unit is still trying to develop an agreement that approval should be for a "package" of care rather than a single consultation.

Problems for the future

Doctors who sit on the district medical committee say that the first year of the reforms don't seem to have produced much benefit to patients, largely because there seems to be no real money for developments. The general practitioners also complain that the hospitals have been preoccupied with waiting lists. The consultants at West Suffolk produced business plans last year, but Bob Jones admits that not much has come out of them: "They have established a base to build on in the future." The urologists managed to persuade the district to fund a transurethral microwave therapy machine because it allowed patients to receive outpatient treatment and increased throughput.

That emphasis on throughput bothers Roger West. There is pressure on purchasers to account for developments in terms of measurable gain over the "lifetime of a manager's contract." Many provider developments, he points out, are qualitative. For example, the authority has approved the appointment of a consultant in accident and emergency medicine and is currently discussing the need for a chemical pathologist (because the royal college is threatening to remove approval for junior posts). "You can't measure in activity terms the effect of either a chemical pathologist or an accident and emergency consultant." Similarly, Bob Jones and Humphrey Piggott worry that reducing

juniors' hours will cost money but not deliver more activity.

Measuring activity presents another problem: investing in information technology. Grant Elliott, district finance officer, agrees that the nuts and bolts of contracting have gone well this year, but he concedes that the West Suffolk Hospital has an antiquated computer system and badly needs a new one. He recognises the dilemma of spending money on information technology rather than patient care, but thinks that a purchaser has to support one of its main providers in acquiring the capital and revenue to provide both parties with the information they need on costs and activities. His other main concern is capital charging. East Anglia region plans to put all capital charges into weighted capitation next year, and some providers will have real problems. "We need to be careful that fear of capital charges means that there will be no capital developments at all." He is a firm believer in making assets work but thinks that the capital charging scheme is ill thought through and shouldn't have been introduced at the same time as the internal market.

Capital charges also raise the question of how to value non-measurable outcomes—patient convenience, for example. Since the authority will have to support West Suffolk Hospital in its bid for a day surgery unit it will have to put a value on patient convenience. Otherwise it might be cheaper to send patients to existing units in Ipswich or Cambridge—and then the consultant's fears about becoming simply another Newmarket might really come true.

For Debate

Public health heresy: a challenge to the purchasing orthodoxy

Paula Whitty, Ian Jones

The purchaser-provider split introduced by the NHS reforms^{1,2} has been enthusiastically embraced by public health physicians.³ This reaction was in marked contrast to that of the rest of the medical profession and was exploited by the former secretary of state for health as support for the changes.⁴ Directors of public health argue that the reforms fully embody the recommendations of the Acheson report on the future of the public health function.⁵ Public health's role in purchasing has since attained the status of a new orthodoxy, without there being reason to believe that the necessary investment of its resources will have any impact on the public's health. This paper questions the acceptability of such a role, thereby raising considerable doubts about the future of public health medicine.

Purchasing and the Acheson report: indistinguishable?

The essential components of the public health function as laid down in the Acheson report⁵ are tripartite: to survey the health of the population; to promote and maintain health; and to ensure that the means are available to evaluate existing health services. The enthusiasm of public health physicians stems from the belief that purchasing clarifies and fulfils the role given to public health in the Acheson report⁴ and moreover anchors the public health specialty firmly within the NHS management structure.

But the assessment of health care needs is already dominating the assessment of the health status of the population. Although this situation is difficult to avoid

in the face of purchasing pressure, it represents a profoundly regressive shift for public health physicians.⁶

Quality monitoring has focused on the "humanity" dimensions of care, such as the improvement of hospital surroundings.⁷ Only rarely has a health authority tackled the monitoring of formal patient outcome⁸; therefore public health skills are presently redundant in this aspect of the public health role.

As for Acheson's third component, "promoting and maintaining health," there is a growing misconception that "purchasing for health gain" is the process by which this will be achieved.⁸⁻¹⁰ This assumption completely disregards the evidence that the state of the population's health is fundamentally determined by social and economic factors,¹¹⁻¹³ as has been emphasised in the recent past by the widening of social inequalities¹⁴⁻¹⁷; therefore the impact of purchasing health services on the population's health would be expected to be minimal. Rather, the promotion of the population's health requires governmental and societal action.¹⁸ The response from advocates of purchasing has been that they might buy non-NHS services,⁹ but this is clearly nonsense in the face of an NHS that most people consider is underresourced. Instead, the public health professional has a hope of improving health by appraising and lobbying on relevant economic and social policy issues¹⁹; coordinating local intersectoral action on health related issues²⁰; and, in a more limited way, by organising disease prevention programmes, such as immunisation and screening.¹⁹

The confusion over purchasing and health gain has

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been fed by the government's most recent green paper, *The Health of the Nation*.²¹ The tacit aim of this document is to improve the health of the population, but the failure to acknowledge poverty as a major health determinant and the focus on approaches advocating change in individual lifestyle as the means of preventing disease show a misunderstanding of effective health promotion strategies. The emphasis on indicators of health service utilisation as targets gives credibility to the belief that purchasing can influence health. Surprisingly, the paper has met with only limited criticism from public health professionals.²² The generally enthusiastic response²³ can only support the impression of complicity, willing or otherwise, with the myth that purchasing health services will improve the health of the population.

No one would of course argue that the maximisation of benefit in individual patients should not be the legitimate goal of purchasing authorities. Public health medicine has an accepted role in evaluating that service benefit.⁵ It cannot be overemphasised, however, that the most important of the three public health functions, to promote and maintain the health of the population, can never be achieved through purchasing. Therefore, if public health physicians must be actively coordinating and participating in the preventive and intersectoral strategies set out above, their most important role is as a service provider.

Obviously, many public health physicians have recognised this paradox and have delegated some tasks to provider units. For example, consultants in communicable disease control have been employed by NHS trusts. But this solution inevitably distorts the public health role by causing a loss of the district perspective, applying pressure to conform to the short term goals of the provider organisation, and leaving little incentive or ability to address the social and environmental factors so crucial to the effective control of infectious diseases.

Direct conflicts between the new role and legitimate public health concerns

Increasingly district health authorities are merging, hoping to pool purchasing expertise and provide a counterbalance to powerful provider units.⁷ However, this is a change pursued solely for contracting purposes, with scant regard for the districts' public health responsibilities. Centralisation of public health physicians to cover populations of 700 000 and more militates strongly against local intersectoral working, especially working with local authorities. Furthermore, the inevitable reductions in public health staffing nationally will directly contravene the Acheson report's recommendations.⁵ From the health authorities' point of view, there are worrying parallels with the disastrous area health authorities, disbanded in the 1982 health service reorganisation.

The corporate responsibility resulting from executive membership of directors of public health in the new style health authorities has been accepted as a necessary trade off of independence for influence.²⁴ However, inadequate thought has been given to the implications, in particular for the independence of the annual report. Admittedly, this tension has always been present to a degree, but the right of health authorities to gag their members has never before been so clearly enshrined. Such constraints are the more worrying should the health service continue to be subject to strong political direction from the government—remember the fate of the Black report?²⁴ The freedom for a director of public health to comment on policies affecting his or her local population is paramount,¹⁹ and this freedom should not be traded for influence over the organisation of clinical health services.

Motives: selfless or self seeking?

The contrasting response to the reforms from the remainder of the medical profession can be partly explained by the threat of curtailed clinical autonomy. Conversely, there may be perceived gains in professional terms for public health physicians, and professional rivalry cannot be discounted as a factor in the response of public health professionals.¹⁹

CAN WE LEARN FROM THE PAST?

There are some historical parallels between the new purchasing role and the status of the specialty in the interwar years (1918-40). Many public health physicians perceive this period as one in which they had considerable power.²⁵ During this time they had administrative control of local government hospitals and were increasingly involved in the running of personal health services. The impact on public health of the medical officers of health during this era was minimal: they had "wearied of their traditional public health activities and ... had progressively been seduced into hospital administration."²⁶ Allowing for the very different social and political backgrounds of the periods under comparison, it would be foolhardy to ignore the implications of this historical precedent. Directors of public health are clearly enjoying the opportunity to get their hands back on the purse strings of the clinical health services, but this opens them up to the danger of being "seduced" into overinvolvement in administration, to the detriment of broader public health activities.

The specialty's future under the new regime: naive optimism?

The goals of public health are, as we have seen, in danger of being displaced from promoting the public's health to ensuring the availability of health services. But there are other dangers inherent in public health medicine's advocacy of the purchasing role (box).

Danger to public health medicine of the purchasing role

- Goal displacement—from health to health services
- Loss of "traditional" tasks
- Rejection by purchasing teams
- Failure of purchasing authorities
- Management's perceived takeover of public health function

THE LOSS OF "TRADITIONAL TASKS"

Whether "traditional tasks" are delegated to provider units or neglected entirely, this loss could lead to the atrophy of a formerly broad based discipline. Take, for example, the possible sequelae of consultants in community disease control moving to provider units, tempting them to separate off as an autonomous specialty as their tasks are increasingly distanced from those of their public health colleagues. Infectious disease problems were purported to be the stimulus for the Acheson inquiry and constitute the major part of remaining statutory public health requirements. The loss of their role in controlling infectious diseases would make generalist public health physicians visibly more expendable.

PINNING THE FLAG TO THE MAST OF PURCHASING

In districts where public health has become dominated by "needs assessment" public health physicians are in danger of becoming "technical assistants" to purchasing teams. Thanks to the persistent rhetoric, expectations of needs assessment are unrealistically

Between the wars medical officers of health had wearied of their traditional public health activities and had been seduced into hospital administration

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high, whereas progress has been extremely slow,^{7 8} and the inevitable failure of public health to deliver the goods is bound to result in bitter disappointment. Already there are instances where this sacred cow of purchasing has been taken over by exasperated providers.²⁷ If needs assessment does not lose favour altogether it is likely to become a more limited activity that could just as easily be contracted out to academic departments, at much reduced costs. In addition, when and if purchasing teams get around to evaluating health care outcomes, the urgent requirement is for original research and development, making contracting out to academic departments the most appropriate option. Where would the specialist public health contribution to purchasing be then?

THE FATE OF PURCHASING

The potential impact of fundholding general practitioners on district health authorities is enormous and could negate the district's role altogether.^{28 29} Public health is in danger of being isolated from "bottom up" initiatives. For example, fundholding general practitioners have the potential to work with case managers in producing integrated primary care. In addition, purchasing authorities are now even less democratic than many trust boards, and therefore providers may prove better able to work with local populations.

"WE'RE ALL PUBLIC HEALTH NOW"

The change in orientation of managers towards health and health gain should clearly be supported by public health professionals.³⁰ But, as discussed earlier, this reorientation to health gain refers mainly to individuals' health status, and the health service's ability to affect the population's health is severely limited. Purchasing managers must appreciate that public health still has this wider role, otherwise they will mistakenly believe that their own "conversion" has made public health redundant.

Conclusions

This paper has examined the relation between the NHS reforms, the Acheson report, and the government's most recent green paper, *The Health of the Nation*. We have shown that the enthusiasm for purchasing among public health physicians is excessive, considering that purchasing is likely to be ineffective in improving the population's health and may even be in direct conflict with this goal.

Time and time again the specialty of public health medicine has been unable to control its future, a scenario that will be fully deserved if repeated because of apathy, naivety, or the pursuit of professional power. In this case, the specialty could prove as expendable as its commitment to the public's health.

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- 1 Secretary of State for Health. *Working for patients*. London: HMSO, 1989 (Cm 555.)
- 2 *The National Health Service and Community Care Act 1990*. London: HMSO, 1990.
- 3 Francombe C. *NHS reforms. The first six months. A survey of directors of public health medicine*. Enfield: Middlesex Polytechnic, Health Research Centre, 1991.
- 4 Secretary of State for Health. *Shaping the nation's health* [speech]. London: DoH, 1989.
- 5 Department of Health and Social Services. *Public health in England: the report of the committee of inquiry into the future development of the public health function*. London: HMSO, 1988. (Cm 289, Acheson report.)
- 6 Bull AR. Perspectives on the assessment of need. *J Public Health Med* 1990;12:205-8.
- 7 Ham C, Heginbotham C. How to make a future champion. *Health Service Journal* 1991;101:20-1.
- 8 Tomlin Z. First faltering steps towards an outcome. *Health Service Journal* 1991;101:12.
- 9 Hunter D. Stormy days ahead. *Health Service Journal* 1991;101:22.
- 10 May A. Apple pie notions and health resolutions. *Health Service Journal* 1991;101:14.
- 11 McKeown T. *The role of medicine: dream, mirage or nemesis?* Oxford: Blackwell, 1989.
- 12 Office of Populations Censuses and Surveys, Social Surveys Division. *General household survey 1989*. London: HMSO, 1991.
- 13 Blaxter M. *Health and lifestyles*. London: Routledge, 1990.
- 14 Black D. Inequalities in health: report of a working group. London: HMSO, 1980.
- 15 Whitehead M. The health divide in inequalities in health in the 1980s. In: Townsend P, Davidson N, Whitehead M, eds. *Inequalities in health*. London: Penguin Books, 1988.
- 16 Marmot MG, McDowall M. Mortality decline and widening social inequalities. *Lancet* 1986;ii:274-6.
- 17 Davey Smith G, Barley M, Blane D. The Black report on socioeconomic inequalities in health: ten years on. *BMJ* 1990;301:373-7.
- 18 European Office of the World Health Organisation. *Targets in support of health for all by the year 2000 in the European region*. Copenhagen: WHO/EURO, 1985.
- 19 What's new in public health? *Lancet* 1991;337:1381-2.
- 20 Ashton J, Grey P, Barnard K. Healthy cities: WHO's new public health initiative. *Health Promotion* 1986;1: 319-24.
- 21 Secretary of State for Health. *The health of the nation*. London: HMSO, 1991. (Cm 1523.)
- 22 Radical Statistics Health Group. Missing: a strategy for health of the nation. *BMJ* 1991;303:299-302.
- 23 Ashton J. The health of the nation. A new consensus emerges. *BMJ* 1991;302:1413.
- 24 Gatherer A. Being executive. *The Public Health Physician* 1991;2:2.
- 25 Godber GE. Medical officers of health and health services. *Community Medicine* 1986;8:1-14.
- 26 Webster C. Medical officers of health—for the record. *Radical Community Medicine* 1986;3(Autumn):10-4.
- 27 Webster D. How to write a service specification. *BMJ* 1991;302:1450-1.
- 28 Roland M. Fundholding and cash limits in primary care: blight or blessing? *BMJ* 1991;303:171-2.
- 29 Scheuer MA, Robinson R. A wild card in the pack? *Health Service Journal* 1991;101:18-9.
- 30 May A. Apple pie notions and health revolutions. *Health Service Journal* 1991;101:14. (Quoting S Adam.)

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