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.
monitoring framework, this could increase iniquities in provision.

Second, while GPs will be in the majority on PCT boards, current'^round accountability remain to be resolved. It is important to understand that as independent financial controllers, the role of governing GPs and the remuneration of their assets and surpluses (if any) are very different from that of the NHS.

At present there is nothing to prevent GPs entering into commercial ventures, owning and employing their own businesses and employing their own staff. The direct effect of this is that some community and acute services could end up being run by private ownership of the PCT and become part of a PCC. 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 service (HCS). Although they will no longer have to account for these budgets separately, both budgets will be capped. This means that GPs in PCTs will now be running care at the point of consultation. Alternatively, or additionally, they may have to make shared decisions about how patients are treated. In the context of the Comprehensive Spending Review, seeming to be a major issue. The Chancellor's £2.1 billion accounting trick has been unravelled into a much more modest annual increase of around 2.5 per cent. Most of the new money is transferred centrally for certain initiatives and for capital investment schemes under the Private Finance Initiative. The PCTs and PCCs will only have to contend with capped budgets, but with the effects of service strategies which in some areas take out up to 30 per cent of capacity. This may roughly the equivalent in acute care, continuing to the community over the next five years.

Subacute services for domiciled elderly or dependent elderly care, home treatment and rehabilitation services, however, will mean a matter of speculation whether the number hospitals seen as surplus requirements in the next five years.

The situation is jeopardised by current policies on disposing of NHS assets and managing trust financial deficits. All NHS land and estate deemed surplus to requirements under health authority purchasing strategies has to be offered first to other NHS trusts. And around the country, former fell, buildings are being bought up by private companies, with the potential to enter into joint partnerships with the private sector. South Devon Health Care Trust and the Dartmouth Health Group have entered into a PFI deal with MacAlpine Healthcare to replace a 17-bed community hospital.

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

Numerous community trust mergers are taking place in a number of trusts becoming an integral part of PCTs. It is not difficult to foresee trusts with growing financial deficits transferring the ownership of assets to a PCC. Levels three and four will be exempt from the current disposal 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 — reducing, on average, to 1.9 per cent of annual income. The disposal leverage to charge the asset will no longer belong to the NHS, but to the board of the PCC.

By devolving rationing decisions to primary care, government can continue to keep a shrinking NHS free at the point of delivery. For unlike its predecessor, 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 PCTs and trusts will be controlled by the private sector.

Unless future legislation ensures it, the NHS now has no defence against the winds of the private sector. This would ensure that health services, health improvement partnerships and joint commissioning could play a vital strategic role.

The legislation should be tightened up in four ways. First, PCCs should have geographic populations, so that they provide universal coverage to the whole population, avoiding the temptation to select in doing this, it is necessary to separate the possibilities for managing practice populations from under-funding and service planning. This would enable primary care to be more effective by removing the potential for competition across the whole of the health care system, including medical advice, primary care, and social services. This would also mean abolishing the private system of capital charging across health and social care. Third, it needs to introduce power and local accountability so that PCCs 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 medical advice, primary care, and social services. This would mean abolishing the private system of capital charging across health and social care.

Establishing a new trust to oversee the NHS would pass 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 improvements, then strengthening our health and social services must be a good place to start.