Studying the College-based education and training programmes of Pathologists' Assistants in the USA, it would seem that biomedical scientists in the UK, have educational attainments at least equal to those required for PAS. Recognised and documented training would formalise the ad hoc situation that currently exists and open it to peer scrutiny. Of course, there will always be cases where inspecting the excised tissue will be of indispensable value to the pathologist.

It is common that staff working at the upper end of their skills and responsibilities perform those tasks better than those who have (or see) the task at the lower end of their skills and responsibilities. The abilities of the professions involved to work together harmoniously is demonstrated by recent collaboration over the IBMS new examination in "advanced" cytology, but hindered by the description of a presentation on possible job expansion of biomedical scientists at a recent CPA conference as a "rant".

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Private Finance and NHS Hospitals

Dr A Pollock

Government policy has been to:
** reduce the size of the public sector through privatisation and contracting out*
** involve the private sector in providing existing and new services, through the private finance initiative and challenge funding.*

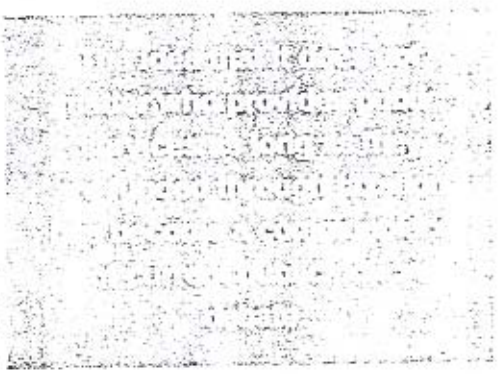
HM Treasury, Financial Statement and Budget Report, November 1996.

The idea that it does not matter who provides public services as long as they are funded through taxation has become a commonplace of current public policy debate. This article questions these assumptions in the light of what is known so far about the effect of capital charges on the NHS and the implications of the Private Finance Initiative. We argue that the current downsizing of the hospital sector has less to do with trends in the delivery of healthcare than with the policy of 'charging for capital' and that the Private Finance Initiative will further exacerbate these pressures.

Capital charges – a tax on the NHS

It has been the policy of both the current and the previous government that future NHS infrastructure development will be provided by the private sector except where the public sector can provide it more cost-effectively. That condition might be expected to have the effect of *ruling out* private provision in most cases, as the public sector can raise capital at a lower cost than the private sector, and is not obliged to make a return to shareholders: in terms of cost-effectiveness, the advantage would seem to be on the side of the public sector.

But this would be to ignore the effect of the financial regime under which NHS trusts operate, where the government in effect takes on the roles of shareholder – demanding a dividend from its investment – and chief lender – demanding returns on the trust's capital 'debt'. ('Capital' in the context of the NHS essentially means buildings and equipment). One of the most neglected aspects of the NHS market reforms has been the obligation placed on NHS trusts to introduce into the prices charged to purchasers a charge supposedly representing the capital cost of providing services. The introduction of capital charging was held to reflect a policy of pricing services in the internal market to reflect their full cost. In this exercise in mimicry of the commercial marketplace, NHS trusts are required to make returns of 6% per annum on their relevant assets to the Treasury. NHS purchasers play the role of consumers: ultimately, capital charges are met out of their budgets.



Including the cost of capital in prices would, it was argued, lead to greater cost effectiveness and thus efficiency on the part of NHS bodies. This, however, demands accepting two highly disputable premises: firstly, that an NHS hospital is sufficiently similar in *relevant* ways to a commercial enterprise that the imposition of a private sector financial regime will lead to greater efficiency; secondly, that NHS capital charges realistically represent the cost of the buildings and equipment needed to deliver services. Taking the latter premise first, NHS assets are valued at current value for land and current replacement cost for buildings, plant services and equipment rather than at historic cost (which would be the usual practice in the private sector). The effect of this overvaluation of the asset base is to

make capital charges cripplingly high. As for the choice of 6% as the rate of return, this has nothing to do with the cost of capital in the NHS: the public sector does not pay 6% interest on its borrowings. Capital charges are set at 6% 'in order to ensure that there is no inefficient bias against private sector supply' (HM Treasury Green Book p. 84). In other words the level at which capital charges were set was intended to create a level playing field with the private sector. Using the private sector to provide infrastructure under the Private Finance Initiative (see below) follows naturally from the capital charging system, as the system was designed to create that possibility.

Concerns about the potential effects of PFI on the quality and level of services are not misplaced, but in the longer term these will to a large extent be determined by the influence of private finance on the *structure* of the acute sector.

What of the incentives for efficiency supposedly created by capital charges? The effect of the system depends essentially on the income to asset ratios of individual trusts: the greater the proportion of a trust's income taken up by its annual 6% return, the more it is threatened with financial non-viability. The pressure on trusts on expensive land sites or those with large quantities of expensive equipment is particularly acute. In order to improve the ratio trusts have a limited number of options. They can try to increase their income, either by taking market share away from other NHS providers or by developing private sector income. The effect of the former is to destabilise neighbouring NHS providers: without significant expansion in purchasers' budgets, competition between NHS providers is a zero-sum game (players can only gain at the expense of other players). As for generating income through private provision, this has been marginal in relation to the effects of capital charges in most cases.

The remaining alternative for trusts is to reduce their asset base, either through disposing of parts of the estate or taking facilities out of service, by closing wards for example. The pressure created by capital charging is thus not so much about increasing efficiency as getting rid of any assets that can be disposed of, whether this is efficient or not.

The Private Finance Initiative

PFI effectively reproduces the existing capital charging regime, but with the private sector occupying the place of the Treasury and with the financial pressure exacerbated.

The private finance initiative for public sector projects was launched by the Treasury in 1992 to transform 'public sector organisations from being owners of assets and direct providers of services into purchasers of services from the private sector'. The types of projects funded under the scheme range from the building and operation of trunk roads and bridges, schools, prisons, computer systems, and vehicle fleets to the construction and delivery of NHS support systems. Early projects in the NHS included carparks, incinerators, computer systems and some radiology and pathology services. Redeveloping entire hospitals under the Initiative has proved more difficult, but since the general election four contracts have been signed for developments at Dartford, Carlisle, Norfolk and South Buckinghamshire. Fifteen other trusts are at an advanced stage in the procurement process, and a second wave of schemes is due to be announced this spring.

Under the PFI, private sector consortia of builders, bankers and facilities operators, design, build, finance and operate hospitals which are then leased back to the NHS for periods of up to 60 years. NHS Trusts enter into concession agreements with consortia under which they make annual 'unitary payments' for the use of the hospitals and for 'non-clinical services' provided by the consortia (all non-clinical services and staff are privatised under PFI). The price trusts charge to purchasers need therefore to cover the costs of construction, the maintenance, the running and the operation of the hospital as well as clinical and non-clinical services *and* the private sector's return on its investment, which can be expected to be around 17.5%. As part of the procurement process district health authorities are committed to continuing these payments for periods of no less than 25 years by providing a guarantee in the form of a 'letter of purchaser support'.

It is important to bear in mind that – at least as originally planned – the full cost of all PFI payments (apart from some funding from disposing of existing assets) was to be met from health authorities' annual revenue budgets. Although this has proved impossible, as we shall see, there was a certain plausibility to the idea given the way NHS capital charges circulate through the system. The 'returns' the Treasury receives from NHS trusts (roughly £2bn a year) are passed on to the Department of Health, which uses them in the funding of health authorities' revenue budgets. Health authorities are thus already funded to pay capital charges: it makes no difference to them whether those charges are destined for the Treasury or the private sector. The costs of private investment could, it seemed, be largely met by diverting capital charges funding.

Two problems quickly emerged to render that original scenario less plausible. Firstly, the original cost estimates for the first wave of PFI schemes proved to be wildly over-optimistic. In the course of PFI procurement the capital cost of the first wave PFI hospital schemes rose by an average of 75%. Secondly, it became clear that the rates of return necessary to make PFI schemes a worthwhile commercial endeavour are of the order of 17.5%. These rises in cost have taken place against a background of very small increases in health authority revenue funding, leading to 'affordability gaps' between the annual costs that NHS purchasers

can afford and the annual payments to be made by trusts to the private sector. 'Making these schemes affordable' (to use an NHS Executive euphemism) meant either reductions in capacity and quality, public subsidy, or a combination of both.

The extent to which proposed developments were trimmed in order to accommodate the costs of PFI will only become apparent when and if the business cases for PFI schemes are made public. However, the scale of bed reductions in the first wave schemes is striking, especially in the light of continuing rises in hospital admission rates: the average reduction in projected staffed acute beds under PFI developments is of the order of 32%.

The level of subsidy that PFI has received is at least becoming apparent. The first wave of NHS PFI schemes will demand *annual* subventions from the NHS capital budget of no less than £2·1m over the lifetime of the PFI contracts (typically, 25-35 years). Two main mechanisms are at work here. The annual unconditional (or 'block') capital allocations which are currently disbursed by NHS regions for maintenance and equipment are to be retained by the majority of PFI trusts: it was originally assumed that, as the NHS would not own PFI hospitals, this funding would be released for the use of the remaining publicly owned hospitals. The 'smoothing mechanism', a subsidy introduced in the last months of the previous government with the aim of getting contracts signed before the election, has been retained by the new government for a number of schemes. This mechanism will meet *half* of the capital costs of PFI developments over the contract period for ten of the first wave schemes.

The source of these subsidies is an NHS capital budget which was cut by 17% in 1996-97 precisely because of the investment anticipated from PFI. PFI has taken a double toll from the capital budget. The cost will inevitably fall on those trusts which do not have PFI developments. The overwhelming conclusion emerging from the first wave schemes must be that PFI has failed to provide affordable investment in NHS hospitals.

Conclusion

The effect of both capital charges and PFI is to create an incentive for Trusts to downsize their facilities, whether or not this is cost-effective and independently of any trends in the pattern of healthcare provision. In fact the evaluation of new models of care – including those set out in the current White Paper – is fundamentally compromised by the financial pressures which are forcing the NHS in the direction of downsizing. In other words, capital charging in conjunction with private investment will lead to a reduced acute sector whether or not this represents a sustainable model for service delivery.

Yet, ironically, the hospital sector will cost no less than it does now after downsizing has taken place. Indeed, a greater proportion of NHS revenue will be tied into paying for bricks and mortar through PFI payments than is the case currently, even though the buildings will not belong to the NHS. Even if future PFI schemes receive the same level of subsidy as the first wave, which is extremely unlikely, in roads will still have to be made on clinical services budgets (in effect, the wages bill, which accounts for 70% of NHS expenditure) in order to pay off the debt.

Does it make a difference whether services are provided by the public or the private sector? This depends crucially on the financial regimes of public bodies. As we have seen, NHS trusts were set up in a manner designed to reproduce precisely those aspects of private sector provision which rendered it less cost-effective than the public sector: the aim was to create a level playing field (or at least to ensure that any bias was in favour of the private sector). As long as the finances of public bodies are structured in such a way as to eliminate the differences between public and private sectors in this way, it may indeed make little difference who is providing services (although there will still be the major difference of the loss of the public sector ethos). Criticism of PFI has to begin by addressing the capital charging regime which made it an attractive option to NHS managers.

The significance of the Private Finance Initiative lies in the way it unleashes the dynamic of capital charging, which has hitherto been mainly an impediment to the 'traditional' provision of hospital care, in a thoroughgoing reconfiguration of the hospital service with potentially irrevocable effects. Concerns about the potential effects of PFI on the quality and level of services are not misplaced, but in the longer term these will to a large extent be determined by the influence of private finance on the *structure* of the acute sector.

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