for the alcohol industry. So should those tackling alcohol issues in the public health community see anything sinister in his having gone over to the other side?

"No, quite the opposite," he



says. "I've always been very transparent about that. I always felt when I was in WHO, dealing with illicit drugs and alcohol, that there was a role for the private sector—not necessarily a controlling role, but a role with respect to alcohol policy."

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At the time, Vivienne Nathanson, the BMA's director of professional activities, said the government had "chosen to rely on the alcohol industry to develop policies. Given the inherent conflict of interest, these will do nothing to reduce the harm caused by alcohol misuse."[3]

Yet not everyone in the public health sector believes it is advisable—or even possible— to tackle the problems of alcohol without giving the industry a role in the search for solutions. Dozens of other bodies have not walked out on the deal—charities such as Addaction, the Alcohol Education Trust, Cancer Research UK, and Heart UK and organisations including the Royal College of Paediatrics and Child Health, the College of Emergency Medicine, and no fewer than 40 NHS trusts.

Thomas Babor, professor of community medicine and public healthcare at the University of Connecticut, who led the 18 strong international committee that drafted the statement of concern, is among those who believe that the industry's efforts to reduce the harm caused by alcohol should not be taken at face value.

"The problem is that when they have examples of partnering with civil society to do activities that appear to be prevention related and addressing the problems connected with alcohol, it's very good public relations for them and distracts attention from the other activities they are doing, like spending a million dollars lobbying the World Health Organization against policies that are demonstrably effective," he told the *BMJ*.

WHO, says the statement he cowrote, should "clarify the roles and responsibilities of 'economic operators' in the implementation of the WHO Global Strategy." The industry should refrain from engaging in health related prevention, treatment, and research activities, "as these tend to be ineffective, self-serving and competitive with the activities of the WHO and the public health community" and the public health community should "avoid funding from industry sources for prevention, research and information dissemination activities."[4]

## Alcohol companies are engaging with WHO and other health initiatives solely in an attempt to influence policy makers

Alcohol companies, says Babor, are engaging with WHO and other health initiatives solely in an attempt to influence policy makers, "so that it appears they are doing something constructive and therefore other more effective remedial action does not have to be taken." At heart, they are "adamantly opposed to policies that restrict access to alcohol, restrict marketing or put constraints on pricing."

This much is true, says Nick Sheron, the head of clinical hepatology at the University of Southampton who, alongside the chief executive of the alcohol industry's Portman Group, co-chairs the Responsibility Deal Alcohol Network Group, which oversees the programme's action on alcohol.

"There's nothing in the statement of concern with which I disagree," he says. "There is a fundamental problem in dealing with the drinks industry, which is that obviously there's a conflict of interest. They exist to make money for their shareholders. They are not in the business of public health."

But that, he says, does not mean the industry can't be persuaded to make "profit neutral" changes that benefit public health.

"There are some members of the public health community who think the government should never speak to industry. I just don't think that is a pragmatic reality. I generally believe that it is better for people to talk to each other, and I also believe it is really important to talk to people who totally disagree with you. And the things we're discussing are really important for society."

Sheron made the decision to remain part of the responsibility deal even when the Royal College of Physicians, for which he is the representative at the EU's Alcohol and Health Forum, pulled out.

"I get flak," he says, "from both sides—probably more from the public health community. But

I see myself as an honest broker. If the government is going to speak to the drinks industry then I would much rather it is in an open forum at which health advocates are present and can put a view that is based on evidence.

"For example, I would prefer that labelling changes were achieved by legislation, but the government isn't prepared to do that. Therefore is it better, in the absence of legislation being likely, to have a voluntary initiative whereby labelling is improved? I think it probably is."

### Positive steps

The responsibility deal has, he says, found common ground on a range of programmes, including Challenge 21 and Challenge 25, an industry supported initiative to ask for proof of age from anyone who looks under 21 or 25, "which I think has been very effective at reducing underage sales," and the industry's unit reduction pledge, "a win-win situation for everybody."

Last year, as part of the responsibility deal, manufacturers agreed to remove a billion units of alcohol from the market by 2015—some 2% of all alcohol consumed in the UK. It has been estimated that this would prevent 1000 alcohol related deaths, in addition to saving NHS costs and reducing the burden on society of drink related crimes.[5]

Even before the deal was conceived, Heineken, which has committed to removing 100 million units of alcohol from sale, had announced in April 2009 that it was reducing the alcohol content of White Lightning, a cider that had become synonymous with cheap, irresponsible drinking, from 7.5% to 5.5% alcohol by volume. Eight months later, the company scrapped the brand altogether, "to reinforce its stance on irresponsible drinking" and went further in August 2010 by "de-listing" Strongbow Black, another cider with 7.5% alcohol. [6] [7]

Both decisions, insists Jeremy Beadles, director of corporate relations for Heineken UK, were driven by a sense of social responsibility.

### GHOSTS FROM THE PAST?

The debate over industry involvement in reducing alcohol harm is entering a gloves-off phase. Almost the first thing Marcus Grant of industry body the International Center for Alcohol Policies tells the *BMJ* is that several signatories on the statement of concern "have strong links with the temperance movement."

This is a reference to the roots of the Global Alcohol Policy Alliance and its partner the Institute of Alcohol Studies in the history of the temperance movement, which flourished in Britain in the 19th century. The institute is funded by the Alliance House Foundation, which is now an educational charity but began life in the 1850s as the United Kingdom Alliance for the Suppression of the Traffic in all Intoxicating Liquors.[11-13]

Some in the industry doubtless suspect that a secret prohibition agenda lies behind the activities of the alliance and the institute,[13] but all of that, says Katherine Brown, director of policy at the Institute of Alcohol Studies, is just so much history. "IAS is open about its funding body, that has historical associations with the UK Temperance Movement," she says. "However, IAS was established as an independent organisation with the aim of promoting the scientific understanding of effective alcohol policies. We do not take a view on whether or not individuals choose to drink."

"These were big, profitable brands, and this was not custom that we were going to make up with the rest of our range, [but] we looked at how those two products were being misused by people and we decided that that was not something we wanted to be part of," he says. The company could only hope that other firms would "follow us out of that sector, and in fact we know at least one of our competitors has indicated they are planning to do that."

Such initiatives, he says, rarely generate good PR. When Heineken went on to reduce the alcohol content of two of its major brands as part of its commitment to the responsibility deal it got "some very difficult publicity," in media ranging from the *Financial Times* to the *Daily Mail*, suggesting the company was profiteering by "watering down" John Smith's bitter from 3.8% to 3.6% alcohol.[8][9] It is, says Beadles, "a serious disincentive for businesses when you get criticised for doing what the government and the public health lobby would like you to do."

Beadles says decisions taken by the company have been influenced by its long term involvement with the drugs and alcohol charity Addaction. The management team visited an alcohol treatment centre and "that was influential in their decision making process" to scrap the Strongbow product. It's a relationship, says Simon Antrobus, chief executive of Addaction, that makes a persuasive case for working with industry.

Addaction, founded in 1967, helps over 35 000 people a year in centres all over England and Scotland. The bulk of its £45m (€53; $68m) income is derived from contracts with local authorities, but the charity says it relies on "donations from companies, trusts and individuals to fund the development of new projects and to address emerging problems."

"I think that the alcohol industry has a vital role to play in dealing with the consequences of addiction," says Antrobus, who is also a member of the Responsibility Deal Alcohol Network Group.

"This isn't an open opportunity to assuage their guilt; there has to be a genuine commitment to what we are trying to do and an understanding of the impact alcohol has on the people we're supporting. But how can we change perceptions, at the very least, without engaging with industry?

"We don't want them to put up the shutters and carry on; we want them to think differently about the way they produce and market their goods and, as much as they can, contribute to minimising and reducing harm. We have a valuable role to play in educating and supporting them as well."

The industry as a whole, however, believes the debate with some sections of the public health sector is becoming more polarised.

"There is a more adversarial tone to exchanges now than in the past, in part because it has become a much more visible issue," concedes industry representative Grant.

"A decade ago it was tobacco. Now that the Framework Convention on Tobacco Control exists it's not surprising that WHO should be concerned about other public health issues, and alcohol clearly is one and so it has moved on to the agenda of the international community."

### Government failure

Peter Anderson, professor of substance use, policy, and practice at Newcastle University's Institute of Health and Society, who helped draft the statement of concern, sees the incursion of the industry into policy areas as a failure of governments.

"Many governments don't accept that they should regulate these industries. Too many say, 'You, the industry, have to be part of the solution.' But of course these industries can't do that: it's not in their interests," he says.

And, in a way, the industry agrees. It rejects the criticism in the statement of concern that the commitments it has made are weak but, says Grant, "They are at least actions, and they are actions the industry can take, because that's what WHO asked for in the strategy: that industry should do things that industry can do. Industry can't limit availability, can't increase taxation—these are government actions. Now it may be that the signatories of this statement of concern believe these are more effective measures, but they're not measures that industry can take."

Sheron believes the alcohol industry faces two possible futures. "You will see statements regarding minimum pricing, for example, that are the same sort of disinformation and pseudoscience that the tobacco industry has used in the past. So one possibility is that the drinks industry ends up being viewed like the tobacco industry by the majority of not only the public health community but also governments."

This, Sheron believes, is the "dark path" on which the industry is currently travelling. But it has a choice, he says, as shown by the experience and evolution of the car industry.

"In the '60s and '70s it was in a very similar position with regard to health. The idea that you would sell motor cars based on the fact that they were safe to drive was a complete anathema.

Thirty years on, we have an industry saying, 'If we make safe and reliable cars our business will prosper,' and it has."

Sheron also points to the experience of the wine industry in France, where manufacturers have shifted from a marketing model based on quantity to one of quality. As a result, as he documented in a paper published in 2010, France has seen a threefold to fivefold decrease in deaths from liver disease at a time when the UK has seen a similar sized increase in alcohol related deaths.[14] Yet "the profitability of the French wine industry has increased at the same time as there has been a massive improvement in public health."

For Addaction, the recommendations in the statement of concern that the industry should not engage in health related prevention and treatment activities, and that the public health community should decline industry funding, make no sense and offer no hope.

"I don't think anybody wins from that kind of statement," says Antrobus. "We do need checks and balances; we do need to make sure that any kind of support is appropriate and right and proper. But we have far too many pressing issues here around alcohol to be turning away funding. When we see the consequences of alcohol addiction every day, we want to do something about it."

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