# Saul Miller

*"... similar structural factors to those that affect patients and practices ... will unequally affect PCNs too."*

## Dynamism has a downside

There is a premium placed on activity. So much so that recent advice filtering down to primary care networks (PCNs) is that those which lag behind in taking on new personnel and claiming the associated reimbursements will find that the more vigorous networks will be given opportunities to claim the laggards' unused resources.

This idea has merit: the wish to reward active networks and avoid resources going unspent. Should we applaud? Surely the idea of better resourcing the proven performers makes good sense?

The predisposition towards favouring the active is there in our language: dynamic go-getters contrast favourably against indolent couch potatoes. For an individual to be described as a man of action is (ignoring the inherent sexism) generally taken to be a self-evident good thing.

In a medical sense, that bias has definite positives. There is, after all, a lot of evidence to support the health benefits of being physically active, not only for physical health[1] but also for mental health.[2] There is evidence that links what goes on in our heads with physical health outcomes too.[3] So, reinforcing all these positive attitudes and behaviours makes lots of sense for promoting healthy outcomes. And that's fair enough, just as long as the many folk on the wrong side of the evidence don't end up blamed for doing so.

Because it turns out, doesn't it, that many of the people on the wrong side of the evidence had other disadvantages too? Such as socioeconomic deficits compounded by discontinuous care[4] and earlier disability,[5] not to mention earlier death.[6]

Among the other obligations placed on them, PCNs are meant to come up with plans to lessen health inequalities. The over-riding pressure on them, however, is to employ new personnel and claim the associated reimbursements. And, of course, like any category of organisations (practices, butchers, charities, knitting groups), some will do better in relation to their targets than others.

It might be tempting to think that those more successful, more dynamic PCNs simply have better leadership. With so much focus on the importance of leadership skills in the NHS, the narrative is perhaps hard to resist that it is the key factor.

In truth, other elements are likely to be more decisive though. Much as we know that primary care funding and deprivation are not neatly matched,[7] we also know that patients who are deprived are more likely to be cared for in their less-well-funded practices by migrant doctors.[8] So, it is hardly a jump to consider that similar structural factors to those that affect patients and practices already will unequally affect PCNs too.

What does all this mean? Allowing successful PCNs to bid for funds unclaimed by less dynamic and successful peer networks will predictably amplify the inequalities that probably underpinned their differing performance in the first place.

Clearly, it is not an easy problem to solve how to set rules around how resources are allocated and used. There is a clear positive here in the commitment to try to ensure that available funding is used. But perhaps the premium placed on activity is not always a self-evident good thing.

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