Private Finance in Health Care: Why Not

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Foreword

The NHS is woefully in need of investment in capital development. The quality of local hospitals and health care facilities is always a source of pride or criticism to the people they serve.

Why do we not welcome any system that allows much needed development?
A Trust Chief Executive I have spoken to has likened the Private Finance Initiative to the domestic property market. If, when you visit an estate agent with the intention of moving up market to a house more suited to your current needs, you are told that it is a better idea to rent a smaller house because the rental company would look after all maintenance (including laundry!), what would you think? If you are then told that the contract has to last for thirty years and that any alterations would attract financial penalties and, by the way, at the end of the contract, you would have nothing, I suspect that you would not be attracted to the deal!

The NHSCA has opposed the PFI since it was proposed under a previous Tory Government. The current Government has made some welcome and necessary amendments but our opposition remains. There is an ideological basis for this in that we believe a tax-funded service should not irrevocably tie up its finances in the private sector. But our concerns go deeper. We believe that the PFI poses a major threat to the ability of the NHS to provide the sort of comprehensive care that the people of the UK expect and deserve.

I urge you to read this document, prepared by Ben Griffith, in which he details the history and thoughts behind the PFI and puts them under scrutiny. I believe that, when you have read it, you will think again if you are a supporter of the PFI, and if you are not, will have gained much valuable information to help you challenge it.

Guy Routh

Chairman
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March 2000

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Contents

Acknowledgements 2

Introduction 3

The policy context 4

What is the PFI? 6

The loss of hospital beds 8

Cost-effectiveness and all that 12
- Is the PFI project affordable for the Trust? 13
- Is the PFI project cost-effective for the NHS as a whole? 15
- What is "risk transfer" all about? 17
- Do the procedures really get the right result? 21
- Is there more to say? 23

Distortion of development 27

Accountability 29

Public services, private owners 32
- Profits, markets and multinationals 32
- The great divide – or doctors and nurses next in line? 34
- Fears, principles and dinosaurs 35

Private finance in primary care 38

So why the PFI? 40

Alternatives 42

Conclusion 45

References 48

Published by NHS Consultants Association, March 2000

Acknowledgements

This report draws heavily on the research reported in a series of publications by Allyson Pollock and colleagues.

Thanks are due to Peter Draper, Peter Fisher, Declan Gaffney, John Griffith, David Player and Guy Routh for their comments on earlier drafts of this report.

Ben Griffith, March 2000

Introduction

The Labour Government boasts of the scale of the current investment in NHS hospitals. By 1999, 35 major hospital developments were under way in the NHS, 30 of them through the Private Finance Initiative.[1]

New NHS services are welcome. But why should they involve private companies owning and managing hospitals in the NHS? Why should they be paid for out of the revenue budget of the Health Service for the next thirty years or so? Why should we pay more for hospitals which include fewer beds than the hospitals they replace? Why is New Labour pursuing a policy introduced by the Tories to drive the profit motive into the heart of the NHS?

The policy context

Let us not forget the Right's hostility to the NHS. According to classical micro-economics, efficiency demands markets, charges and the profit motive. The NHS has kept its distance from all three and therefore must be inefficient. What is more, the NHS is paid for out of taxes and taxes should be reduced (especially those paid by the rich) to promote incentives and deepen freedom. Also, with freedom goes responsibility and people who can afford to go private should stop being an unnecessary burden on the taxpayer. Finally, the NHS is a successful socialist institution: it provides largely effective, competent and caring services which, compared to the known alternatives, are both cheap and equitable. It has earned the affection, respect and trust of the British people.

The Tories, of course, opposed the creation of the NHS and they have repeatedly toyed with the idea of dismantling it. Under Margaret Thatcher, an investigation into alternative financing for health care was set up by Patrick Jenkin, the Secretary of State, but stood down by his successor Norman Fowler. A Think Tank report on radical options to cut spending was considered but rejected by the Cabinet. "When the voices were collected she said, in what one Minister called a petulant huff, 'All right then, shelve it'."[2] There were two main obstacles to fundamental change – financial (all the known alternatives to the NHS were more expensive) and political (the Tories liked winning elections).

So a piecemeal approach to the NHS was taken. The private sector was encouraged through a range of policies including changes to consultants' NHS contracts and the withdrawal of the NHS from dental and ophthalmic services and from long-stay care. Hospitals were forced to put their "ancillary" services out to competitive tender and to bring in private companies when savings would result. General managers were brought in to clarify who was in charge and, in effect, to tackle problems associated with professional domination.

By 1987, following years of financial stringency, the NHS appeared to be at crisis point. On 25 January 1988 Margaret Thatcher announced her third fundamental review, which led to the purchaser/provider split in the NHS. Hospitals were hived off to NHS Trusts which had to strike contracts with health authorities and GP fundholders. The market was supposedly "internal" in that the hospitals were not being sold off. The NHS Act of 1990 however made a distinction, little noticed at the time, between those Trusts which would be responsible "for the ownership and management of hospitals" and those which would "provide and manage hospitals" but not own them.

While the internal market was a significant advance for the Right, the reforms still failed to bring the profit motive into the core of the NHS. In 1992, therefore,

came the next step: new hospitals would be owned and managed by private companies under the Private Finance Initiative.

Daniel Finkelstein, Director of the Social Market Foundation:

"The aim of the supply side reformers, for whom the PFI represents a major advance, is to disassociate the state from its role as a provider of services for which it is ill-suited, so it can concentrate on being a guarantor of public services for which it is uniquely suited".[3]

Barry Legg (former Conservative MP):

"PFI taken to its logical conclusion is a much more radical challenge to notions of Government activity than earlier economic reforms. Privatisation was a hiving-off of certain peripheral state activities, in essence stopping the extension of the public sector. PFI's potential is greater in that it could dramatically alter public sector ethos and management at its core. The injection of private finance, expertise and management in this area in time will strip the term public sector of any meaningful content since the Government will merely be hiring private agencies to fulfil tasks formerly done by state employees."[4]

What is the PFI?

Before the Private Finance Initiative, public projects were financed by the Treasury, with an impact on the Public Sector Borrowing Requirement. A health authority submitted a proposal for a hospital. If approved, a detailed specification was drawn up with builders appointed and paid through capital allocations separate from the revenue budget available to the health authority to purchase health services.

Under the PFI, however, "DBFO" applies: a consortium of companies Designs, Builds, Finances and Operates the hospital. Designing involves meeting a specification drawn up by the NHS Trust in question, but in very general terms compared to traditional briefs. Building is as it sounds. Financing means working with banks and other financial institutions to obtain loans to allow the development to go ahead (with the interest being paid in the first instance by the consortium). Operating means that some aspects of hospital (not including employing doctors, nurses and other health care professionals) are managed by companies in the consortium for the term of the contract: thirty years or so. It will be a consortium because Designing, Building, Financing and Operating hospitals are very different skills. Companies therefore come together and create a "Special Purpose Vehicle company" which, if successful, holds the contract with the Trust. The financiers may sit outside the consortium.

Instead of being financed by a capital allocation, a PFI project is paid for by regular fees funded out of the revenue budget of the hospital Trust, in addition to sites being transferred to the consortium or sold off as surplus to requirements. The fees consist of an "availability payment" for use of the hospital and a "service charge" for the various services provided by the consortium. The consortium needs a long-term contract to refund the costs of capital construction and associated interest payments and returns to shareholders.

This arrangement is supposedly designed to fund developments more cost-effectively than would otherwise be the case. It is assumed that private companies are more imaginative and ruthless than public sector bodies. An underlying idea of the PFI is that by bringing the capital development and running costs together under one consortium, the companies will have incentives to find the most efficient ways of combining capital and labour (at labour's expense, naturally). In the NHS, however, the consortia are constrained by the exclusion of the clinical staff who account for a large element of a hospital's running costs. Also, efficiency is supposedly achieved through "risk transfer" meaning that, where appropriate, costs resulting from things not going according to plan should be met by the PFI consortium.

The steps in a PFI development are as follows. The Trust is initially obliged (due to a Labour Government reform) to draw up a Strategic Outline Case which must be approved by the Department of Health. An Outline Business Case is then drawn up, giving a broad view of what is wanted. Companies are invited to bid for the work and other documentary material is made available to the bidders. Favoured consortia are identified and they negotiate with the Trust. The most apparently advantageous proposal is then set out in a Full Business Case (which includes a Public Sector Comparator (PSC) which must appear to be less cost-effective than the PFI proposal). Given approval, the development can start.

Services which may be provided by the PFI consortia.[5]

Grounds and gardens maintenance
Property and building maintenance
Equipment maintenance
Domestic services
Catering
Laundry
Waste disposal
Pest control
Portering
Security
Non-emergency patient transport
Courier services
Information management and technology
Financial services
Car parking
Telecommunications
Sterile supply services
Stores
Reception
Postal services
Residential accommodation
Energy and utilities

The loss of hospital beds

Finally, in February 2000, the Government accepted what had been blindingly obvious to everyone else for years. In publishing the report of its National Beds Inquiry – albeit only for consultation – the Health Secretary acknowledged that the NHS needs more beds. The report suggests that continuing the trend of the last thirty years or more of reductions in hospital bed numbers would not keep pace with the need for care.

Alan Milburn, Secretary of State for Health:

"The Beds Inquiry suggests that the trend of the last decade or more of reductions in hospital bed numbers cannot keep pace with changing needs, additional activity and the new services that we envisage for the NHS. We have to make sure that, in the future, we get the right number of the right sort of beds in the right places...Modernisation, as the Inquiry shows, means expanding NHS services and it means changing them too – so they're better able to meet the needs of patients."[6]

By contrast, PFI projects have involved a significant reduction in the number of beds available to treat NHS patients. For 12 PFI projects studied by Gaffney and Pollock, the reduction in beds varied from 7 per cent to 44 per cent with an average cut of 32 per cent.[7]

These reductions have been defended largely on the basis of assumptions about the scope to increase the number of patients treated per bed by reducing the length of time they stay in hospital and by increasing the percentage of beds occupied at any one time. But the rise in emergency admissions suggests that changes in health care provision, and in the root causes of ill-health, are posing real challenges to NHS planners wishing to close hospitals. Some policy initiatives - such as relying on day treatment for minor surgical cases, or on community care for people with mental health problems, or on primary care and social services for people with ongoing conditions - may have come to, or be near, the end of their usefulness, at least without significant investment in new services outside hospitals.

In any case, shorter stays are likely to be achieved by patients being discharged in poorer health than would otherwise be the case, leading in some cases to problems with pain relief or readmission due to complications. Generally, earlier discharge shifts the costs of recuperation and caring onto patients' carers or the budgets of community health services or social services.

Increasing the occupancy rates sounds sensible. However, the number of patients needing to be admitted on an emergency basis fluctuates. Very high

occupancy levels reduce hospitals' flexibility and their ability to cope with a surge of admissions. This leads to long stays in A&E (especially during cold spells and flu epidemics) and cancellations of non-urgent operations which can be extremely distressing to the patients concerned but, it would appear, of little interest to NHS planners.

It is also argued that reductions in admissions will result from the development of more local services outside the hospital, often associated with the "primary care led NHS". This argument may not always be supported by the identification of pots of money to pay for the new services. Or the pots are mysteriously found to be empty after the hospital beds have been closed.

Also, it is a basic axiom of health economics that the supply of services itself creates the demand for them. Conversely, GPs may become less likely to refer patients to hospital consultants if there are no hospital beds available. It is likely that this theory encourages the moves to impose massive cuts in the capacity of NHS hospitals. The axiom is not daft, but does ignore the fact that an untreated illness is no less serious when there are no hospitals around.

Declan Gaffney and Dr Allyson Pollock:

"Bizarrely, trusts and health authorities see these cuts in bed numbers as a way of responding to the consistent rises in hospital admissions over the last ten years. In particular, health authorities are worried about rises in emergency admissions, which have soared in recent years as elective services have been cut back. Increasingly, they are buying the message, zealously promulgated by private sector advisers, that their problems in meeting caseload are the result of having ***too many*** *beds: the best way to reduce emergency admissions it seems is to make sure that when people turn up there's no bed for them, so they can't be admitted!"*[8]

Nigel Edwards, Director of the London Health Economics Consortium:

"It may be time for a radical rethink of the approach. The service cannot simply continue to reduce elective work and make acute services work ever faster. I believe that, in some circumstances, the best approach to reducing demand for emergency admissions and expenditure may be closing beds."[9]

Defenders of the PFI argue that this scale of bed losses would have been no different if the developments had been funded by public borrowing in the normal way. It is quite true that much of the pressure for cutting capacity has come from

the NHS Executive. Under procedures put in place by Labour, a decision on the number of beds needed locally must now be made before choosing between the PFI or a public sector procurement route.[10] No doubt the PFI consortia would be happy to develop bigger hospitals if the price was right. But equally, the bed reductions are obviously driven by cost (as opposed to, say, the needs of ill people). For a PFI project, the costs **are** high – so the bed numbers must be kept low – because of the need to pay off the shareholders and the bankers. In some cases, such as developments in Worcester, Swindon and Bromley, bed numbers have gone down in the course of procurement as a result of PFI proposals proving not to be "affordable".[11] For the Public Sector Comparator, the costs **appear** high – again, requiring bed closures – due to an arbitrary discount rate and dubious calculations of "risk" (more on these points later). This artificial inflation of Public Sector Comparator costs is fundamental to the Private Finance Initiative and helps to win contracts for the consortia. In this sense, yes, of course, the bed closure programme is due to the PFI.

However, the main point here is simply to note the dramatic fall in the beds available to the NHS. When the Government boasts of the scale of the capital development programme, assisted by the PFI, it would be natural to assume that this involves a significant expansion of NHS facilities. Clearly the opposite is the case.

In truth, the report of the National Bed Inquiry is ambivalent about the need for more acute beds over the next twenty years. It suggests that another 2,000 acute beds will be needed by 2003-2004. In the longer term, the report suggests that an extra 22,000 intermediate (residential or nursing) beds will be needed by 2019. But the number of acute beds required depends on the scenario chosen. In the 'acute bed' scenario, the number of general and acute hospital beds needed rises from 136,000 to 171,000. But the 'closer to home' scenario envisages a reduction to 124,000 beds, alongside significant increases in services from GPs, district nurses and home helps.[12]

It is possible that all will be well despite the reduction in beds associated with PFI projects. Maybe increases in the throughput of patients, alongside the development of other NHS facilities, will take place without serious effects for the patients concerned (but with additional costs borne by their carers). Other outcomes are however likely: many patients will feel forced into the private sector (further undermining the equity of care which the NHS was created to bring about); or, as waiting times increase, funds will be found to allow Trusts to use spare capacity in the private sector (again enhancing that sector's profitability); or patients with potentially curable diseases will instead be forced to wait longer or find their treatment placed off-limits by NHS rationing devices.

One debate has been over "additionality": does the PFI result in more capital development or does it facilitate cuts in the conventional capital programme? Certainly the argument that the PFI crowds out other capital development looked persuasive under the Tories who imposed massive cuts in the conventional capital budget. Admittedly, it could be argued that those cuts were required to reduce the Public Sector Borrowing Requirement (not least, to satisfy the Maastricht criteria for monetary union) and so would have taken place anyway. More likely, however, the PFI did make it easier to cut the conventional programme. While Labour is now spending more on public sector capital in the NHS, the PFI allows the Treasury to withstand pressure for the scale of investment required.

The NHS needs capital development. However, there is always a danger of being swayed by, and perpetuating, the subliminal message that PFI capital development is a gift which it would be churlish and foolish to refuse. So it is worth remembering that PFI hospitals are paid for, through payments which consume a major chunk of the revenue budgets of the Trusts (likely to affect their spending on clinical staff) as well as through the sale of many buildings and a significant net reduction in the number of beds available to treat patients. PFI hospitals are not freebies: they are bought, and the price may be too high.

Cost-effectiveness and all that

The advocates of the PFI assert that it is more efficient than conventional procurement. The private sector companies bring new skills and radical thinking, especially when given the right incentives and allotted the appropriate sorts of "risk". The opponents of the PFI emphasise that the private sector companies need to borrow money at interest rates higher than those which the public sector pays. Newchurch, a leading consultancy firm, acknowledges that "central government is able to negotiate a substantially keener rate of interest".[13] Some of the costs are met through equity finance in addition to bank loans - so returns are also due to the shareholders. In 1997, KPMG concluded that an average annual return on investments in the range of 15 to 20 per cent in real terms was normal.[14]

Maurice Fitzpatrick, head of economics at the City accountants Chantrey Vellacott DFK, argues that the Treasury can borrow at an interest rate of 4.5 per cent. Typically a consortium's members may themselves finance a fifth of the cost of a PFI development with rates of return for equity holders of, he suggests, 15 to 25 per cent: contributing around four per cent to the inherent interest rate. The other four-fifths of the total cost might be borrowed at, say, seven per cent pa, adding another 5.6 per cent to the interest rate. Altogether, therefore, the PFI option involves an annual inherent interest rate of around 9.5 per cent, which is five per cent more than the cost of Treasury borrowing. So that: "for every net £1bn of PFI contracts outstanding this is an extra cost to the public sector of £50m pa".[15] The true situation may be even more dramatic. Fitzpatrick reports that actual PFI contracts in the public domain suggest returns of over 9.5 per cent; and NHS capital money largely comes, not from borrowing at all, but from sales of "surplus" property and savings out of Trusts' revenue budgets.

To which the advocates reply with a knock-out blow: a PFI project will not be approved unless it is both affordable and more cost-effective than the conventional alternative. This alternative - the Public Sector Comparator - is developed for the Outline Business Case while its final form is set out in the Full Business Case. Unfortunately, a number of doubts have been cast on whether this is a fair fight and these can be bundled into four or five sets of issues:

- Is the PFI project affordable for the Trust?
- Is it cost-effective for the NHS as a whole?
- What is "risk transfer" all about?
- Do the procedures really get the right result?
- Is there more to say?

Is the PFI project affordable for the Trust?

This is in a sense a question of comparing the costs between a Trust going for a PFI hospital development or continuing to cope the best they can out of the present inadequate facilities. While the latter is obviously unattractive, it must be borne in mind that the costs of making do are artificially inflated as a result of financial measures associated with Margaret Thatcher's imposition of the "internal market" on the NHS. Part of the idea of the internal market was that it would put pressure on hospitals occupying valuable land.

Each year, NHS hospitals have to pay to the centre a sum equal to six per cent of the assessed value of their capital. The figure of six per cent was imposed to bring NHS assets into line with private sector reckoning although the NHS is not designed to make a profit and the public sector can obtain loans for development more cheaply than the private sector. The Treasury describes the decision to require a capital charge of six per cent as a "practical choice" and "an operational judgement, reflecting, for example, concern to ensure that there is no inefficient bias against private sector supply" – in other words, to make privatisation more attractive.

The cost of the status quo is also inflated by the requirement to value existing NHS assets on a replacement cost basis rather than at historic cost (as would happen in the private sector).

These two requirements increase the costs involved in a hospital Trust sticking with the status quo and thereby bolster the attractiveness of a PFI-funded alternative – but bear no relationship to the real costs borne by the NHS and the taxpayer.

Also, ten PFI projects have been subsidised by Tory hand-outs shortly before the last General Election. A "smoothing mechanism" was introduced, presented as "loans" to Trusts involved in PFI projects. These "loans" are paying for around half the capital costs of the PFI schemes affected, clearly making an enormous difference to their viability. Gaffney and Pollock argue: "The notion of a loan by the public sector to the public sector with the first payments due in thirty years time is an amusing distraction".[16] It poses two questions. First, how is the value of that "loan" costed when the Trust assesses the total costs of the PFI proposal? Secondly, how realistic is it to expect the "loan" to be repaid, as promised, after the life of the PFI deal? Thirty years is a long time so many of us will not be there to find out. By then, the NHS will most likely be dead too.

The PFI was also bailed out by the Department of Health agreeing to make capital allocations available to the Trusts involved for the maintenance of equipment which, it had been assumed, was among the consortia's

responsibilities. This reduces the costs faced by the consortia, making their bids more affordable than they would be if capital allocations were restricted to hospitals operating outside the PFI. Since capital allocations are separate from the revenue agreements with health authorities, the costs to the Trusts of maintaining the equipment do not compromise the affordability of the PFI project which has thereby effectively been subsidised by the NHS as a whole. Alternatively, equipment may simply be removed from the PFI scheme, with the same effect.

Finally, PFI projects may become affordable because the health authority which pays the bills agrees to find more money to commission services at the new hospital – leaving less, of course, for other NHS services.

The upshot of all this convolution is quite clear: the annual payments to be made to the PFI consortia can be substantially higher than the capital charges the Trusts have been facing, despite significant cuts in beds. Even taking account of the maintenance and other services provided by the consortia, the size of the annual payments may mean that less money is available to meet the Trusts' other costs such as paying the salaries of nurses and doctors.

Newchurch & Company:

"Increasingly the cost of the schemes has to be met through savings in the core, clinical activities of the Trust...Improving clinical productivity invariably means employing fewer doctors and nurses – making clinicians redundant is viewed by many as being highly unattractive and may have deletorious consequences for quality"[17]

Allyson Pollock, Matthew Dunnigan, Declan Gaffney, David Price, Jean Shaoul:

"The most common way of balancing the books is to cut the workforce. The workforce plans for the new Edinburgh and North Durham hospitals under the private finance initiative show that the projected clinical staff budget will be 17% less than in 1996 for Edinburgh (...) and 22% less than in 1994-5 for North Durham (in cash terms). In Edinburgh there will be 18% fewer staff; similarly in North Durham there will be 14% fewer qualified nursing staff. In both cases a greater proportion of nursing staff will be unskilled: 37% (compared with 25% in 1996-7) in North Durham and 30% (compared with 21%) in Edinburgh."[18]

Is the PFI project cost-effective for the NHS as a whole?

Again we can start with a technical but important point around that infamous proportion: six per cent.

While the costs involved for the NHS in a PFI project are met in regular payments over the length of the contract, hospital developments funded through conventional means involve costs being met much sooner.

It is generally thought that a cost payable this year hurts more than the same cost payable in twenty years - even leaving aside inflation. If you pay out £1000 this year, rather than £100 each year for ten years, you lose the opportunity to gain interest. To take account of this, a discount rate can be used to adjust the value of payments made down the line.

The discount rate used can make a lot of difference. The Treasury requires NHS Trusts to adjust future payments to PFI consortia (or whoever) at a discount rate of six per cent. This means that £100 paid in ten years' time has a "present value" of under £56. £1000 spent at £100 a year for ten years has a "present value" of £736. Clearly this can make a PFI project paid for over 30 years look better value that a conventional development paid for much sooner. Take the Carlisle hospital project. Using the six per cent discount rate, the PFI option came in £1.7 million cheaper than the PSC. If the discount rate had been five per cent, the PSC would have been £3.1 million cheaper.[19]

The relevance of discounting to the NHS at any rate is not clear. When the Government builds a hospital, it is not foregoing interest payments as it does not tend to put money aside for a rainy day (only, in the relatively short term, to fund pre-Election hand-outs and splurges). Nor is our general preference for putting off paying relevant. In thirty years, another generation will be paying the taxes. **Our** preferences are not the point: how will **they** feel about our failure to pay for the hospitals we decide to develop (and to privatise)?

Audit Commission:

"The choice of discount rate...is important. In the NHS, the Treasury indicates the discount rate to be used...a relatively small difference in the discount rate used can mean the difference between a PSC being either above or below that of a PFI bid".[20]

House of Commons Committee of Public Accounts:

"...assessing the value for money offered by a PFI deal by comparison with a conventional project will involve comparing the value of money now with that of money later. Such comparisons can be very sensitive to the assumptions on which they are based."[21]

A massive expansion of costs in PFI projects from the Outline Business Case stage to the Full Business Case stage has been clearly established. In 1997, Newchurch reported that the cost of acute hospitals was turning out to be around 40-50 per cent more than the NHS had expected three years previously. (They did not accept that the PFI companies were to blame.)[22] Subsequently, Gaffney and Pollock reported that 14 PFI hospital projects demonstrated an average increase in capital costs of 75 per cent between the Outline Business Case stage and the position in July 1997.[23]

It is quite true that some projects become genuinely much more ambitious, reflecting the greater profits for the companies which are expected from larger projects. But it is just as true to say that the original proposal is typically much cheaper.

The Public Sector Comparator may also become more expensive during the planning process largely as a result of the Trust rethinking its proposals following the tendering exercise and discussions with the preferred PFI partner. Yet in drawing up the final version of the PSC the Trust is not allowed to consider the tenderers' suggestions. The playing conditions have been changed benefiting the PFI consortia and the consortia have studied the form of their public sector opponents – who have, in effect, been blindfolded.

In general terms, the PFI bid and the PSC are supposed to meet the same specifications. However, this does not mean that costs are the only issue which should be compared. Do both proposals make identical assumptions on throughput or is the PFI bid more ambitious? If the latter is the case, does that establish more commitment to efficiency or simply more willingness to discharge patients early? If domestic staff are privatised, will that make them less free to act flexibly in a ward team and contribute to a caring atmosphere for patients? Is the PSC tied to public sector specifications which do not apply to the PFI bid? Courtney Smith, an economic adviser to the NHS Executive, suggests that the PFI can improve value for money by "ensuing that assets are fully fit for purpose but no more than is strictly necessary (ie removing the historical tendency to over-design or gold-plate)".[24]

PFI deals involve the sale of "surplus" NHS property and the transfer of sites from the Trust to the consortium. These assets cannot in future be sold off or used by the Trust, perhaps in combination with other "partners" in the new NHS, for projects to improve people's health. But far from retention of these assets being seen as a positive aspect of the Public Sector Comparator, Gaffney and Pollock report that the appraisal effectively excludes assets which are disposed of to fund PFI projects and that the value of land transferred "simply vanishes from the appraisal".[25] And anyway who is to say that the property sold or transferred has been properly valued? Is not the whole saga of privatisation the story of one asset after another being sold at bargain basement prices?

As a final twist, official guidance points out that approval will not necessarily be given immediately for a development which is funded in a conventional manner. This further delay may impose additional costs which must be considered. Courtney Smith, the NHS Executive adviser, says the base estimates should assume the same timescales for the PSC and the PFI option. However, "sensitivity analysis should be conducted to explore the effects of any evidence-based uncertainty about the timing in the availability of public funds for the development".[26] Gaffney and Pollock conclude that this system of appraisal cannot be said "to inform choice of whether to use public or private finance. The non-availability of public finance is assumed and costed in the appraisal."[27]

What is "risk transfer" all about?

At the heart of the Private Finance Initiative is "risk transfer". Without the calculations and negotiations around transferring risk, the Public Sector Comparator would, in the great majority of cases, come out more cheaply than the PFI option.

So "risk transfer" is very important - but what is it? It is certainly multi-facetted. The box shows the main categories of risk, based on an Audit Commission analysis. A major scheme may involve identifying hundreds of specific risks, or dangers of things not going to plan. For each risk, three things must be worked out: how likely is it? what would it cost? and how long would it go on? And then - here is where the "transfer" comes in - who should pick up the bill: the Trust or (in a PFI deal) the consortium?

Risks likely to apply to major construction schemes in health care:

Design risk - risks related to ensuring the asset is fit for its intended purpose
Construction and development risk - costs of not being able to provide the services by the agreed date and within the budget set by the project company
Availability and performance risk - the services (including facilities) provided not being available or up to the standard specified
Operating cost risk - the risk of fluctuating operating costs
Variability of revenue risk - level of service being significantly different from that planned with a resultant impact on the payments to the project company
Termination risk - the Trust exercising its rights to step in and make alternative arrangements for the provision of the service
Technology and obsolescence risk - possibility of the underlying asset becoming an inefficient way of providing the required service because of technological changes
Control risk - the Trust having such a level of influence over the way the project company delivers the services that it inhibits the ability of the project company to influence its own operating costs
Residual value risk - the allocation of the asset/liability associated with the residual value of the underlying asset at the end of the contract period
Other project risks - risks not covered under the above categories.[28]

While these calculations may be complex they are also based on guesstimates. The risks associated with a thirty-year project in a field as fast-changing and unpredictable as health care are both huge and largely speculative (to be polite). The calculation of risks is therefore an exercise of imagination: an art as much as a science, with beauty in the eye of the beholder (with all the beholder's interests).

Private Finance Treasury Taskforce:

"An important point to consider when undertaking a quantitative risk analysis in a PFI context is the danger of spurious accuracy, ie that the results could be misinterpreted as implying a degree of accuracy that is not warranted because of the limitations of the inputs into the model. Given the inherent assumptions and judgements underlying such a quantitative analysis, it is important not to apply a model in a mechanistic way".[29]

Crucial questions, then, are how much risk is actually transferred to the PFI consortia and what does this transfer save the taxpayer? The consortia, of course, are in it for the money and will only take on responsibility for risks where

this is in their financial interest. In practice, their bankers and investors are "risk averse": they prefer certainty of good returns, all things being considered. So you end up with curious - or not so curious - differences in stress. For example, Meridian plc's Prospectus for the PFI hospital at Greenwich stated: "there are intended to be few risks inherent in the Project which are retained by the Issuer". But the Trust charged a risk transfer of £20 million against the Public Sector Comparator.[30]

John Hamer and David Kilduff, Walker Morris solicitors:

"...PFI deals rely on private sector funds for the capital investment needed to deliver the underlying assets. Typically, these will be funded through a mixture of senior debt, subordinated debt and equity. The last two require a higher return and thus cause higher service charges, and the levels usually depend on a combination of factors, such as the nature and scope of the project, the risks attached and a lack of competitiveness in the market for senior debt funding. More affordable PFI projects will thus depend substantially on the degree of comfort that senior debt funders can take from the structure of individual projects, in terms of their viability over the projected life of the contract, as well as the degree of risk to their investment."[31]

"Risk transfer" is of course gobbledegook, and can easily mislead. What we are in fact talking about is not transferring risk to the PFI consortium so much as adding notional costs to the Public Sector Comparator which handicap its chances. The conventional option is weighed down by the sins of its fathers, all the delays and cost overruns which have arisen in past hospital developments, for good reasons or bad. We are talking heavy weights. The Business Cases have mostly assumed that public sector projects overrun by 12.5 per cent or more.[32] For the Dartford and Gravesham project a 24 per cent overrun on construction costs was added to the Public Sector Comparator. For the Norfolk and Norwich Trust a figure of 34 per cent was used.

Are these heavy weights fair? KPMG have calculated that past hospital projects have shown average cost overruns of 11 per cent compared to the Full Business Case costings and 34 per cent compared to the Outline Business Case costings.[33] Citing the National Audit Office, Gaffney and colleagues say the average increase in cost over approved tender sums came to between 6.3 per cent and 8.4 per cent during the 1990s.

And what about the PFI? Does nothing ever go wrong there? Does everything turn out as originally planned? At the Outline Business Case stage, how much are the PFI options weighed down to take account of PFI cost overruns and delays and the number of projects that have ground to a halt? At the Full Business Case stage, will account be taken of all the past miscalculations and

overenthusiasms? Like the National Audit Office finding that the savings from going with the PFI option at Dartford and Gravesham had been overstated: their calculation puts the real saving at £5.1 million, not £17.2 million. Should we therefore - on the basis on past experience - inflate future PFI costs by £12 million?

Where risks are effectively outside the control of the consortium, it will generally make sense for the Trust to keep them because the companies will aim to make a profit from any transfer and will have no scope to demonstrate efficiency in relation to events they cannot avoid or manage. Put another way, whether the Trust follows the PFI route or conventional procurement, the bad risks are its problem.

The risk of "variability of revenue" is obviously important. Courtney Smith reports that this risk is generally borne by the consortium. "The main exceptions include variability of payments arising from changes in the amount of resources available for funding the services (eg healthcare provision), changes in the volume of demand for services (eg arising from demographic factors or medical technology) and changes in the epidemiology of the population in the catchment area".[34] An option which looks cost-effective now may look very different in a few years as health care technology, and patients' expectations, storm ahead. Thirty year contracts restrict the flexibility of services and priorities and make it harder for Trusts to adjust to changing circumstances.

Audit Commission:

"Not only is this commitment likely to limit the ability to switch resources in the future but, in the event of a need to cut spending, the PFI contract payment is likely to be protected from any cutbacks. The corollary is that non-PFI expenditure may have to carry proportionately deeper cuts."[35]

The logic of risk transfer must favour the PFI option over the PSC: risks should be transferred only if the estimated cost of the Trust keeping the risk is less than the price charged by the consortium to take it on. But why should we assume that all the innovations, all the room for improving incentive structures, can apply only to PFI schemes? In fact, penalty provisions for delays in public schemes are already common and contractors usually have to absorb cost overruns.[36]

House of Commons Treasury Committee:

"Although the testing of value for money can be approached as a systematic and impartial science, our evidence has shown that a series of subjective judgements will impinge upon the testing process. This subjectivity is reflected in some of the Treasury guidance...there is no ***a priori*** *reason why public procurement should not run to time and cost. Indeed, many of the assumed benefits of PFI would appear to be available to better managed and controlled conventional procurement."*[37]

It seems uncontroversial to say that risks should be borne by the party best equipped to do so. Yet something logically must have gone wrong when this truism is used to justify the PFI as opposed to conventional procurement. Otherwise all private sector companies – and private households for that matter – would reach deals which involved the builders owning and running the offices and houses they put up. Yet strangely many people are attracted to owner occupation. It is certainly not blindingly obvious that we would all be better off as the tenants of building companies, tied into contracts for half our lifetime, and obliged to pay out for the privilege of the builders/landlords also coming in to do the cleaning and the laundry. Maybe some hospital Trusts, like many families, would prefer to find arrangements for giving builders sensible incentives while hanging on to the capital tied up in their buildings and enjoying the security of knowing they will continue to have a place to go about their business, and dealing with their own maintenance and cleaning in the context of all the pressing demands on their time and money.

Do the procedures really get the right result?

Not only is the calculation of the risks and costs involved in the PSC largely a matter of taste but also it is carried out by Trusts desperate for new facilities, deeply committed to the PFI route, headed by individuals whose self-esteem and career prospects are tied into getting a "result". If for this reason alone, the PSC exercise cannot be taken at face value.

Coopers & Lybrand:

"The decision about whether a PFI solution is acceptable or not is based on two tests – value for money and risk transfer – which are both difficult to measure and applied subjectively."[38]

Alongside the unavoidably subjective aspects to the decisions being reached, cock-ups are already common and conspiracies may emerge. The House of Commons Public Accounts Committee reports: "In this new field, new mistakes are being made... But not all the mistakes are new: departments are not always applying to PFI the lessons which have long been learnt in conventional procurement". Similarly, Courtney Smith, an economic adviser to the NHS Executive, points to the National Audit Office reviews (not restricted to the NHS) finding "evidence of inappropriate public sector comparators, spurious risk analysis, double-counting of benefits, including nominal with real values in discounted cashflow analyses, inappropriate discount rates and inadequate sensitivity analysis".

Nor can reliance on expensive "expert" advice get around the problems of subjectivity and error. Courtney Smith acknowledges that the belief that the PFI was the only game in town "may well have created perverse incentives for departments and their advisers to distort the results of the economic appraisals". He also says: "Poor advice, often obtained at extortionate costs, has been a major reason for a number of the failed or abortive PFI projects".

The consultants may be working at the same time for both the NHS and the private sector on different schemes but representing opposite sides. This may raise concerns about possible conflicts of interest. And the ultimate source of advice to the NHS hospitals - the Private Finance Unit at the NHS Executive - has itself largely been staffed by secondees from the private sector, particularly lawyers and accountants. So that's good: loads of incentive flying around.

Richard Smith, editor of the *British Medical Journal*:

"...A third problem lies with the generous scope for corruption. The ingredients are all there: big sums of public money; closed decision making and inadequate accountability; and 'consultants' jumping backwards and forwards from the private to the public sector. Sooner or later we will have a scandal."[39]

The Government has announced the establishment of Partnerships UK (PUK) to "employ City experts to help the public sector get the best deal from the Private Finance Initiative and other forms of public-private partnerships".[40] PUK will be able to provide development funding to get PFI deals off the ground where existing forms of private finance are not available. A majority interest in PUK will be held by private sector investors and this will be reflected by a majority on the Board and a private sector Chair. However, the Treasury press release pointed out: "The Government will be entitled to appoint a minority of non-executive directors to represent its interests". The Treasury is expected to put up £20 million cash and a £100 million loan guarantee.[41]

PUK may earn its money in a variety of ways which include taking an equity stake in projects. Some see a conflict of interest in PUK negotiating both the best deal for the public sector and a deal which will produce the best return for itself. But others, of course, offer reassurances.[42]

The Audit Commission suggests that a true assessment of the cost-effectiveness of the PFI must wait a while: "Whether PFI contracts generally offer value for money in terms of service delivery will become apparent only once the service is being provided; only then is it possible to compare costs and services with those of similar PFI contracts and with those procured by other means".[43]

In fact the situation is even less open to resolution than this suggests (the Audit Commission like to think everything can be measured). Effectiveness must be measured according to several criteria and weights must be attached to each criterion before a full picture can be assessed, and then it will be a subjective assessment by a body which will no doubt have its own reasons for bias. In any case, once the service is being provided by the consortia, the alternative public projects have not gone ahead and hospital development has been largely financed through the PFI. It is, in other words, much too late.

Is there more to say?

A few thoughts to conclude this section:

1. Cost-effectiveness is not the only thing that matters (unless everything that matters is bunged into the "effectiveness" element of the calculation which poses the question of how all these different things are to be measured and weighted, and by whom and in whose interests are the measurement and the weighting to be conducted). Accessibility, equity, availability, accountability, acceptability, the views and morale of staff and public confidence and support also matter.

2. Cost-effectiveness in relation to labour can sometimes be difficult to distinguish from exploitation. Paying low-paid people less, or forcing hard-working people to work harder, is not necessarily a good thing. Nor is making people redundant. Under the Labour Government, the rights of staff transferred to the consortia have been strengthened. However, the House of Commons Health Select Committee point out that they have not seen evidence that services can be maintained "with reduced staff costs whilst maintaining good employment practices".[44]

3. The comparison between the PFI option and the PSC is not like-for-like – or, therefore, fair. The PFI option is the picture as presented by the consortium whose ideas seem most attractive to the NHS Trust. It is an

ambitious blueprint, showing the benefit of substantial investment of money and time, drawing (they say) on the latest ideas and full (they say) of innovation. But the PSC may be just a drab thumb-nail sketch of run-of-the-mill hospital developments in the past. Seldom will bright young things have been brought in (let alone bought in) to make the PSC a real runner, incorporating the latest ways of enhancing quality or reducing costs. That would go against the whole point of the PSC: which is, of course, to fail.

4. What happens at the end of the contract? The public still needs a hospital and the company has the only hospital in town which has already been paid for by the NHS. If the PFI deal does not provide for the hospital passing back to the Trust, the company will be quite happy to sell off the site to the highest bidder. This is a monopoly position with teeth.

5. A true economic appraisal would include the costs borne by the communities the NHS is supposed to serve. But dream on. The hospital plans (PFI or otherwise) involve a quicker turnaround of patients so that the costs of caring for patients recuperating (which used to be known as nursing) are pushed outside the hospital walls. In addition, centralisation of services means more time and money spent travelling. And the advocates of the PFI point to the scope for increasing charges for using facilities like car-parks and restaurants. And yet these charges are to no account in the comparison between the PSC and the PFI bid. In fact, it's even worse than that. Insofar as the charges generate a stream of revenue for the companies, they facilitate a lower PFI fee paid by the Trust: charges to patients actually favour the PFI bid against the PSC option. In a fair world, the opposite would be the case.

6. People who believe that the private sector has unique skills and is best placed to maximise efficiency should consider this: the NHS operates in a capitalist economy. Its hospitals are built by private firms even under conventional procurement, it hires architects and management consultants, it contracts out many of its "ancillary" services. If private designers can come up with better ideas, why not just hire them? You do not need a PFI bid to privatise your domestic staff if you really must: indeed, without a PFI deal you will have more flexibility to choose between a number of companies (and you can get rid of them sooner if you want to). If competition is what you are after, you should **unbundle** services, not tie everything up in knots guaranteed to last thirty years.

7. In any case, the idea that the private sector consortia are uniquely and innately skilled is just so much right-wing twaddle, albeit peddled by the nastier New Labour elements. In 1997, the leading consultancy firm Newchurch was quite clear that "too many in the private sector have to be

given considerable guidance and help to come up with even conventional proposals". PFI contractual structures demand the "formation of inexperienced, possibly unstable, supplier consortia, consisting of numerous, diverse parties that often have little or nothing in common".[45]

8. In fact, competition – that great driving force for efficiency and innovation – has often been limited. For four out of fifteen early PFI hospital projects, there was only one final bid. As the House of Commons Committee for Public Accounts reported as late as mid-1999: "for some aspects of PFI procurement the market may be too immature for competitive tension to provide value for money. For example, there are still very few financial institutions willing to provide risk capital for PFI projects".[46]

9. By focusing on a comparison between a PFI bid and the PSC, there is a risk of ignoring the costs of PFI process as a whole. The exercise is enormously expensive and time-consuming for the Trusts involved. Just buying in advice cost the Trusts involved in five early projects a total of £12.6 million, around three per cent of the capital value of the developments.[47] Under the last Conservative Government, £30 million was spent on advice from lawyers and accountants.[48] Yet the exercise has often been fruitless: the vast majority of the projects approved before May 1997 never got off the ground. (There are also huge costs for the companies, including those associated with failed bids, which are reflected in the charges to the Trusts or otherwise disseminated through the economy). Left to their own devices, not forced to go through this rigmarole, Trusts could improve services in line with the plans set out in their Outline Business Cases: at a fraction of the final cost.

Dan Corry, Julian Le Grand and Rosemary Radcliffe (IPPR):

"Is PFI delivering value-for-money? We cannot answer the question at this point; indeed nobody can, so the issue has to be taken on trust."[49]

Newchurch & Company:

"The final crunch test for all PFI schemes is whether the purchaser, the NHS and taxpayer can pay for them? Are they affordable? Do they deliver Value for Money? In a distressing number of case, the answer appears to be 'no', at least not without significant subsidy and yet further creative distortions of the NHS accounting rules."[50]

John Kelly, director of consultants RKW:

"They are making all these assertions about value for money and the private sector delivering innovation, but I'm not sure that's been proved."[51]

Distortion of development

Brian Abel-Smith:

"Planning is needed to prevent waste, make full use of scarce resources, contain costs to what is affordable and see that they are distributed geographically on an equitable basis."[52]

The profitability of a hospital may not coincide with the need for its services. This creates a number of fears that reliance on the PFI may distort the development of hospitals. Of course, this distortion is nothing like that which applies in the private sector proper. Trusts receive their money from GPs and health authorities as payment for essential services. The GPs and health authorities get their money from the government in accordance with measures of health care need. Also, the approval of the NHS Executive and the Treasury is necessary before large PFI projects can go ahead.

Nevertheless, the PFI shapes the development of the NHS:

1. The PFI has favoured large-scale projects. These allow the costs of tendering to be carried more easily.

2. The PFI is more feasible where Trusts have valuable sites (eg in city centres) which they can dispose of as part of the deal. This will depend, as Newchurch says, on "specific local economic circumstances".[53]

3. The Construction Industry Employers Council suggests that the PFI is particularly suitable for "projects where there is a high residual asset value at the end of the contract with the public sector".[54] Newchurch says a crucial factor is "alternative value of the site as a location for private health care provision or for other industrial or residential use".

4. PFI consortia look to increase revenues from patients, eg through car-parking charges or new private patient facilities. Areas where patients have lower disposable incomes, or use cars less often, or are less likely to subscribe to medical insurance policies, may therefore be less attractive. After further consideration, the consortium for the Dartford and Gravesham Hospital decided that a private patients unit would not be viable; and asked the NHS Trust for £1.3 million per annum as compensation.[55]

While Labour is determined to tackle inequalities in health, these distortions to hospital development could worsen the health of the poorest. Hospitals – with their associated services and employment opportunities – are closed down in

inner city areas with their clusters of deprivation, ill-health and premature mortality. New hospitals are opened in areas which are richer, requiring poorer people to travel further when they are ill. An important condition for PFI developments is, according to Newchurch, "a thriving local economy underpinning the attractiveness of the area".[56]

House of Commons Treasury Committee:

"It would be unacceptable if the Government's planning for the future provision of roads or hospitals began to be driven by the shorter-term perspectives of private bidders".[57]

Of course, not all capital development is funded through the PFI so these distorting effects may be counteracted by the Government using public borrowing disproportionately to finance projects in less favoured areas or for smaller projects. However, it is possible that conventionally funded development will also be distorted, supplementing the bias of the PFI, since the Initiative encourages assumptions, priorities and perspectives which may seep into the mind sets of Trusts, Health Authorities and the Department of Health. Joe Grice, head of the health expenditure division at the Treasury, has said: "If the private sector looks at a scheme and says 'We can't see this being viable', then at the very least it should make us in the public sector think seriously before committing capital. That is not to say there may not be good reasons to go ahead anyway".[58] Jolly good.

Labour has brought a more systematic approach to the PFI. Before much work can be done, Trusts must prepare a Strategic Outline Case for approval. This is designed to avoid Trusts wasting too much time and effort and to prevent the skills available in the private sector and in the NHS, and among the management consultants who advise both, becoming too thinly spread around.

The Labour Government prioritised a number of projects and stopped further work on others. Three criteria were used – Service Priority, PFI Status and PFI-ability. The second and third criteria clearly related to the fit between the project and PFI funding. Gaffney and Pollock have shown that even elements of the Service Priority criterion favour PFI projects. So it is not clear that this prioritisation process does anything to tackle the biases created by the PFI. On the contrary, those biases are reinforced and institutionalised.

Accountability

Public services should be accountable to the public, decision-making should be open, information should be freely available, consultation should be frequent and genuine and senior personnel should be removable. Private companies are of course primarily accountable to their shareholders and jealously guard information under the cover of "commercial confidentiality" on the grounds that competitors would unfairly benefit from shared knowledge.

The PFI therefore threatens the openness of NHS developments and services and the prospects of genuine consultation. The official guidance attaches great importance to allowing the companies to exercise their imagination in meeting broadly defined descriptions of the services needed. The design of the hospital is determined largely in private discussions between the selected consortium and the Trust. Business Cases are made public only after they have been approved, ie when it is too late to influence them. Even when the Business Cases are released, some information may be withheld as commercially confidential. The documentation is also huge and complex.

All substantial variations in NHS services are supposed to be subject to a formal consultation process whereby the health authority seeks the views of the appropriate Community Health Council and the CHC has the right to refer contested changes to the Secretary of State. But is the consultation genuine?

One problem is that the real agent for change on the NHS side is the hospital Trust. Health authorities may lack detailed knowledge of the issues or choices involved and yet it is they who have the legal obligation to consult on the proposals.

Newchurch & Company:

"In healthcare PFI the operator, the NHS Trust, has taken the lead with the paymaster and strategic decision maker, the purchasing Health Authority, being left largely in its wake...the scale of the assets and the length of the contracts ensures that the strategic decisions of purchasers are being driven by the specific and local interests of the Trusts, with the NHS and taxpayer accumulating long term liabilities with little regard to their appropriateness and benefit".[59]

When should the consultation take place? The private consortia do not want the worry and potential expense of getting involved in a scheme which is contested by the CHC. It follows that the consultation should take place before tenders are invited. Nevertheless, the scheme may already have been effectively endorsed by the health authority and the Department of Health by being prioritised at the

stage of the Strategic Outline Case. This poses the question of whether the health authority can consider objections with an open mind and similarly whether the Department's advice to the Secretary of State on a referral by the CHC is likely to be impartial.

NHS Executive:

"It must be clear that...purchasers support the scheme in concept and are able and willing to afford its financial implications. Chief executives must ensure that this support is explicitly given by main purchasers before a business case can be submitted to the NHS Executive for approval".[60]

Moreover, the PFI procedures entail that the specification of a scheme at this stage relates to health care outputs rather than sordid details about the numbers of beds or the design of the new hospital. If detailed requirements are specified, the PFI companies cannot work their magic and produce their rabbits. If requirements are not specified, however, the CHC will lack the information it needs to be properly consulted. And that's just the formal problem. In reality, the endless negotiations between the consortia and the Trusts often result in schemes which break free of the constraints set in the original specification. In which case, in theory, the CHC should be consulted on the new proposal. Yet if this consultation took place – and if the health authority and the Secretary of State were even at this stage wholly free of preconceptions about the benefit of the scheme – then the consortia's investment in the project would be put at risk.

Sometimes in life there are choices:

- Certainty for the consortia **or** influence for the CHC
- Commercial confidentiality and intellectual property **or** openness and the sharing of good practice
- Profit-led vague vision things **or** full consultation on worked-up proposals
- Commitment and involvement by the health authority and the Department of Health **or** their retention of open minds, without prior assumptions, to consider objections to plans which often involve the loss of public assets, reductions in hospital beds and less money to pay doctors and nurses.

We must wait to ascertain the accountability of PFI companies when owning and providing services at the hospitals which they have developed. How will they respond to requests for information about their staffing levels or about claims made against them elsewhere or to complaints about the quality of their services or to investigations by CHCs into the standard of cleaning, reception or record keeping? How keen will they be to explain their actions, expose their decision-making and justify their priorities to local authorities, campaign groups, trade

unions, the media, members of national Parliaments and Assemblies or even the relevant Secretary of State?

The Conservative Government insisted that the NHS should respect the "public service values" of accountability, probity and openness. This poses a number of questions:

- How can private companies be trusted with public service values?
- How can the Conservatives justify imposing the PFI on health care?
- What on earth is New Labour up to?

Public services, private owners

Is there something inherently wrong about health services being provided by privately owned hospitals? Yes, of course there is.

The NHS is not wholly apart from capitalism and market forces. It relies on equipment and medicines from the private sector (the latter in particular raising serious issues about efficacy and efficiency). GPs and dentists are independent contractors, often owning the premises they work from, and are not salaried public sector employees. Many "ancillary" services have been contracted out (when Thatcherite policies were proud to be called by their name). NHS consultants are allowed to practise privately, nearly all do so, and much of this activity takes place in NHS hospitals.

Nevertheless, there was a point in Nye Bevan's taking the country's hospitals into the NHS. The PFI does not wholly undo the good done then because the commissioners of services are within the NHS, there is still a planning process and, for the time being at least, the professional staff are still working for the NHS. But the PFI may distort service development and decrease accountability and openness while allowing the private owners to reap profits which could benefit from monopolistic positioning, exploitation of staff, threatened standards of care, inadequate provision of beds, higher charges, private care for the reasonably affluent, early discharge and a phoney comparison exercise.

Profits, markets and multinationals

There is a vast empirical and theoretical literature on private ownership, profit motivation and markets in health care. Profit-maximising companies clearly aim to minimise costs. In the right circumstances this generates efficiency. But where consumers are poorly informed, or have little effective choice, costs may be cut in undesirable ways. In health care, quality may be reduced in subtle ways. Professional staff can be encouraged to see the pursuit of the second-best option as honourable where it saves money (and may not strive officiously to explain to their patients that alternative forms of treatment would do them more good). And as Brian Abel-Smith pointed out: "The easiest way for a hospital to economise and add to its profits is by the dilution of the quality of the staff. Patients rarely enquire what qualifications are possessed by persons dressed in white coats when they are described as 'nurses'!"[61]. Certainly, cost-conscious managers will take a close interest in the scope for savings from tweaking the "skill mix" of their staff. Alternatively, patients may be discharged earlier, or spending on teaching and research cut back, or costs shifted over to informal carers and social services.

The risks from cost-cutting under the PFI are high since the consortia will face consumers (ie the Trusts, or at one remove, health authorities and GPs) which have little ability to take their custom elsewhere. Courtney Smith (economic adviser to the NHS Executive) warns: "The importance of qualitative criteria should not be down-played. 'Soft' criteria such as the 'culture' and 'values' of the bidders will have an important bearing on long-term *partnership* arrangements".[62] However, over a thirty-year period relatively benign or sleepy companies in the original consortium may well be bought up by other companies which take a more aggressive approach to minimising costs and maximising income. This could include multinationals.

When governments own the organisations which provide public services, transnational corporations cannot rely on elbowing their way in. By contrast, services run by indigenous private sector companies are inevitably at risk of foreign takeover, especially since the rise of free-market ideologies associated with the World Trade Organisation (WTO) and the General Agreement on Trade and Tariffs (GATS). When GATS was introduced in 1995, only 27 per cent of WTO members agreed to open hospital services to foreign suppliers. Some governments saw hospitals as part of their "national heritage", according to the WTO Secretariat.

This was offensive to those who see free trade as the shining pathway to global growth, personal freedom and human well-being. So we have the World Bank declaring that "if market monopolies in public services cannot be avoided then regulated private ownership is preferable to public ownership". So the secretariat of the WTO points out that while governments are entitled to protect public services from foreign takeover under GATS Article 1.3, the hospital sector is "often made up of government-owned and privately-owned entities which both operate on a commercial basis...". The secretariat asks how WTO members can ensure that health care systems are "whenever relevant, market based".[63]

American hospital corporations have had an eye on the undernourished NHS for decades. The US Coalition of Service Industries points out that historically health care services in other countries have been within the public sector. "This public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries."[64] But for the UK at least, things must be looking up.

Some argue that well-constructed contracts involving close monitoring can help protect the position of the Trusts and the patients. But one down-side is the financial cost involved in monitoring and challenging where necessary. Another down-side was suggested by the Treasury's Private Finance Panel who advised that the performance regime should not be "adversarial": "Too much checking

and re-checking of what the supplier is up to implies a lack of trust. This approach could be counter-productive".[65]

The great divide – or doctors and nurses next in line?

The worst risks of profit maximisation in hospital care are reduced in the present version of the PFI because the consortia are not allowed to employ clinical staff including doctors and nurses. But non-clinical staff are often important contributors to the hospital team and the boundaries between clinical and non-clinical staff are not set in concrete. Co-operative working, shared objectives, day-to-day give-and-take and efforts beyond the call of duty may be compromised by staff working to different employers, by the offensive demarcation between valued professional staff who are kept in the NHS and the rest whose jobs are privatised and by those apparently disposable staff being forced to work for companies whose driving goal is to make the maximum profit out of the NHS. Andrew Foster, human resources chair of the NHS Confederation, says the PFI has been "a very damaging development in terms of staff morale and inter-disciplinary working".[66] Meanwhile, the Trust may have to cut clinical staff numbers - or adjust their "skill mix" - to fund the annual payments to the consortia.

David Whitney, Chief Executive of the Central Sheffield University Hospitals NHS Trust:

"The domestic housekeeper is a key part of the clinical team. How do you engage that service from a non-NHS employee, if you like, whilst making sure they remain as a core part of the clinical team? When you talk to the patients on the ward the housekeeper is a key part of that team...we have the multi-skills of some of our housekeeping staff. For example, in one of our directorates they take blood, they are phlebotomists."[67]

House of Commons Health Committee:

"...the division between clinical and non-clinical staff is artificial. Hospitals function best through integration of work of many different staff groups. Porters and cleaners as well as nurses and doctors need to understand the primacy of patient care in everything they do. A division in the management of clinical and non-clinical staff is unlikely to be conducive to high quality services to patients. We heard anecdotal evidence supporting this argument...The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients. We believe the Government should limit PFI to a number of pilot schemes until a proper evaluation of the impact on staff and patient care is produced."[68]

Moreover, the consortia will take a close interest in the financial well-being of Trusts and will be keen to contribute ideas on how spending can be reduced. Chris Ham suggests: "Those providing private finance and putting their investment at risk will not expect to play a passive part in the management of services, and they will no doubt take a close interest in the appointment and performance of trust managers".[69] According to Simon Cox, Managing Director of ISS Mediclean which will be responsible for all non-clinical services at Hairmyres and Stonehouse Trust Hospital: "at the end of the day, the way a long-term relationship progresses depends on how the parties concerned integrate, and work together".[70]

Also, the consortia may in time acquire the power to employ doctors, nurses and other clinical staff, bringing the PFI closer to the right-wing vision of investor-owned, profit-maximising health care providers. The pressure is already on and it is open and explicit. Back in 1995, Sheila Masters, a member of the NHS Policy Board and John Major's Private Finance Panel, argued: "In principle there is no reason why a private finance deal should not be used for clinical services...But at this stage it may be seen as a bridge too far – doctors and the public may not be comfortable with it".[71] More recently, Richard Meara, co-ordinator of the PFI Watch for the Institute of Health Services Management (as it then was), described the exclusion of clinical services as political dogma.[72] Keith Ford, former chair of the Healthcare Financial Management Association, says: "I'm not sure it is necessarily sensible to exclude clinical staff in every case". John Kelly, director of the consultancy firm RKW, reports "some voices in the private sector who want to get their hands on clinical services".[73] Philip Matthews, director of infrastructure finance at the British Linen Bank, asks: "Where is the problem in the private sector employing doctors and nurses?...Look at David Blunkett, who says that failing schools will be contracted out to the private sector".[74]

Contracts of thirty years will see New Labour and all its compromises long consigned to history. Very likely these contracts will outlast the NHS and see in a service dominated by private hospitals employing all the staff according to the dictates of profit maximisation. If this happens, it will be largely because Labour has failed to trust its instincts on private finance and in the process has driven capitalist motivations so near the core of hospital care.

Fears, principles and dinosaurs

The public's attitudes to the local hospital may change once it is owned by a private company aiming to maximise its profits. Even where standards are not in fact reduced by commercial incentives, the patients may suspect otherwise – lowering their confidence in the health care provided and fostering a litigious

climate which is helpful for neither patients nor professionals. Will the public come to see a hospital's shortcomings side-by-side with its directors' salaries and its shareholders' profits? Do we really want the public to regard local hospitals with the distrust with which they regard water companies and other profit-making monopoly suppliers of essential services?

Beyond this is a more general reason why the NHS is, for many of its members, the Labour Party's proudest creation. Given the ideological drift of New Labour, it is not wholly surprising that the case is best put by a Conservative politician, the former Health Secretary Virginia Bottomley.

Virginia Bottomley MP:

"The NHS is not a business. The only profit it makes is measured in the cure of illness, the care of the sick, the relief of pain and its contribution to a healthier nation. We are all its shareholders: but our interest is human, not financial".[75]

For many people who are perfectly at home in a capitalist society, there is something which jolts about health care being provided for profit, even beyond the risks to accountability, standards and public confidence which are associated. Even in private health care, and even in the United States, many patients prefer to be treated in hospitals owned by charitable bodies or not-for-profit companies. Patients understand that health care staff must be paid (although they are rightly worried about the incentives facing professionals paid on a piece-work basis). But the great majority of health care professionals and other staff are focussed on the needs of their clients on a personal basis. The investors in the private hospital corporations are interested solely in the profits to be made from the ill. Is that taking advantage, and is taking advantage wrong? There is still the odd dinosaur who thinks so.

Some people go even further, of course, and have doubts about capitalism generally, not just in health care. For them, the NHS is a socialist project that works, for all its drawbacks and limitations: it is a real-world, flawed model of how things ought to be organised because it aims to distribute services according to need and without the materialist and selfish incentive of profit maximisation. So the PFI undermines the foundations of that model of a better world, and reinforces capitalist structures and mind-sets. For the PFI is itself an ideological project, close cousin to privatisation, competitive tendering, rolling-back-the-State and Thatcherism. But, the end of history notwithstanding, there is still more than one ideology knocking around (and more things in heaven and earth than are dreamed of by any ideologue).

Mark Freedland:

"I wonder whether the whole discourse and rhetoric of risk transfer is subject to an inherent bias in favour of private finance contracting, in that it encourages the view that the commercial bearing or insurance of public burdens is a beneficial thing in and of itself...I wonder whether the idea of risk transfer, especially when it comes to what are described as 'regulation risks' and 'demand risks' may operate as a rationale for arrangements which present real worries in terms of public policy. This would be the case where 'risk transfer' resulted in the delegation to private contractors of public decision-making powers affecting the interests and welfare of citizens. It would also be the case where it resulted in private contractors acquiring large commercial interests in the way that those decision-making powers are exercised, even though those powers remain, nominally at least, in the hands of the public authorities"[76]

Dan Corry, Julian Le Grand, Rosemary Radcliffe (IPPR):

"Public service ethos and trust, once lost, may be impossible to recover. The reputation of public servants making decisions in a disinterested manner, once gone, is gone for ever. In fact, accountability is also difficult to re-impose in a stronger form, once the private sector is in the driving seat of too many things. Governments will simply not want to take them on, and will find that they are stuck in contracts that make it difficult even if they did."[77]

Private finance in primary care

The Private Finance Initiative is poised to push into primary care. The Government envisages the attractive model of local centres bringing together GPs with a range of other health and social services. But of course they cannot bear the idea of this involving simply the provision of public services out of public buildings funded through taxes and government borrowing. So the Department of Health's annual report states: "The next challenge is to replicate... PFI in non-acute settings, and to explore the scope for PFI-type solutions in primary care".

Kingsley Manning, Managing Director of Newchurch & Company, foresees the development of 2-300 primary/community care centres, requiring an investment of perhaps £5-20 million each time.

Kingsley Manning:

"...the positive economics of integrated care is attractive to private sector investors because of the characteristics of these 'centres'. For example, the ratio of review (sic) to capital will be positive (each pound of capital generating more than a pound of revenue); significant opportunities for generating additional income exist (possibility of 'alternative use'); replication of successful centres offers the possibility of economics of scale and service branding; each centre is likely to bring together a mix of public sector revenue, reducing its operating risks; and once established, each centre will tend to create a local monopoly or exclusive franchise."[78]

This could mean a further blurring of distinctions between NHS and private services. As Manning says, one possibility would be the development of "for profit centres...with a range of non-NHS services being delivered alongside NHS services". Now that GPs in England are brought together in Primary Care Groups and Primary Care Trusts, with analogous arrangements in Scotland and Wales, they will, like the old fundholders, be more inclined to take costs into account in their clinical behaviour. If they can persuade patients to use private services rather than the NHS, their budgets will be relieved, at least in the short run. And if the patients can then be persuaded to see the GPs privately – pehaps by joining an insurance scheme provided at the centre – then the GPs may be personally quids-in. Under the current national terms of service, however, patients and GPs must make a choice: GPs are not allowed to treat patients privately if they are on their NHS list. So the income from the insurance subscriptions and other private charges must exceed the capitation payment to the GP and other NHS fees if patients going private is to benefit the GP's pocket.

In May 1999, the Norwich Union launched a public-private partnership fund and committed itself to £100 million for PFI investments in small projects including health, education and social care. This following the launch the previous May of a medical insurance scheme called "GP First". However, a Norwich Union press officer insists: "This is really an opportunity to expand our investment into property. It's not an indication of any desire to operate healthcare facilities".[79]

The development of the PFI in primary care is likely to be even less accountable than in the hospital sector. As the schemes are relatively small, they are less likely to attract the interest of the Treasury or even the Department of Health. They may not be seen as substantial enough to require formal consultation with the local Community Health Council. CHCs do not even have visiting rights in relation to primary care premises which are not owned by the NHS.

The context is the deliberate downgrading of the bed capacity of the hospital sector where the clinical staff remain public employees. Instead, patients will increasingly receive services at local centres, run by private companies and by GPs who are themselves independent contractors to the NHS. And those centres, as Manning says, will tend to monopoly and allow "service branding". Welcome to MacNHS.

Courtney Smith:

"...effort is being made to adapt the classical DBFO [Design, Build, Finance, Operate] approach to meet the particular requirements of schemes in the primary care, mental health and community care sectors. These include batching of schemes, relocating or locating services where they can maximise the returns to the private sector and, at the same time, meet the NHS' service requirements, and creating imaginative partnerships between GPs, NHS organisations and the private sector."[80]

So why the PFI?

With so much room to question the value of the PFI, why has it taken place?

Certainly, a very important reason is that it appeared to facilitate a reduction in the Public Sector Borrowing Requirement by pushing capital investment off the balance sheet. Obviously it does this by tieing the NHS into ongoing revenue requirements instead. Nevertheless, the PFI has allowed cuts in the PSBR and thereby has helped the UK to meet the convergence criteria for European monetary union. In any case, there was seen to be a pressing need to bring down the PSBR when the PFI was initially being promoted. In the five years to March 1997, aggregate Government borrowing increased from 28 per cent of GDP to 44 per cent.[81]

In addition to pointing to the intrinsic evil of public borrowing (even when its purpose is to fund public investment in facilities to cure people who are ill), the Right see the PFI as part of their project to roll back the public sector. The PFI was the third prong, along with privatisation and competitive tendering. Norman Lamont says he was initially sceptical about John Major's enthusiasm for the PFI. But he was turned around: "the idea eventually opened up a whole new dimension for privatisation".[82]

In addition to the PSBR factor and the loony-tunes ideological element, there is a third reason for the PFI which tends to be over-looked in polite society. There is a lot of money to be made. The Right like privatising services, and passing facilities over to private companies, partly because they sincerely believe this makes the world a better place generally, but also because it gives them and their friends new opportunities for personal enrichment and empowerment. This is both through involvement in the consortia companies and their bankers and through the consultancies and accountancy and legal firms whose services need to be purchased by the Trusts.

The attachment of Labour to the PFI takes a little more explaining, but these days not a lot more. Labour politicians are less likely to gain financially from the PFI, or see their friends doing so. They are also less ideologically enthralled by market forces and privatisation. But Labour is much more enthusiastic about monetary union than the Conservatives, making the PSBR argument persuasive.

More generally, Labour is keen to be seen as a good friend to big business, multinational and home grown, and as sympathetic to its goals and its prejudices. Internationally, business wants to exploit the opportunities presented by health care and other services which, up to now, have been largely developed, owned and managed by governments. Only where health services are privately-owned and market-based can international free trade (and

multinational control) work its magic. The PFI, therefore, opens the door to the ownership and (part of) the management of NHS hospitals being acquired by organisations whose priorities and strategies are determined in other continents.

This is the context in which Tony Blair thinks it appropriate to complain to the British Venture Capital Association about the "scars on my back" from trying to reform public services: "People in the public sector are more rooted in the concept that if it's always been done this way, it must always be done this way than any group of people I've ever come across".

How far Labour politicians are genuinely hostile to public services, and how far it is for show, it is difficult to say. It also makes little difference.

Chris Ham:

"Labour's support for PFI undoubtedly lends credence to its claim to be 'new'; whether private finance is preferable to properly managed publicly financed schemes remains to be demonstrated".[83]

The something-for-nothing surface of the PFI is also a great attraction to politicians who do not want to be associated with the taxes which pay for NHS services. They can point to spending on capital programmes **and** spending on revenue budgets without bothering to stress that that the former is largely paid for out of the latter. And of course PFI projects are paid for some time in the future, under another generation of politicians (perhaps not even from the same party). They can cope with the consequences: less money to employ doctors and nurses; or higher taxes so the NHS can pay the PFI companies so they can pay their bankers and shareholders.

Alternatives

PFI is sometimes presented as an unfortunate necessity. To a greater or lesser extent the various downsides may be acknowledged, but it is alleged that new hospitals are required and that PFI is the only show in town.

At one level, that is quite true. People who have been campaigning for years to replace shoddy, inappropriate and inadequate hospitals may welcome privately funded developments when public funds are not available. This is understandable, perhaps even admirable in its determination not to let pursuit of the best obstruct achievement of the good. Also, apologists for the Department of Health may insist that PFI is the only way to build hospitals, implicitly blaming the Treasury for the policy. Or Old Labour politicians may defend PFI as the best hope for hospital development given the ideological implications of New Labour domination. All this is very well, but it does not address the most important question: is it necessary for the Government to impose the PFI on NHS hospital development?

Are conventional procurement and the PFI really the only alternatives? Who knows what schemes could have been identified had a tiny proportion of the intellectual effort devoting to dreaming up the PFI instead been directed to more benign purposes:

1. One option might be the evolution of PFI into a model where private companies own the hospitals as absentee landlords and are not involved in their management. That would not meet all the objections to PFI, but might be worth considering. The Labour Government has taken a step in this direction by stating that in future there will be no requirement under PFI deals to transfer catering, cleaning and portering staff to the consortia.[84] It remains to be seen whether Trusts and consortia will strike many deals in line with this option; and, if the option is pursued widely, how far it will affect the potential influence of the companies, and of the profit motive, over the management and policy of the NHS.

2. Alternatively, the King's Fund has proposed a health development bank modelled on Railtrack. All the physical assets of the NHS would be transferred to the bank which would be able to raise money on the private market. This would mean that NHS Trusts would not need to set up their own deals site by site. Trusts would need to apply to the bank for funding and the bank would raise the finance if the project was approved. The loans would be secured against the new assets and should not be counted against the Public Sector Borrowing Requirement, according to the King's Fund.[85]

3. Maurice Fitzpatrick, head of economics at Chantrey Vellacott DFK, suggests another "third way". The public sector would borrow the money. The building contractor would operate under the "open book" system used by the Ministry of Defence, making its costs visible to the NHS. Any savings can then be shared, giving the contractor appropriate incentives and the NHS a chance to benefit from any efficiency gains. On completion, "the asset can then be 'run' by the private sector to any extent which is deemed desirable (ie servicing a building and its equipment)".[86]

4. Another option is the introduction of 'NHS bonds'.

Harry Keen (NHS Support Federation), Peter Fisher (NHS Consultants' Association), Peter Draper (Health Policy Network):

"Many health professionals mistrust the private finance initiative in the NHS but see no other way to raise capital for hospital or other schemes. We propose a better and less costly alternative. The issue of government backed NHS bonds would present an ethically highly acceptable opportunity to large institutional investors such as pension funds and insurance companies with a stake in sound social infrastructure and would attract private individuals seeking safe and worthwhile investment. NHS bonds would command a much lower rate of return for shorter periods than would the private finance initiative - a far better bargain for the taxpayer. Of no less importance, healthcare policy would remain firmly in public hands.

"Objections that NHS bonds would contribute to the public sector borrowing requirement and offend against the 'Maastricht criteria' for a single European currency are questionable. Borrowing for social investment can be excluded from the ratio of general government debt to gross domestic product (the Maastricht indicator of the sustainability of government debt), and the public acquires a capital asset. Alternatively, NHS bonds could be issued locally, regionally, or through a public corporation."[87]

The Government should consider the range of alternatives and give us considered reasons for their adoption or otherwise.

But we should not rule out conventional ways of paying for new hospitals through public borrowing. After all, the ebbs and flows of the Public Sector Borrowing Requirement are not due to the turning on and off of NHS capital expenditure. The size of the PSBR is determined by the total expenditure and income of the Government and largely by the impact of the economic cycle on social security outgoings and taxation revenues. But the Government has many

options for influencing its income and expenditure. The present lot choose to reduce the PSBR by privatising the ownership and (part of) the operation of new NHS hospitals. They also in effect increase the PSBR by cutting the standard rate of income tax (thereby also increasing the income gap, and no doubt the health gap, between the poor – who do not pay income tax – and the rest of us). Far from being tied to unavoidable facts of life, the Government has room for manoeuvre and chooses short-term tax cuts rather than public ownership of NHS hospitals. Fine – New Labour, like the rest of us, is defined by its choices.

In any case, it is now more likely that a PFI-financed hospital will count as an asset of the NHS Trust and therefore be relevant to the Public Sector Borrowing Requirement. Accountants say that whether a hospital is an asset of the PFI consortium or the NHS Trust depends on which party bears the bulk of risks associated. If, at one extreme, the consortium genuinely bore all the risks, the hospital would count as their asset. Since risk assessment is both complex and subjective, determining whether the Trust or the consortium owns the asset is not at all straightforward. The Accounting Standards Board has decided – and in June 1999 the Treasury agreed – that "service risks" (eg, relating to the consortium facing penalties due to poor standards of cleaning or catering) should be ignored in determining ownership of the asset. This makes it more likely that the Trust – retaining much of the risk associated with the hospital building once it is up and running – will be deemed to hold the asset. In which case, it must feature on the public sector's balance sheet and borrowing requirement.

It is too early to be sure about the practical effects of the Accounting Standards Board ruling. The advisers may find smart ways of avoiding a hospital counting as an asset of the Trust. Or there may be genuine efforts to transfer more risk to the consortia and reduce the danger of the NHS Trusts ending up with unforeseen liabilities in the future. Since, however, the consortia and their financial backers would in effect expect to be paid for bearing any additional risk, the benefit to the NHS is not obvious.

There is an even bigger question, however – why try to cut the PSBR? We are told that this was necessary, and at one remove that the PFI was necessary, to meet the convergence criteria for monetary union. Let's not get into whether monetary union is a good thing. It is enough that our leading politicians have not demonstrated any interest in challenging the public borrowing requirements in the convergence criteria, which were agreed by politicians, not brought back by Moses. Has Tony Blair tried to negotiate an opt-out to allow the UK to keep the profit motive out of our hospitals? Of course it is always helpful to blame foreigners, but the convergence criteria have now been met, and still the Government promotes the Private Finance Initiative.

Conclusion

Of course it is true that the NHS needs investment. And it is true that many of the brightest sparks in design, project control and management work in the private sector. And it is true that, in the right circumstances, competition can promote efficiency and innovation. And it is true that with any large contract close attention needs to be paid to the system of penalties and incentives. But none of this demands, or justifies, the Private Finance Initiative.

The PFI was not drawn up by common-sense pragmatists interested in a non-ideological way in getting the best possible 'partnership' between public services and for-profit corporations. On the contrary, the PFI was designed as a stand-in for privatisation, given the unpopularity of any proposal to directly sell off the supply of health care services. It was a highly complicated scheme to smuggle in the profit motive where – due to decades of neglect – the NHS was at its weakest. And this Heath Robinson Trojan Horse was initially unimpressive, not least to the private sector: during 1996 and 1997 the Initiative appeared still-born. It required three pieces of legislation and the return of New Labour to acquire its present health.

And why not the PFI? Because there are good reasons for the NHS to remain a public service, publicly funded and publicly owned. Those characteristics express our recognition of our common humanity and allow us to hold the decision-makers to account. The NHS needs to be more accountable (not less) and more focused (not less) on the needs of its clients rather than the demands of its vested interests.

The present Government has abandoned the explicit model of an 'internal market' which assumed that health care goals could be maximised through competition. The new NHS structures are based on ideas of 'partnership'. So far as it goes, this is an eminently sensible development: it allows information to be shared, risks to be pooled, projects to be planned, patients to receive the treatment most appropriate to them. But this shift from competition to partnership – the cornerstone of Labour's health policy – is severely compromised by the PFI which underlines and underpins the separation of interests between one Trust and its neighbours.

These are still very early days for the thirty-year contracts. It will of course be fascinating to see what actually happens. But we can expect that both nationally and locally the PFI consortia will become major players in NHS management and policy. The more they are embedded, the more their confidence and influence will grow. They will become another vested interest rooted in political

compromise – like the pharmaceutical companies which drive up prescribing costs and the private medical sector which draws staff away from the NHS. They will become a new for-profit force within health care politics with its own ambitions, its own vision as to how health care could be reshaped, its own imaginative schemes for maximising the return to its shareholders. Locally, the consortia will take a close interest in the clinical and financial management of their hospitals. Nationally, they will push for the goal-posts to be moved even further in their favour including, political circumstances being favourable, through the privatisation of clinical services. How many of our leading politicians – outside Scotland, anyway – can we trust to stand up to the consortia over the next thirty years? Once it became the accepted wisdom that it was in Labour's interest to embrace the PFI in health care, the silence has been deafening – and interrupted only by cooing sounds.

The Private Finance Initiative has cost and will cost the NHS dear. Huge expenses have been incurred – directly and indirectly – due to the processes which NHS Trusts have been forced to go through, often fruitlessly. The tests of Affordability and Value For Money are bogus or, at best, ineffective, failing to prevent consortia being bailed out with subsidies from the public purse. The new hospitals are far smaller than the old, creating additional demands for primary care services, and they are far more expensive, leaving the Trusts with less to pay for nurses, doctors and other clinical staff. Above all, the PFI developments must be paid for out of the Health Service revenue budget, not out of capital allocations funded by public debt. Politicians boast of additional revenue for the NHS but do not stress that a large chunk of that must now go on capital costs which used to be funded separately. Without significant new increases in funding, the NHS will end up handing over a larger and larger proportion of its income to the consortia. Even Norman Lamont, who brought in the PFI, acknowledges the risk of a "silting up of public expenditure with a stream of never-ending rental payments".[88]

NHS Confederation:

"We do not want to have demoralised, demotivated staff who are unhappy to work for us...the PFI process...is at best a hindrance to the way we plan our capital developments. PFI is slow, it is bureaucratic, it requires us to put up a vast amount of management time and consultancy fees at risk without the certainty of success. The schemes are not...necessarily better value for money...or, they achieve that by reducing the terms of working conditions of the staff involved. There is an element of profit in PFI, which is necessarily taken by the private sector to motivate them to go into it in the first place, which results in an element of bad value for the NHS...At ground level [PFI] is a very damaging development in terms of staff morale and inter-disciplinary working."[89]

Like a park, an NHS hospital is a public space, a public asset and a public service. We can use it not because we are rich, or poor, but because we are citizens. It says we all get ill, we are all mortal and in the eyes of God (even if there isn't one) we are all equal. When things go wrong, there are people to blame. If we want to spend more money on it, or less, we elect politicians to that effect. The staff work for us and their managers bear cost in mind, but other things too.

In future, the hospital will be owned by Something plc (and later, no doubt, Something International inc). The staff will wear their uniforms and uniformly smile and wish you a nice day. But the bottom line will the only one that counts. The responsibility for failures and corner-cutting will be lost in the usual morass of who-pays-who-for-what (with lawyers, like flies, to sort it out). And there will - for thirty-odd years - be nothing you can do about it.

Despite the massive cuts in beds, the high costs and the threats to quality, equity, accountability and public service values, PFI projects are supported by many people whose intelligence, awareness and commitment to the NHS is beyond question. But for all their virtues, they are closing down hospitals and passing assets and control over to another set of men and women who have not necessarily demonstrated any interest in health care, let alone any enthusiasm for the guiding principles of the NHS. Apart from their own personal ambitions, the driving motivation of these people is to maximise the profits of the companies for which they work.

And all other considerations can go hang.

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