Specified food allergens covered by the new European Union directive

- Cereals containing gluten
- Crustaceans
- Eggs
- Fish
- Peanuts
- Soya beans
- Milk
- Nuts
- Celery
- Mustard
- Sesame seeds
- Sulphur dioxide and sulphates

most severe anaphylactic reactions to food occur when eating out in restaurants and cafes.[10] Vulnerable people are left with one of two options—either to take the risk of asking about the ingredients of food and trusting in the advice of catering staff, many of whom will have not received any training in the dangers of food allergies, or to curtail or completely avoid eating out. The European Union should adopt the same requirements as Australasia, where all food suppliers have to make available to consumers detailed information on ingredients on the packaging, or on a display alongside the food, or to the purchaser on request.[6]

Furthermore, this EU legislation will do nothing about the highly frustrating general warning "may contain traces of nuts."[11] To protect people with food allergies effectively, production lines for the main allergens should be separated completely from other production lines in factories and other settings for processing and packaging food products. In the meantime, food suppliers should provide consumers with a much clearer idea of the likelihood of trace exposure to nuts and other products.

Policy makers, legislators, and food suppliers need to appreciate that neither underplaying nor overplaying the risks of exposure to allergenic foods are helpful for those living with what is often a highly debilitating lifelong condition. People with food allergies need accurate, clear, and easily understood information to make truly informed choices and to live with and control their condition with a sense of confidence.

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We thank Sue Clarke and David Reading of the Anaphylaxis Campaign for helpful discussions on this subject.

Competing interests: AS has family members with serious food allergies and serves on the Scottish Executive's Review of Allergy Services in Scotland Working Group. CA has no competing interests.

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Primary care trusts: do they have a future?

Yes as guardians of public sector commissioning; no as service providers

Primary care trusts (PCTs) are the local statutory organisations in the English NHS responsible for improving public health, providing primary health care, and commissioning secondary and tertiary care services for populations of around 250 000 people. When created in 2002 primary care trusts were intended to become powerful local purchasing agencies, rooted in primary care, and well placed to integrate primary health care, community services, and hospital care.[1] In the international context, one of the most notable features of primary care trusts has been the continuing belief by NHS policy makers in England in the value of integrating the purchasing of health care with the delivery of primary care. However, over the past year or more the view that primary care trusts are failing to "punch their weight" in the health system has gained currency, in particular in relation to their supposed inability to achieve strategic change in secondary care.[2–4]

This has led to renewed interest in strengthening the commissioning function in the NHS. The assumption is that there will be fewer primary care trusts and that these will concentrate on funding and contracting for primary care, supporting the purchasing of other services led by practice based commissioners, and divesting themselves of their provider responsibilities such as community nursing and health visiting.[5] This is driven partly by the perception of the trusts' "failure" as commissioners. But it is arguably driven more so by policy makers' encouragement of a greater range of providers of primary care beyond traditional NHS general practice[6] and the planned roll out of practice based commissioning (a scheme whereby practices are delegated a purchasing budget for their enrolled population) to all general practices in England by the end of 2006.[5]

See *News* p 1164

The recent encouragement of a more plural primary care market, where patients can choose to enrol with or use a greater range of providers as well as conventional general practices, arguably represents the strongest reason for a change to primary care trusts. Practice based commissioning challenges their com-

BMJ 2005;331:1156–7

missioning role, and the development of a market in primary care threatens their constitutional integrity. As long as primary care was almost entirely provided by practices owned by general practitioners operating to a national NHS contract, the conflict of interest inherent in having the commissioning function run by bodies dominated by NHS general practitioners was manageable, justifiable, and arguably a strength. The development of a market in primary care provision requires that ultimate responsibility for local commissioning should be undertaken by a body entirely separate from all providers. Despite an apparent backtracking by policy makers about the need to remove provider functions from primary care trusts, it is hard to justify them having a continuing provider role in what is clearly a primary care market.

However, the reintroduction of general practitioner budget holding (in the guise of practice based commissioning) appears to contradict this since it is intended to increase general practitioners' engagement in the purchasing of services, facilitate a further shift of care from acute to community settings, and provide a demand management counterweight to the power of the new, more autonomous foundation hospitals.[7] Primary care trusts have to determine which practices can take devolved purchasing responsibility—and ensure that all practices are engaged in some commissioning by the end of 2006.[5] Primary care trusts also have to find resources for new forms of management, information, and analytical support for local practice based commissioning.

A more pluralist yet still publicly financed health system calls for stronger market development, management, and regulation. While some elements of these functions will fall to national bodies regulating healthcare standards, patient safety, and levels of access to and choice of care, a local body (with a more appropriate name) is still needed to act as both the local "brain" in the system and its "conscience." As brain it needs to determine public health priorities, overall resource allocation, and service design across primary and secondary care; as its conscience it needs to assure service quality, manage and oversee contracting on behalf of practice based commissioners, govern conflicts of interest, secure public involvement, and assure probity in the use of public funds.

Recently, it has been argued that non-NHS bodies should be eligible to become commissioners of NHS care.[8] In a publicly funded system, however, it seems reasonable to assert that the brain and conscience should be a public body, particularly in a mixed economy of providers. That is not to say that elements of commissioning cannot be contracted out to actuaries, contracting specialists, and disease management plans, and that some commissioning could be delegated to private providers of primary care, but rather that ultimate accountability for use of public funds should remain with a public body.

So do PCTs have a future role? The answer is unequivocally yes in relation to the need for stronger strategic purchasers and governors of local health systems as detailed commissioning decisions pass to practices and perhaps in time to their private sector competitors as well. But, as the primary care system becomes increasingly diverse, they should no longer be service providers. This leaves unresolved the question of where current community health services such as community nursing and public health will be relocated, a conundrum that would seem to be yet another unintended consequence of a policy shift towards a more plural primary care market.

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The private health sector in India

Is burgeoning, but at the cost of public health care

Foreigners in increasing numbers are now coming to India for private health care. They come from the Middle East, Africa, Pakistan, and Bangladesh, for complex paediatric cardiac surgery or liver transplants—procedures that are not done in their home countries. They also come from the United Kingdom, Europe, and North America for quick, efficient, and cheap coronary bypasses or orthopaedic procedures. A shoulder operation in the UK would cost £10 000 ($17 460; €14 560) done privately or entail several months' wait under the NHS. In India, the same operation can be done for £1700 and within 10 days of a first email contact.[1]

The recent remarkable growth of the private health sector in India has come at a time when public spending on health care at 0.9% of gross domestic product (GDP) is among the lowest in the world and ahead of only five countries—Burundi, Myanmar, Pakistan,

BMJ 2005;331:1157–8