BRIEFING NOTE

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PRIVATE FINANACE INITIATIVE IN THE NHS : AN UPDATE

In 1994, the Health Policy and Economic Research Unit prepared a paper on the use of private capital in the NHS. Since then, some privately funded schemes have been completed and many more are planned. Meanwhile, the scope of the government's private finance initiative has been extended further into NHS services. Comment from policy experts, the media and the public has ranged from an acceptance of the need for alternative finance to concern over its implications.

The following paper will provide an update on the use of private capital, its background and framework, and the numbers and scale of projects within the NHS. Main topics covered will be the private finance initiative and the involvement of private sector providers in the contracting process. Criticisms and concerns over the effects of private finance are also considered.

The private finance initiative

The Government introduced the 'private finance initiative' (PFI) in autumn 1992 as part of a move to encourage private companies to fund and/or manage projects which would previously have been financed and run directly by the public sector. It was envisaged that these would be projects in many sectors of state provision, including health. The Government's main stated aims in recommending PFI were to improve cost effectiveness and reduce the risk born by the public sector in capital projects.

The Treasury's Ryrie rules were altered to allow much greater use of private finance. Public bodies were allowed to use a higher level of private capital (up to £10 million) without necessarily obtaining central approval. Since November 1993, trusts and health authorities have been expected to consider private sector alternatives in capital projects. In June 1994, a database was set up to match private companies and NHS projects by the firm Newchurch and Company. NHSE issued the *Capital Investment Manual,* which made it clear that private finance options must be considered first.

Four further guidance notes from the NHSE have followed in 1995, including two on market-testing[1] [2] and one on PFI and capital investment projects[3]. These emphasize that PFI options must be rigorously explored before any request for public funding can be made. The process of

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1 Market Testing for Healthcare Services - A Guide for Purchasers. EL(95)28, NHSE, 1995.

2 Marketing Testing in the NHS. EL(95)29, NHSE, 1995.

3 Private Finance and Capital Investment Projects. HSG(95)15, NHSE, 1995.

completing a PFI contract is complex and lengthy, but ministers claim capital projects will still be completed more quickly. The most recent guidance note is on post-project evaluation, which must be carried out for projects costing over £1 million, and planned for before the tendering process[4].

The initiative received a further boost in November 1995 with the launch of the Treasury Private Finance Panel's report "Private Opportunity, Public Benefit"[5] and in the budget, which made clear the Treasury's expectations that a significant proportion of public sector capital projects must be financed in future through the PFI.

Development of PFI schemes

In spite of concerns over whether the NHS could commit to purchasing services to a sufficient extent to attract investment, and whether acceptable agreements could be reached on risk sharing, private capital has been involved in several schemes and interest has been expressed in many more.

By July 1995 324 private organisations and 400 NHS trusts or commissioning agencies were registered on the Newchurch database. 133 projects were completed or close to completion, and a further 800 projects had been identified as suitable PFI schemes, representing £2 billion in costs[6]. In November 1995, 44 NHS schemes with a value of £1 million each had been approved with a total capital value of £166 million. A number of other schemes of under £1 million had received approval locally[7].

Some schemes involve mixed funding, some the leasing of NHS land, whilst others involve design, building, financing and operation by the private sector (DBFO). Forward sale of NHS land is also possible with Treasury approval. Examples of large schemes include:

- Mid-Sussex NHS Trust with private sector - MRI scanning (mostly private capital, company rents site and offers Trust preferential fees and profit-sharing)
- William Harvey Hospital, Kent - waste incineration plant serving 9 NHS Trusts (DBFO)[8]

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4 Capital Investment - Post Project Evaluation. EL(95)102, NHSE, 1995.

5 Private Opportunity, Public Benefit - Progressing the Private Finance Initiative. H M Treasury, 1995.

6 Testing Private Finance in the NHS. Paul Nash and Kingsley Manning of Newchurch and Co. British Journal of Healthcare Management, 1995. Vol 1, No 9, 21 July 1995.

7 First Major Private Finance Initiative Scheme Approved. DoH Press Release, 95/557.

8 Laing's Review of Private Healthcare, 1995.

The importance of the PFI to the future funding of NHS was stressed in the November 1995 budget, in which the Chancellor announced that although the NHS budget would increase by £1.3 billion, government spending on the health service capital programme would fall by 16.9%, with the expectation some of the shortfall would by met through obtaining funding from private sources. In practice this will mean that the NHS will be expected to obtain £165 million worth of funding from the private sector in 1996-7, and a total of £700 million over three years.

The current Secretary of State for Health is also committed to the development of the PFI in the NHS and in November 1995 announced the first private sector funded hospital building scheme with the approval of a contract for £35 million for the redevelopment of the South Buckinghamshire NHS Trust. The trust will lease the buildings from the contract consortium, who will be responsible for maintaining them.

The private sector has, in the past, been sceptical about involvement in providing more mainstream facilities such as hospital building projects, for reasons already outlined and some of this scepticism remains. However it appears likely that further large hospital building projects will be approved in the next six months, including a £90 million rebuilding of the Swindon and Marlborough NHS trust facilities, a £140 million hospital building project at the Norwich and Norfolk trust and a £70 million scheme at North Durham trust[9]. The buildings will be owned by private companies but sited on NHS land, and leased back to the NHS with support services provided privately.

In a recent speech[10], the Secretary of State for Health stressed that in such projects there would remain a distinction between privately owned support services and clinical services. Trusts would continue to be the direct employer of clinical staff *in the overwhelming majority of cases.* The speech acknowledged that some trusts had explored local arrangements for private sector provision of some clinical services, however, such arrangements were nothing to do with the PFI.

This is not the case in Scotland. The successful bidder for the Stonehaven project will be expected either to provide the specialist input into the new hospital in the fields of urology, ophthalmology, dermatology, audiology, diabetes, leg ulcers, back pain, ante natal care and gynaecology or to make arrangements with NHS trusts to continue and extend existing provision. Nurses, other professional posts and support staff will be employed by the successful bidder[11]. Eight expressions of interest from NHS Trusts and seven from private providers have been received. The outcome of the tendering process will be announced in May 1996.

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9 Health Service Journal. 30 November 1995.

10 Speech to Royal College of Physicians. 21 November 1995.

11 Grampian Health Board. Hospital Provision in Kincardine. Background notes. 1995.

Contracting with the private sector

The NHS continues to purchase healthcare services from the private sector, but the relationship is complicated as services may be purchased through the contracting process by health authorities and fundholders or by trusts and health authorities through market testing.

The perception of private companies remains that the NHS is not able to enter into long-term commitments to purchase, and therefore the private sector is unlikely to make large investments involving any substantial transfer of risk. Lengthy contracts, however, reduce competition, particularly if the need for commitment is pointed out by a private provider in their outline proposal or tender. These problems have not dissuaded some companies from forming consortia in order to bid for NHS contracts, including McAlpine Healthcare and Tarmac Health Estates. Furthermore, some long term contracts have been agreed for clinical services, such as a 7 year contract for pathology services in North Hertfordshire.

The private sector's ambivalent relationship with the NHS is increased by the competition posed by NHS paybed units. There are also limitations to the development of independent hospitals because increased day surgery reduces the need for beds. Laing's 1995 Review of Private Healthcare estimates NHS purchases from independent hospitals in 1994 as £45 million, only a small percentage of the total market.

Concerns and criticisms

The cost of using private finance in capital investment schemes must ultimately be greater in terms of interest charges (i.e. public capital is cheaper), but it is difficult to compare this cost with that of waiting for desperately needed facilities when public money is not forthcoming. The financial pitfalls of private/public partnerships have been demonstrated by the £300,000 losses of the incinerator built and run by the Royal National Orthopaedic Hospital and Motherwell Bridge Environtech in Stanmore, Middlesex. Closing it down will involve further losses of £3.5 million[12].

The ultimate savings (if any) to the public purse cannot yet be evaluated. Also, the principle of involving private finanace in the NHS is not new - for example - the provision of loans for GP practice premises. Of more pressing concern are the principles which may be at stake in the NHS. A report from the Association of Community Health Councils of England and Wales in August 1995 outlined many of these and gave examples of problems encountered around the country[13]. At the same time, they noted that many of these schemes could not have taken place in the foreseeable future without private capital, since there is no indication of how long it would be before public money becomes available.

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12 NHS Trust Deal Lost £3.5 million. David Brindle. The Guardian, 6 October 1995.

13 Private Finance and Public Health. Association of Community Health Councils in England and Wales (ACHCEW), 1995.

One of the major practical problems are the delays due to the contracting process and the expense of tendering. In the Prison Service, secure units for mentally ill offenders have been delayed in Oxfordshire and West Berkshire (ibid). In Swindon, a new women's and children's hospital had been planned for over a decade, but when Treasury approval was finally received, implementation was delayed again due to PFI. The process is further lengthened and complicated by the application of EC procurement rules to PFI projects.

The government's argument is that tendering costs and delays are outweighed by efficiency savings. It is all but impossible to make a fair and accurate comparison of the cost of NHS and private provision. The independent sector argue that the NHS does not include the cost of overheads in assessing the profits from paybeds, for example. At the same time, the private sector has not yet had to make any contribution to the NHS for the cost of training clinical staff.

The impact of the PFI must be seen in the wider context of other aspects of the involvement of private sector provision in the NHS, including contracting directly for health care and the market testing of services. Although it has been stressed that the PFI in itself will not result in the employment of clinicians by private companies, it forms part of an environment which encourages a diversity of non-NHS suppliers, some of whom will be supplying clinical services, whose main motive has to be profitability. Of particular concern is that a profit-making company may be tempted to cut costs by reducing the quality of the service. There may also be financial pressure on clinical decisions, leading to ethical problems for clinicians and to a reduction in the choices patients can make about treatments. There is also a likely human cost where privately employed staff have lower wages and poorer terms and conditions, affecting morale and reducing commitment. Such staff may also be more likely to have 'gagging' clauses in their contracts, preventing them from speaking out about low standards of care.

This last point leads on to the principle which is the greatest instinctive objection to private finance. Private sector involvement in the NHS is bound to affect its ethos. Indeed, it is arguable that it will no longer be the *National* Health Service, but a fragmented and competitive market. Private companies making a considerable capital investment will expect some element of control, perhaps to the extent of the appointment of Trust managers[14].

Equity of access and quality of care may also suffer. Criticism from many sections of the media have reflected public fears about the implications of privately run NHS services. The PFI has been described as 'an instrument of systematic inequality', as those parts of the service owned by private companies will attempt to increase revenue and lower costs by seeking out private patients and catering for fundholding GPs with the largest budgets, threatening the care of others[15]. Cost cutting may also be attempted by shifting costs out of hospitals and avoiding expensive patients/treatment. Any charges, even for 'additional' services, may deter patients from using services[16].

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14 Profiting from the NHS. Chris Ham. British Medical Journal, 18 February 1995.

15 Will Hutton. The Guardian, 5 June 1995.

16 ACHCEW (op lit).

It may be difficult for health authorities to obtain quality control information from private providers. Public fears already suggest that goodwill towards the NHS may be undermined even if quality and equity are maintained, since staff will not be seen as having the altruism or dedication of NHS employees.

The Labour Party has not ruled out the continuation of PFI should they come into office, but have been strongly critical of many aspects. Meanwhile, the more private investment and involvement, the more dependent the NHS becomes on private provision. Where the private sector owns a building or equipment there will be no publicly owned facilities when a PFI contract comes to an end.

Future developments

The private sector expects that purchasers will have to become more involved and has welcomed the change in the Treasury's language from 'transferring' risk, to 'sharing' risk[17]. The recent Health Service Guidelines also stress purchaser involvement. For example, Trusts may make a PFI proposal, and the purchaser may decide to market test the private sector directly (ibid).

As already noted, under current government policy, the PFI seems set to continue and to accelerate the growth and completion of schemes. The amount of capital to be made available to the NHS has been reduced to encourage this acceleration, but doubts have already been expressed[18] about whether the private sector will be willing or able to make up the shortfall in NHS expenditure.

Where PFI funded hospitals are planned, private finance will be involved in every aspect of NHS healthcare including in some cases the supply of medical practitioners. Much will depend on the success or otherwise of these schemes, their public reception, and their value for money over the long term.

Finally, the willingness of the private sector to become involved in a new building project will increasingly influence whether that project goes ahead or not. This raises the prospect of the siting of hospitals in the future and type of provision being determined by commercial considerations rather than planned on the basis of local health need. The likely future impact of the PFI on the future shape of hospital provision in the UK cannot be ignored.

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17 Laing's Review of Private Healthcare, 1995.

18 For Better or Worse. John Appleby. Budget Special - Health Service Journal, 1995.