in community settings. Consultant colleagues will be employed by PBC consortia (or UnitedHealthcare next door) to deliver this improved, cheaper care. New forms of collegial relationship will emerge and over time all distinction between primary and secondary care could be lost.

Services will be delivered via organisations that look after >50 000 people. These will no doubt contain semi-autonomous units that are accessible to their populations and that represent the symbiotic endpoint of current general practices. Such symbionts may well retain their status as profit centres together with a large measure of independence. But they will willingly cede sovereignty to the larger organisations over many aspects of clinical care and management in order to access things that will protect them from the pressures of inadequate size and isolation.

Prime among these will be access to capital. Currently we are entwined in a love–hate relationship with PCTs whom, one way or another, we expect to provide for us. One side effect of this dysfunctional dependence is that we have become like anorexics in relation to capital — we look in the financial mirror and think we are reasonably well off when in reality we are, in terms of investment, grossly malnourished. Happily, new ways to raise capital and share financial risks using limited liability partnerships (LLPs) are emerging just in time.

Larger consortia will force us to develop new forms of governance. Newer legal vehicles, such as LLPs, are likely to offer competitive advantages — not least by offering ways to make the whole organisation transparent, flexible and fair to all staff groups. The more enlightened consortia will find that the highly skilled, multidisciplinary teams on which they depend can only be guaranteed by transparent and fair rules for sharing surpluses and deciding strategic direction. Large pay differentials will continue to exist in such organisations but nursing colleagues will no longer feel that they are an exploited and colonised tribe.

Thinking about the shape of 21st century medicine in the community is both inspiring and frightening. It moves us on from tired old debates and frees us to really think about how we might combine the latest medical advances with new ways of practicing medicine that provide world-class care for our patients. Along the way those old nags of 'GP' and 'consultant' will be put out to grass. In their place we will have a body of doctors who are great community diagnosticians, enthusiastic and skilled in delivery of advanced therapeutics and dedicated navigators of the complex archipelago of services and meanings that will face our patients. The Iron Curtain between primary and secondary care will have disappeared — and we will have reinvented ourselves. The new horse-less carriages will be multiprofessional organisations that can grasp the opportunities of high bioscience and late capitalism while preserving the best of 20th century general practice for our patients. Of course we may fail — but the real danger is that we are too addicted to our well-paid comfort zone to allow ourselves to be inspired.

Paul Hodgkin

Disclaimer

The views expressed here are entirely personal.

Neville Goodman

MONEY MATTERS

I have in front of me two newspaper articles. The headlines tell it all. Nick Cohen asked us to, 'Just imagine what the NHS could do with the £20bn wasted on sick IT.' (*Observer* 4 June, 2006). The *Guardian*'s health correspondents (13 June, 2006) wrote, 'Doctors fight to save drug guidance from government axe.' Cohen's story is not just of the runaway costs of the government's determination to bring in a comprehensively computerised NHS, but of the large amounts of money paid to management consultants. These are the people to whom our elected representatives turn for advice, to avoid asking anyone who knows about the subject. They charge enormous fees, add on enormous expenses, and suggest systems that don't work. I have only Cohen's word for it, but '26-year-olds can charge an NHS trust £3000 a day for their services'.

Unlike *Drug and Therapeutics Bulletin*, the *Guardian*'s subject, the IT programme does not strike as good value for money. Anyone familiar with even small computer programs knows that it's best to go for simplicity. When you have as many different institutions needing to use the systems as the NHS has, the best bet would be a core with easily followed specifications, so that locally sourced programs could interlink with it.

Set against the IT costs, £1.4m providing a paper copy and online access to the *DTB* for all doctors is negligible. It is impossible not to think that the *DTB*'s stance on, for example, drugs for multiple sclerosis and dementias, upset someone, a someone with a lever on the Department of Health. The *DTB* did not need to pull any punches, so the DoH has decided to stop it punching. NICE does not render all other medical advice redundant. NICE has too many problems with political direction (even if not interference), lobby groups, and Big Pharma. There have been times when NICE has been 'privately furious' with ministers but, as Professor Joe Collier — who was editor of the *DTB* for a long time — pointed out, that is dishonest. And to weigh against *DTB*'s £1.4m, Big Pharma spend £33bn persuading us which drugs to use. Although it wouldn't have to be so much, a drug company spokesman explained, if they were able to advertise directly to patients. The word for this is 'chutzpah', witness another *Guardian* headline (26 June, 2006): 'Kickbacks, cartels and chatrooms: how unscrupulous drug firms woo the public'.

But Patrician Hewitt has more important things on her mind: she has to explain how selling off the commissioning work of the PCTs to BUPA and friends is not privatisation.