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The use of private finance in primary care premises has seen the entry of commercial property developers and for-profit healthcare companies, paralleling developments in the NHS hospital sector.[1] As funding for capital investment in the NHS has become more complex, with the requirement that public-private partnerships generate a mixture of state and commercial revenues, the risks and costs of investment make general practitioners' ownership of premises increasingly unlikely.[1] At the same time, the government's NHS Plan expects a rapid move of general practitioners into a salaried service, the end of independent contractor status, and an increasing role for the private sector.[2] These changes raise questions about how government policy will affect the control of clinical decision making in managing NHS budgets and the core principles of the NHS. In this article I examine these issues from the perspective of the duties imposed by the NHS Plan on primary care trusts, which are the new NHS structures for health and social care, and show how the Health and Social Care Bill 2000 could move the United Kingdom towards a US-style health care system.

Summary points

For the first time, an NHS body will be able to charge for personal care and hotel costs

Government guidance on intermediate care restricts entitlement to NHS care to six weeks except in exceptional circumstances

NHS reimbursement mechanisms are being altered in ways that facilitate a shift to personal insurance rather than social insurance and universal coverage

By 2007, NHS trusts will have to find £4.5bn from annual revenue allocations to service debt incurred by using private finance and capital charges

The incentive structure of the new system will force care trusts to find ways of constraining expenditure through rationing, user charges, and commercial activities

If the principles of the NHS are to be upheld, the Health and Social Care Bill must be amended to abolish charges for personal care and prevent privatisation of clinical services and staff

Primary care trusts and care trusts—NHS trading bodies

The Health Act 1999 introduced primary care groups and primary care trusts. Primary care groups and trusts[3] hold unified, cash limited budgets to pay for their patients' use of hospital and community health services, general medical services, and prescribing.[4] The government intends that primary care trusts will hold around 70% of the entire NHS budget. There are currently 434 primary care groups and 40 first wave primary care trusts in England; a further 124 primary care groups are to become trusts in April 2001.[5]

The Health and Social Care Bill also provides for primary care trusts to become care trusts holding social care budgets under delegated authority from local authorities. Although this has been hailed as a means of integrating health and social care budgets, it means that for the first time a NHS body in England and Wales will have a mechanism and the powers to charge for personal care and hotel costs. This is because health care is funded from central taxation and is free at the point of delivery, whereas personal or social care in England and Wales is partly funded from user charges.[6] Scotland has decided not to introduce charges for personal care or to implement care trusts, which means that patients in Scotland and England will be treated unequally within the NHS.

The Health Act constitutes primary care trusts as trading bodies required to manage the risks and costs of care.[7] Like other NHS trusts, their main statutory duties are financial, and they must remain within the resource limits set them and pay a charge on their assets. The NHS Plan has put in place a series of measures that will enable failing trusts—that is, those that do not meet their statutory financial targets—to be taken over by private firms or by other trusts. Currently, NHS trusts can generate income only through fees from private patients and funds for commercial research, both of which are restricted by capacity constraints.

In the next sections I explore the cost pressures that trusts face relating to capped budgets, drug prescribing and new technologies, and the use of private finance and the various ways in which they might respond to the requirement to keep within budget.[8–10]

Cost pressures related to capital investment

The debts incurred using private finance to fund capital investment will present an important new cost pressure. The NHS plan predicts that by 2007 the NHS will become liable for an extra £7bn capital investment using private finance. Although NHS trusts must repay debts from their annual current expenditure, the government has not published the current or future annual revenue implications of using private finance. The only aggregate data relate to the £319m annual rental reimbursement scheme for primary care.

Published data for the £2bn of first wave private finance initiative deals signed by November 2000 show that the annual availability fee and total private finance initiative charge average 12% and 17% respectively of

the total capital investment.[11] Based on these averages, the annual payments made by trusts for private finance will increase threefold, from £654m annually for schemes signed in November 2000, to over £2.1bn by 2007 (table 1). NHS trusts also have to pay capital charges of £2.4bn to the Treasury on land, buildings, and equipment owned by the NHS. By 2007, NHS trusts will have to find £4.5bn from their annual revenue allocations to service their private finance debts and capital charges. Since trusts are locked into private finance initiative deals for 25-30 years, the escalating cost of private finance will be at the expense of clinical services and patient care unless there is a commensurate increase in funding.[11–13]

Table 1 Estimated annual cost to NHS in 2007 of investment using private finance

Existing and planned investment under private finance initiative	Annual revenue implications at 1999-2000 prices (£m)
Existing investment	659
£2bn under private finance initiative (up to Nov 2000)[12]	340*
GP premises (rental reimbursement 1999)	319
Planned NHS investment†	1140
£7bn under private finance initiative, 2000-7	1190
To clear 25% of £3.1bn backlog in maintenance by 2004	250
Total	2099

*Derived from health select committee data.[13]
†Under NHS Plan.

Strategies for dealing with cost pressures

The four potential ways in which care trusts and primary care trusts might deal with cost pressures are listed in the box and discussed below.

Reducing expenditure on premises

Trusts may seek to reduce expenditure on general practice premises. Currently, many general practitioners opting into personal medical services pilots are given a generous baseline budget for practice premises and salary costs, which they negotiate locally. Trusts faced with revenue shortfalls may be tempted to reduce general medical services expenditure on non-ringfenced capital schemes. General practitioners could face the risk of not being adequately reimbursed for their premises, a situation they currently encounter when the payments they make as part of a lease or finance deal exceed the district valuer's market rent valuation. General practitioners will no longer have the same control or ability to negotiate rental reimbursement when trust boards are in place, and for-profit market entrants may make generous offers to buy out general practitioners from their share of ownership.[1] This is not inconsistent with the government's aim of making general practice into a salaried service.

Increasing income from commercial and retail outlets and sale of health care

The procurement of new premises and health centres under public-private partnerships relies on generating new income streams from the provision of social services, housing, and private health care (such as nursing and residential care homes) and from commercial and retail outlets. Many of the new entrants into ownership of NHS premises fund the capital investment raised under the private finance initiative from commercial revenues.[1] There are currently no restrictions on trusts setting up business ventures, and the government has introduced an equity arm to drive the process known as the Local Improvement Finance Trust (LIFT).

The government's export advice agency, Trade Partners UK, describes the NHS as "one of the world's best health care brands."[14] Some primary care trusts may enter into joint ventures with private health insurers and health companies to sell insurance products such as long term care and private healthcare cover to their patients.

Reducing expenditure on NHS care and increasing income from charges

The Health and Social Care Bill allows primary care trusts to generate non-NHS income through user charges by becoming care trusts and holding pooled budgets for health and social care. The most obvious area for the introduction of charges is the intermediate care sector. This is the new care sector identified by the government to reverse the decline in NHS capacity resulting from decades of closure of NHS beds and services in long term care, rehabilitation, and recovery.

Care trusts can reduce their liabilities by introducing rationing or eligibility criteria for NHS care. The Department of Health has issued guidance on planning for intermediate care, which implies that NHS care will normally be limited to a maximum of six weeks.[15] This means that people requiring prolonged NHS hospital and community health care after complex surgery, trauma, or acute medical conditions such as stroke and those with chronic conditions such as Alzheimer's disease or multiple sclerosis may find their eligibility for NHS care seriously curtailed. This situation is analogous to the situation that occurred after the implementation of the NHS and Community Care Act in 1993, when panels of geriatricians and nurses and social workers developed local eligibility criteria to determine eligibility for long term care funded by the NHS and local authorities.

Introducing eligibility criteria for nursing and NHS care and charging for other services will be easier where provision is on non-NHS premises. As in long term care, where local authorities and the NHS had incentives to dispose of their assets and privatise provision, the incentives and pressure on primary care trusts will be towards disposing of existing NHS estate (where they pay the entire cost of care) in favour of private provision, perhaps as a joint venture with a private sector provider, where they can charge for personal care and hotel costs. In many respects, the new intermediate care sector could be a rerun of the incentives that have operated in long term care over the past two decades.

Strategies for reducing costs

- Reducing expenditure on primary care premises
- Increasing income from commercial and retail outlets through public-private partnerships
- Reducing expenditure on NHS care and increasing income from charges for personal care through private insurance and intermediate care
- Maximising income by altering case mix

Table 2 Comparison of NHS with US healthcare system

	NHS 1948-2000	US healthcare system	New NHS 2001
Coverage	Universal	Voluntary insurance; 55 million people uninsured	Universal*
Unit of risk	District health authority	Provider	Primary care trust/provider
Basis of resource allocation	Geographical population	Enrollees	Practice lists
Method of resource allocation	Population weighted capitation	Risk adjusted; individual capitation	Capitation based on practice lists
Turnover	Stable	50% annually in some health maintenance organisations	Not known
Ownership	Mainly public (except GP owned premises)	For-profit corporations; some public	For-profit corporations, public ownership, GP owned premises
Funding sources	Central taxation 90%; patient charges 2%	Private health insurance; state funding; federal funding; user charges	Central taxation; user charges; local taxation

*Personal use is paid for. NHS care has been and is being redefined, particularly in rehabilitation, intermediate care, and long term care so that it is no longer universal.

Maximising income by selecting patients for case mix

Cherry picking

Primary care trusts have a built-in incentive to select patients, known in the United States as cream skimming or cherry picking. The NHS covers all patients in the United Kingdom. However, because general practitioners can choose their patients, trusts will have the potential to select patients on the basis of risk either by encouraging private health cover or by selecting lower risk groups. For example, walk-in centres and NHS Direct provide trusts with a mechanism for identifying high risk patients and selecting them out. Trusts in prosperous areas will have a built-in advantage as well as the ability to promote greater use of private insurance.

Another method of selection used in the United States is restricting the range of services under offer—for instance, by excluding services for mental health, learning disabilities, rehabilitation, or intermediate care. The current blurring of the boundaries for provision and funding (table 2) makes it increasingly likely that some care trusts will resort to selecting patients by restricting services available on the NHS.

Risk adjusted funding or capitation

Unlike health authorities, primary care trusts are not reimbursed on the basis of geographically defined populations but on the basis of practice lists. This marks a fundamental shift in the principle of resource allocation and risk pooling over geographical populations. The change could come to be seen as a major opening for a move to an insurance based system.

As care trusts are funded on the basis of practice lists, they could demand to be reimbursed on the basis of each patient's potential risk rather than on overall risk. This is the system used by US managed care organisations and the private health insurance industry, which has developed risk adjustment payment systems based on individual risk, such as the diagnostic cost group and the disability payment system.[16 17] This process of risk selection, known as medical underwriting, was considered unethical in the United States but proved irresistible to the for-profit insurance sector.[18] Reimbursement schemes based on individual risk are currently being piloted in long term care in the United Kingdom as part of the privatisation of funding and the move to a private voluntary insurance based system. The NHS Plan stated that the Treasury is taking steps to regulate private long term care insurance products. The structures and incentives in the plan suggest that these policies will be extended across the rest of the NHS.

Will public-private partnerships take us down the American way?

In September 2000 the Institute for Public Policy Research working group on public-private partnerships advocated transferring NHS and clinical staff to the private sector and allowing health care companies to run primary care trusts.[19] Pilots are already up and running, with NHS trusts subcontracting acute and intermediate care services and pathology services to private hospitals. Clinical services under these contracts are being privatised.[6]

The government presents its NHS Plan and the Health and Social Care Bill as a move towards greater integration coupled with long overdue investment. The principles are to be applauded, but the reality is different. There is the spectre of US-style health maintenance organisations, to which the new structures of the NHS conform. Like health maintenance organisations, primary care trusts will increasingly operate in the market as trading bodes. Clause 4 of the Health and Social Care Bill enables the secretary of state to transfer public funds to the private sector as direct grants or loans, and it also allows the private sector to operate and run clinical and social care services on his behalf. Care trusts will be responsible not just for the risks and costs of care but also for reconciling the competing objectives of meeting the returns required by shareholders and public health needs.

As with health maintenance organisations, the reimbursement mechanisms of care trusts are being altered in ways that facilitate a shift away from social insurance and universal coverage to personal insurance, user charges, and time limited care. The integration of budgets and responsibilities for health and social care creates the mechanisms and incentive structure for introducing charges for personal care and hotel costs. This, combined with the recent guidance which limits NHS intermediate care to six weeks, means that more patients are likely to find themselves paying for elements of care that they once received free under the NHS.

Restoring public health principles

There is still time to ameliorate this policy. Firstly, the government should reaffirm the principle of universality by requiring that care trusts serve, and are reimbursed on the basis of, geographical populations rather than practice lists. This will preclude any tendency to cherry pick and minimise a drift to private health care insurance. Secondly, the central recommendation of the Royal Commission on Long Term Care—that personal social care be provided free at the point of delivery and funded from general taxation—should be implemented (as it is in Scotland). This will make it more difficult to make care a personal responsibility and prevent NHS care trusts from shunting costs to individuals and introducing eligibility criteria for NHS care. Thirdly, commercial activities such as the sale of private health insurance and private health care should be prohibited from any premise in which the NHS pays for care. This would prevent the blurring of the boundaries for responsibility for funding care and conflicts of interest as trusts struggle to meet their statutory financial duties. Fourthly, the bill should remove the statutory financial duties on trusts, including capital charges. It should also abolish the contracting system, which drives market behaviour. Finally, it should establish proper mechanisms for local and parliamentary accountability to reverse the current democratic deficit. Unless the legislation is amended along these lines, Bevan's legacy and the principles of universality and comprehensive care upon which the NHS was founded will be destroyed, and the Health and Social Care Bill will indeed be the last act of the NHS.

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When I use a word …

Oh? Why?

The responses to the article in which I argued the case for using the term adrenaline rather than epinephrine as the recommended international non-proprietary name (*BMJ* 2000;320:506-9) were almost all supportive. And some of the respondents cited other difficulties with names of drugs. For example, Tom Sargent, a West Lothian general practitioner, mentioned hydroxocobalamin: "Look for it in the *British National Formulary* or *MIMS*," he wrote. "Hydroxocobalamin does exist. The 'fuzzy logic' between my ears allows the mark one eyeball to pick out the index entries for vitamin B-12 but [computer] search engines balk at the use of 'o' and 'y' in the middle of the word. Some have a built in ability to substitute by using a '?' or '*' but you have to be aware of the need to do so. Changes of drug name are not so easy to assimilate as might be thought."

As Dr Sargent implies, those who are accustomed to prescribing vitamin B-12 probably know well not to write "hydroxycobalamin" or to look for it as such in indexes to formularies and the like. But not everyone does. When I searched the titles and abstracts of articles listed on Medline, I found 268 instances of "hydroxocobalamin" and 48 of "hydroxycobalamin." There was even one publication in which both forms were used, in the English translation of the German abstract (*Ther Umsch* 1992;49:118-23), although I haven't seen the original paper to check. Now the number of articles in this survey is small, but this represents an error rate of 15%, which is high as these things go. For comparison, my latest count on gentamycin/gentamicin is 1144/11 070, an error rate of 9.3%. And for thrombocytopaenia/thrombocytopenia the total count since 1965 is 180/14 510, a 1.23% error rate; I last mentioned this error in 1996 (*BMJ* 1996;313:1201), since when the Medline counts have been 27/2731, an error rate of only 0.98%, which I'm glad to say represents a small improvement.

Why, when all other commonly used compounds begin "hydroxy-" should this one start with "hydroxo-"? Well, many common organic groups and radicals that contain oxygen, sulphur, or nitrogen can act as ligands, undergoing lone pair donation to metals that form complexes, as in the cobalamins, which contain the metal cobalt. When this happens, chemists use a different name for the radical; for example, hydroxy- becomes hydroxo-, sulfonyldioxy- becomes sulfato-, and ammonio- becomes ammine-. That's why the chemical name for cisplatin is *cis*-diamminedichloroplatinum and why hydroxocobalamin doesn't have a *y* in the middle.

O, so that's y.

Jeff Aronson *clinical pharmacologist, Oxford*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.