

## The partnership is dead! Long live the limited liability partnership!

TRADITIONAL partnerships are a pretty useless vehicle for delivering modern general practice. Who in their right minds would volunteer to accept unlimited 'joint and several liability' for any part of modern health care? And how many practices have not found, at one time or another, that the sharing of risk and reward that constitutes their partnership is causing them financial or emotional problems with all the stress that goes with it?

Help is at hand. Almost inadvertently the government has created a new legal form that has huge implications for general practice. In 2000 the Department of Trade and Industry placed a new entity — the UK limited liability partnership (LLP) on the statute book. The LLP is a new and, arguably, optimal legal vehicle for existing practices. It is also potentially suitable for many other enterprises — including some of the new service developments that may flow from alternative personal medical services and practice-based commissioning.

Unlike the traditional form of partnership that we all know and love, limited liability partnerships are, like a company, a 'body corporate', that is, they have a continuing legal existence independent of its members. This means that, unlike traditional partnerships, LLPs can themselves own property and enter into contracts in their own name, rather than through individual partners on behalf of the partnership. Moreover, also like a limited company, LLPs are indeed limited in liability: members cannot lose more than they put in.

And, er, that's it. Unlike a limited company, there is no requirement to have a memorandum of incorporation, articles of association, shareholders' agreement or any of the other legal paraphernalia necessary to manage the relationship between shareholders and the rest of the world, particularly the shareholders' agents, the directors.

There isn't a requirement for an LLP agreement even to be in writing between members, because simple regulations based on partnership principles apply by way of default. However, it goes without saying that taking this route requires a great deal of trust and is not recommended. If you want to, you can legally register your new LLP by filling out the form on the Companies House website and paying the princely sum of £95.

As for the thorny question of taxation, as far as the Inland Revenue is concerned, the LLP is a partnership — so for GPs it's business as usual.

There are two particular properties of the LLP that should be of interest to GPs:

- anyone — not just investors — may become a member of the partnership,

- it introduces the potential for a simple, but radical, new financing option capable of revolutionising the health service.

It is, of course, possible for a practice to simply reconstitute as an LLP and enter into similar contracts with all other stakeholders to the ones they already have, for example, contracts of employment, or contracts with primary care trusts (PCTs). Alternatively, rather than have staff 'outside the box', it would be possible to extend the LLP to individual staff members, or to separately constituted cooperatives (possibly constituted as LLPs themselves) serving multiple practices across a variety of administrative disciplines. More radical still, the LLP could be open to admit to membership 'cooperative' associations of patients.

Important although the above possibilities are, they pale into insignificance compared with the potential of a new financial model based on a revenue-sharing 'capital partnership'. And here things do get a bit complicated ... but bear with it because it's worthwhile getting your head round this, especially if you are involved with raising capital or have negative equity premises.

A limited liability capital partnership involves an investor (such as a pension fund) putting money into the practice, (or more likely into the capital assets, such as buildings and equipment). In return, instead of interest, the investor receives a 'capital rental' consisting of an agreed proportional share of the practice revenues. Thus, the investor's return varies with the performance of the practice and is completely independent of the interest rate. Unlike a bank loan secured on a capital asset, the investor's interest is aligned with those of the practice — both want the business to do well.

Let us take a hypothetical example: Bloggton Road Practice wishes to upgrade its dilapidated premises. These are worth roughly £1 million but, unfortunately, the £1.2 million debt to the bank secured on it means that the practice is in negative equity. Worse than this, the practice is having difficulty recruiting new young members as a result and a vicious circle has set in, affecting the practice because although the NHS covers the interest on the loan, it does not cover any capital repayments.

The partners wonder if the local citizens, who really want the practice to continue, might want to invest; they devise the following structure:

The Bloggton Road Land Partnership is formed as an LLP and has two members: a community association (essentially as trustees), and Bloggton Road Practice LLP

(as occupiers of the land). A nominal peppercorn rent is payable for the land, which, therefore, enters community ownership while the occupiers have the right of occupation for as long as they pay the nominal rent. The result is essentially an indefinite form of right of property occupation, neither permanent (as with freehold) nor temporary (as with a lease or licence for a defined period).

Bloggton Road Practice LLP now enters into a capital partnership, raising £1.5 million, which pays off the bank, upgrades the buildings, and buys new much-needed equipment for the practice's enhanced services initiatives.

The capital raised is divided into 10 000 proportional 'shares' or partnership interests of £150 each. Some of these are sold to individual patients, some are bought by the partners and staff, some by local businesses, and some by members of a local church and a local mosque. All are acting partly out of self-interest — the practice is not going to go bust and the return on capital is not bad — and partly out of a genuine desire to ensure that local services remain viable. Each 'share' entitles the investor to one 10 000th of the agreed capital rental, and this is set initially at £5 per share. This constitutes a 3.33% return, costing the practice £50 000 initially and far less than the 7% (that is, £84 000 per annum) it receives under cost-rent for its original loan of £1.2 million.

Now for the alchemy. Say the capital rental of £50 000 constitutes 10% of the practice's £500 000 income from the NHS that year. The agreement with investors, therefore, entitles them to a 10 000th of 10% of the practice revenues for each share held; we see that the rate of return of 3.33% is not, therefore, either fixed or based upon Bank of England interest rate decisions (as with rental or mortgage loans), but may vary with the increase or decrease of revenues and, hence, the activity of the practice.

The Bloggton Rd LLP (that is, the GPs and any staff who had joined the LLP) would be able to buy back equity simply by paying amounts in excess of the capital rental to those who had bought the shares at £150 each. Repaying half the capital back to the community association shareholders would halve the revenue share that went to them from 10% of practice revenues to 5%.

Such proportional shares are a simple but radical new asset class, and one that the local mosque would undoubtedly be pleased to recommend to its members due to its Islamically sound basis — no debt or interest being involved. This asset class is ideal for pension investment, constituting, as it does, a secure revenue stream originating from government and backed by the property assets of practices.

The mechanism will work on any scale: from a doctor's practice to the channel tunnel; from the London Eye to new, fair,

equity release plans for property-rich and cash-poor pensioners.

For a practice, an LLP could be revolutionary. But why stop there? A group of practices could use an LLP to provide joint services or hold an indicative budget. They could 'rent' capital by agreeing to give an agreed percentage of the revenue stream delivered by the new services to the bank or investors. Or a PCT could enter into an LLP with practices to deliver, for example, an orthopaedic service in which there was no direct fee but, instead, savings were shared in agreed proportions between the PCT and the practice. Indeed PCTs themselves would arguably be better configured as LLPs instead of the complex and frequently conflict-ridden entities we currently see.

The LLP — like a partnership — is

inherently a cooperative model and, through the capital partnership, offers what the cooperative movement is pleased to call the cooperative advantage, that is, the freedom from paying returns to City investors who are interested only in a quick buck.

So there is an alternative to grinding your teeth with frustration at your partners, or worrying about the negative equity of the practice, or getting frustrated by the local improvement finance trust (LIFT) scheme and the seeming impossibility of ever building the new consulting room you desperately need. It may not sound the sexiest of topics, but perhaps a limited liability partnership really might be able to reach the parts that your ordinary partnership can't.

Chris Cook

## Unbundling the NHS

'Oh great! Yet more change! And the world's biggest IT programme for them to screw up. Just what we need!' Working as local clinical lead for the National Programme for IT (NPFIT), such comments are routine. For all the talk of clinical engagement it seems that the old NHS duchess ain't moving into gear yet, no matter how many fancy new IT cogs she gets. And, of course, it is easy to get engaged to the software when it's all dressed up in flimsy vapourware but, like any long-term relationship, making it work is about getting through the trouble and strife.

But I am an NPfIT enthusiast. Choose and Book may not be to your taste (although I think in a world of online holidays, and e-Bay we will wonder what all the fuss was about once it is up and running). But the Care Record Service (CRS) promises to integrate services across settings in a way that has huge benefits for patients and clinicians.

Initially hospitals and GP systems will communicate via the NHS Information Spine but, over time, all patient records, including primary care data, will be stored in a few large data warehouses. As GPs we will still look at this data set via a proprietary front end, supplied by EMIS, Torex, or whoever — but, in principle, primary and secondary care data within any region will form a single dataset.

At this point it becomes possible to unbundle the NHS. Providing a diabetic service to half a million people will no longer depend on the ability to access 10 000 paper records held in five different hospital basements. Consequently, it will be much easier for new providers to enter the market. If I can read what the pharmacist providing anticoagulation did this morning, and the results of the outpatient appointment this afternoon, then services no longer need to be provided by monolithic hospitals. Or by 10 000 small, under-capitalised general practices.

Instead of unpopular hospital closures, services will be unbundled: the A&E and trauma departments stay open to avoid a local political firestorm, Nuffield wins the contract to turn Out Patients into an integrated geriatric service, 70% of which is delivered in the community, and all other services are transferred up the road to St Elsewhere's.

The ability of CRS to unbundle the NHS will bring many changes. Joint ventures between practices, vertical integration of practices with secondary care, and alternative providers of GP services are all possible — many driven by the limited liability partnerships outlined in the adjoining article. The trick will be to seize these opportunities to bring a radically different version of primary care into being, one that combines high bioscience and community, but also retains the best of NHS values.

Paul Hodgkin