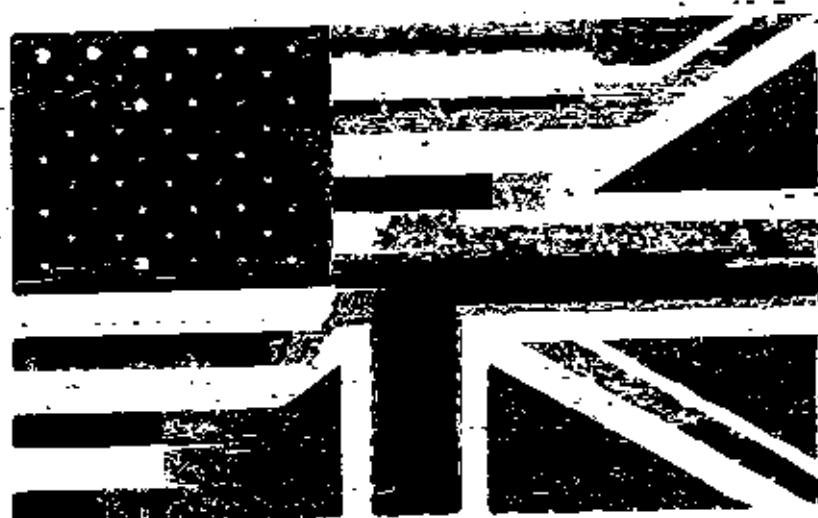


The American way

The white paper may force the NHS down the route of the US health maintenance organisation, argues Allyson Pollock



trum of models ranging from the 'mini DHA' to fundholding and the American HMO organisation.

PCGs as mini health authorities

The white paper states that PCGs should develop around local communities, taking account of the benefits of coterminosity with social services. The potential benefits of these 'mini HAs', typically serving around 100,000 people within a defined geographical area, are universal coverage, the restoration of service planning, local accountability and greater equity in resource allocation and service provision. Since PCGs will serve small populations they won't be able to carry much financial risk. Risk will rest with the HA. This could strengthen its role in strategic planning and health-care monitoring, but would also increase the political liability of the government for underfunding.

PCGs as fundholders

The white paper also says that PCGs will grow out of existing local groupings (ie fundholding, total purchasing projects and locality commissioning). The capping of the PCG budget ends fundholders' ability to limit risk using the safety-valve of emergencies and, for non-fundholding GPs, through their open-ended prescribing budgets.

This may push them towards income generation. The elements of care which are free at the point of delivery may then be increasingly difficult to monitor; and PCGs with capped budgets may try to limit their financial liabilities by excluding high-risk patients such as those with mental health problems, severe disabilities or chronic disease.

Allocating resources is more difficult with population-based practices than with geographical populations. The potential exclusion of vulnerable groups will raise new questions about funding and access to healthcare for these groups. In the US, the health authority is the provider of last resort, a poorly resourced, minimal, public sector safety net. *The New NHS* suggests that further mergers of HAs to become leaner bodies may be required. Will these leaner bodies become the withered remnants of the NHS, providers of last resort, with only statutory functions and responsibility for the care of the most vulnerable people?

For PCGs that want to be independent there will be the primary care trust. It would employ all relevant community health staff and run community hospitals and other community facilities. The trusts

The *New NHS* white paper could signal a radical departure from universal public provision towards a privatised, fragmented healthcare market.¹ The white paper is a 'broth' made up of the privatisation policies of the previous Conservative administrations.^{2,3} On top of this come the basic structures of the US healthcare system: the health maintenance organisation and the hospital chain. Primary care groups are to replace GP fundholding, but GPs remain pivotal as gatekeepers to care and as the link between the private sector and patients and markets.

The structure and function of PCGs is not clear. Will they purchase care for practice populations or on behalf of the whole population? Will they provide comprehensive universal care or partial care? How will they generate income? Will they be able to enter into public-private partnerships and compete for patients?

In exchange for capped budgets, PCGs will enjoy greater autonomy over spending decisions, with the freedom to pool budgets for hospital and community health services with those for primary care. But this means PCGs will be – and will be seen to be – responsible for rationing care.

At present, those 'tough choices' fall to health authorities. Unlike HAs, PCGs would be able to generate income from the sale of private health-care insurance, patient payments, user charges and commercially sponsored capital investment. But this will mean a major departure from the founding principles of the NHS – equity and universality. The structure of the new PCGs is critically important, yet the white paper is confusing with its spec-

Key Points

- The white paper will move the NHS towards an insurance model where a capitated budget will be held by a single agency.

- Public accountability will be weakened by allowing primary care trusts and PFI hospitals to combine the planning and provision of services.

- Primary care groups could sound the death knell of equity, universal coverage and care free at the point of need in the NHS.

would hold resources for general medical services cash-limited allocations, hospital and community health services and prescribing.

Until 1991 the NHS separated planning from the provision of services, but primary care trusts and PCGs will continue the trend of the internal market, where trusts started to plan services independently of HAs. The white paper moves the NHS towards an insurance model where a capitated budget will be held by a single agency, the primary care trust or by trusts employing salaried GPs. Patients will access all their care through their GP.

The concept of the primary care trust is virtually the same as that of the American HMO, which combines insurance with provider functions. HMOs screen out and exclude those patients at greater risk and with lower ability to pay; they also compete for patients across the same geographical areas and load premiums against high-risk groups. Most HMOs are now for profit and floated on the stock market. Many are owned and managed by groups of doctors. HMOs have high patient turnover and lack needs assessment and service planning.

Although *The New NHS* prohibits mergers between NHS community and acute trusts ('vertical integration'), these restrictions would not apply to primary care trusts or the commercial sector. Primary care trusts, like their fundholder precursors, will be free to contract with private acute and community hospitals.

Vertical integration will occur by redefining the boundaries of care and developing loose networks of providers outside the NHS. Some GPs are already buying up 'surplus' NHS land and buildings, including community hospitals. Others are entering into private finance initiative agreements on their practice premises and other facilities. In these ways, primary care trusts could progressively destabilise local NHS services by shifting funds away from NHS providers into private care or their own privately owned settings.

PFI is the critical route through which private sector capital will gain access to the NHS market. It receives only one mention in the white paper. Under PFI, facilities are designed, built and operated by the private sector and leased back to the NHS. Of the first 18 PFI acute hospitals planned in England, four have been signed, tying up a large proportion of the HA's budget, which is ringfenced to the PFI hospital for the next 30 to 60 years.²

In these 18 areas, PCGs and HAs will be limited in their ability to manage risk or plan health services. Under these circumstances, the budgets for care could revert back to the HA or, more likely, PFI hospitals will seek to become insurers and providers in partnership with PCGs or trusts. Trusts will hold the contracts for clinical staff, the PFI consortia will hold the capitation. Unlike NHS hospitals, PFI hospitals have no restrictions on their commercial activities, nor are they prevented from vertical integration.³

Many of the members of the PFI consortia have well-developed community-based facilities such as nursing homes and residential care homes. PFI

hospitals, like primary care trusts, may be able to buy up surplus NHS assets being disposed of under HA financial disinvestment plans, or they may design, build and operate community and primary care centres to compete with NHS provision.

Partnership arrangements would allow clinical staff to be employed by trusts, but the ownership, control and management of clinical services would be undertaken by the private sector. HAs are unlikely to oppose such moves since their financial reserves are already seriously depleted by the escalating costs of PFI.

The government is open to extending PFI to

The white paper debate

'Primary care groups could be the unwitting executioners of the NHS'

mental health and community-based services, giving the private sector a way into every aspect of NHS delivery. PFI facilities are built by a consortia of bankers, builders and service operators. When the construction phase is complete the contracts will be sold on and, at this point, the large health-care insurers, pharmaceutical companies, hospital chains and the same HMOs that dominate the US marketplace will take their place.

Public accountability

The internal market has reduced the accountability of HAs by creating trust boards. Public accountability will be weakened further by allowing primary care trusts and PFI hospitals to combine the functions of planning and provision. By failing to define the structural nature and relationships of PCGs the white paper sacrifices the public health function, and the population focus hitherto exercised for the NHS by HAs is lost. In the US, HMOs and hospital chains combine both purchaser and provider functions, but as they have no responsibility for meeting the local population's needs there are no mechanisms for ensuring local accountability. Redress is only through protracted and laborious complaints procedures. Although it is intended that PCGs and primary care trusts will be accountable through their board to the HA, what will happen when their populations are not coterminous with the HA?

PCGs could be the unwitting executioners of the NHS, disposing of the central tenets of equity and universal coverage and NHS care free at the point of delivery. The white paper legislation must guarantee universal coverage, equity and local accountability. It must distinguish between NHS and privately funded care and provision.

It must also reverse the handicap imposed on the NHS by capital charges and lack of public sector investment. Policy needs to address the serious deficits in planning and information, but cannot do so until the structure of PCGs has been determined. Tough choices and bold policies are required to secure the future of the NHS. Can Labour afford not to make the right choices? ●

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