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Unlike its predecessors, New Labour does not have a blueprint for the NHS, but it will have to reveal its values soon, warns Allyson Pollock

How are NHS and social services staff managing to make sense of the snowstorm of Green Papers, White Papers and Department of Health guidance? The new performance framework exhorts improvements in quality, performance and value for money across a public sector pared to the bone by years of efficiency savings, contracting out and budget shortfalls.

And then there are the papers on partnerships and joint commissioning and on priorities – but without the budgets and the resources, will joint commissioning simply be a vehicle for fostering mutual suspicion, exposing individual users to financial risk?

The success or otherwise of all these initiatives will depend on the direction of government policy, soon to be enshrined in legislation. At the time of writing, we are still waiting for the Social Services White Paper, but the NHS is embarking on yet another full-scale reorganisation.

Will the promised structural changes mean the abolition or the continuation of the market in health and social care? The NHS White paper doesn't commit itself one way or the other – but as the legislative timetable approaches, the government is going to have to choose the future direction of the NHS.

The founding principles of the NHS included comprehensive care – free at the point of delivery – and universal coverage. When the patchwork of private voluntary and municipal services were nationalised, all staff were salaried on national pay scales – except for dentists, opticians and GPs, who are still independent self-employed contractors today. The NHS's population focus came through the regions and health authorities, which were responsible for monitoring health care needs and for service planning. But weaknesses included the lack of coterminosity with social services, and a continuing democratic deficit in the health authorities.

The NHS and Community Care Act 1990 eroded local accountability further by placing responsibility for service developments in the hands of trusts and GP fundholders. Although many GPs opposed fundholding, financial incentives ensured that 50 per cent of them were holding budgets for their patients within five years. Primary care groups should "develop around local communities,but take account also of the benefits of coterminosity with social services. . [PCGs] may typically serve about 100,000 patients," says The New NHS.

Also: "Primary care groups will grow out of the range of commissioning models that have developed in recent years but will give a sharper focus to their work."

And later: "The Primary Care Trust – for primary care groups which wish to be independent...will employ all relevant community health staff and run community hospitals and other community facilities."

The NHS White Paper invests GPs with even greater powers through primary care groups. These are replacing fundholding practices, but will be additional to the 419 trusts and the 100 health authorities (HAs) in England, each of which already has its own board and management structure. There are four levels of primary care group (see box).

The timetable is tight; PCGs have to be up and running by 1 April 1999. In the first year, all groups will be at levels one or two, but the government is keen for them to move on to levels three and four. The critical question is whether PCGs will remain part of the NHS, or whether they will evolve into large corporate organisations similar to the US health maintenance organisations (HMOs).[1]

Although PCGs resemble health authorities, there are several very important differences. First, all primary care groups are configured around practice lists rather than serving a total population in a defined geographic area. This will make ensuring equity in resource allocation and monitoring health care challenging tasks, since practice populations are neither stable nor representative of the population as a whole.

Allocating resources will be particularly difficult where patients come from a number of neighbouring health authorities. Working with social services will not be easy, due to lack of coterminosity. Unless there is a

PRIMARY CARE GROUPS

- **Level one: acts in an advisory capacity to health authorities in commissioning care**
- **Level two: allowed to manage its own health care budget, acting as part of the health authority**
- **Level three: allowed to become freestanding body, accountable to the HA for commissioning care**
- **Level four: Primary Care Trust (PCT) status; a freestanding body with the added responsibility of providing community services, as well as holding the total budget for NHS care**

monitoring framework, this could increase inequities in provision.

Second, while GPs will be in the majority on PCG boards, issues around accountability remain to be resolved. It is important to understand that as independent financial contractors, the rules governing GPs and the treatment of their assets and surpluses (profits) are very different from the rest of the NHS.

At present there is nothing to prevent GPs entering into commercial ventures, owning and operating their own businesses and employing their own staff. The direct effect of this is that some community and acute services could end up leaving public ownership of the NHS and become part of a PCG. This is very much what is envisaged in the level three and four primary care trusts (PCTs).

Third, GPs will be allowed to hold and combine both the General Medical Services (GMS) budget for primary care and the budget for hospital and community health services (HCHS). Although they will no longer have to account for these budgets separately, both budgets will be capped. This means that GPs in PCGs will now be rationing care at the point of consultation. Alternatively or additionally they may have to make careful decisions about which patients they enrol. In the context of the Comprehensive Spending Review, rationing becomes a major issue. The Chancellor's £21 million accounting trick has been unravelled into a much more modest annual increase of around 2.5 per cent. Most of the new money is ring-fenced centrally for waiting list initiatives and for capital investment schemes under the Private Finance Initiative. But PCGs and PCTs will not only have to contend with capped budgets, but with the effects of acute service strategies which in some areas will take out up to 30 per cent of capacity, shifting roughly the equivalent in acute caseload into the community over the next five years.[2]

Substitute services for displaced caseloads do not yet feature in either government policy or health authority plans, leaving it as a matter of speculation whether the

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government intends to assume responsibility for patients denied care. Will the story of long-term care, where costs were devolved to individuals, their families and local authorities, and where a system of eligibility criteria was introduced, be repeated in other areas?

Like NHS Trusts, PCGs with a cash-limited budget may need to generate income in order to make ends meet. What is to stop them selling products like health insurance or nursing home and rehabilitation services, to patients who can afford them? This is already happening in some parts of the country, as groups of former fundholders use their profits to buy up community hospitals seen as surplus to requirements by the NHS. This situation is aggravated by current policies on disposing of NHS assets and managing trusts' financial deficits. All NHS land and estate deemed "surplus to requirements" under health authority purchasing strategies has to be offered first to other interested NHS parties. And around the country, former fundholders are buying up pieces of NHS estate with private sector backing. In Epsom, GP fundholders have bought the Epsom and Ewell Cottage Hospital in partnership with the private sector. Elsewhere, GPs and trusts are entering into joint partnerships with the private sector. South Devon Health Care Trust and the Dawlish Medical Group have entered into a PFI deal with McAlpine Healthcare to replace a 17-bed community hospital.

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Transferring NHS assets to private ownership and management is ultimately funded from NHS revenue. With a cash-limited system where GPs can shift income away from NHS Trusts to commercially-owned enterprises in which they hold a leading stake, it is not difficult to see the potential for further NHS destabilisation. And as GP budgets come under pressure, the temptation to mortgage NHS assets to the private sector will increase.

Numerous community trust mergers are taking place as a prelude to their becoming an integral part of PCGs. It is not difficult to foresee trusts with growing financial deficits transferring the ownership of assets to a PCG. Levels three and four will be exempt from the current punitive system of capital charging, while trusts currently have to make a 6 per cent return on the current value of their asset base to the Treasury – amounting, on average, to 8-10 per cent of annual income.[3] The disadvantage is that the asset will no longer belong to the NHS, but to the board of the PCG.

By devolving rationing decisions to primary care, government can continue to keep a shrinking NHS free at the point of delivery. For unlike its predecessors, New Labour does not yet have a blueprint for the NHS. As a result, the NHS could rapidly move towards a system where hospitals, and ultimately PCGs and trusts, will be controlled by the private sector. Unless future legislation ensures it, the NHS now has no defence against the inroads of the private sector. This is where health action zones, health improvement partnerships and joint commissioning could play a vital strategic role.

The legislation should be tightened up in four ways. First, PCGs should serve geographic populations, so that they provide universal coverage to the whole population, avoiding the temptation to select. In doing this, it would be necessary to separate the responsibilities for managing practice populations from budget-holding and service planning. This would inhibit entrepreneurial commercial activity, restore a population focus and allow a greater chance of coterminosity with social services.

Second, it could restrict PCGs' commercial activities, such as selling products and purchasing private assets with NHS funds. This would mean abolishing the punitive system of capital charging across health and social care. Third, it needs to introduce proper mechanisms for local accountability so that PCGs serve, and are seen to serve, their local communities. Fourth, it must introduce a proper monitoring system across the whole of the health care system, including standardised datasets for public and private care.

Rebuilding public confidence is a core theme of the NHS White Paper, and rebuilding public sector infrastructure using the values of social justice which originally shaped the welfare state would be a positive step. And if the government is really committed to health improvement, then strengthening our health and social services must be a good place to start.

[1] A Pollock, "The American Way", *Health Service Journal*, 9 April 1998

[2] D Gaffney, and A Pollock, *Can the NHS afford the PFI?* British Medical Association Report, 1997

[3] A Pollock and D Gaffney, "Capital charges: A tax on the NHS". *British Medical Journal* 1998, 317:157-8

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