

The NHS goes private

Allyson M Pollock

In 1992, the UK government launched the private finance initiative (PFI) to encourage private sector involvement in public services. Items of NHS expenditure eligible for PFI include projects relying purely on user charges—eg, car-parks and restaurants. The government has also extended compulsory competitive tendering or market testing to a range of services and capital projects; included in this category are ancillary services such as laundry, waste, catering, and cleaning; equipment leasing; and the buying in of clinical services such as pathology, radiology, and operating theatres. Extra expenditure funded this way is not included in the public sector borrowing requirement. In practice, however, PFI is an enormously expensive form of public borrowing under another name, driven by the UK government's strategic aim of opening up social welfare institutions to the private sector.¹ In the long term this policy is likely to prove more costly than public sector borrowing (since Western governments can always borrow much more cheaply than the private sector²) and its effects on healthcare provision could be disastrous.

Consider the most capital-intensive PFI projects now underway, relating to NHS building programmes and leasing for acute hospital provision. Around 59% of PFI expenditure goes on these items.³ Capital and maintenance costs of UK NHS sites are growing. One estimate is that the NHS has accumulated £2.4 billion in maintenance and repair bills alongside capital expenditure of about £2 billion a year. The government does not wish to finance these directly and has been steadily reducing NHS capital spending, which this year fell by 6.4% to £1.78 billion. There are now over 800 PFI projects either in the pipeline or awaiting approval, at a cost of over £2 billion.

Under the terms of the PFI capital costs agreements, private investors all over the UK are being given NHS hospitals and land sites in exchange for new buildings, which they in turn will lease to the NHS. This means that they are guaranteed NHS contracts for ancillary staff, lighting, laundry, and waste services—everything except direct clinical services. They are, in effect, exempt from competition and innovation. This effectively suspends compulsory competitive tendering, a cornerstone of the UK government's privatisation policy. Designing, building, and operating these services have become the exclusive prerogatives of the private sector.

In line with its anti-interventionist principles, the government has not lent its weight to the NHS in these agreements. In some privatisations government reserves the right to claw back subsequent property profits. However, it is not clear, on what basis the market values of prime sites are calculated, nor whether the NHS is to be compensated for the loss of future market values.⁴ This

approach works to the advantage of private investors and weakens poorer hospitals, whose desperation for capital investment may be such that they will not be able to exploit their market position optimally. Senior civil servants recently calculated that a new hospital would have a life of 20–30 years. Based on this figure, the contractor could hope to recoup the capital investment in the first 5–10 years. In effect, the NHS would use its scarce revenue funds to pay the entire capital costs of the building but never own it. At the end of the lease period (anything from 5 years upwards⁵), the NHS will have little option but to renew the lease, since to go elsewhere would presuppose spare capacity. Thus the NHS will be placed at the mercy of its landlords and there is no reason to suppose that these will settle for less than the 25% profits currently expected by the private residential care sector.

One reason the government ought to intervene is to ensure that services are planned for populations needs. Private investors will now be expected to design, build, and operate hospitals. Alarm bells should be ringing at the slide towards a system where, as in the USA, provider-controlled supply is the norm and where profit rather than population health is the priority. Quality of care and terms and conditions for staff are unlikely to be protected in the newly privatised services; the experience of compulsory competitive tendering is that both have been detrimentally affected, and shareholders may well trade quality of care for "efficiency" gains.

Moreover, these deals effectively do away with public accountability for public funds. For the most part, the NHS will be represented by unaccountable hospital trusts. In 1991, NHS hospital and community trusts ceased to be servants or agents of the Crown and became "bodies corporate", owning their own assets and making their own contracts with private entrepreneurs. The public's perception remains that the assets of NHS trusts are publicly owned, but their business activities are protected from scrutiny either by the public or by health authorities.

Supporters of PFI make much of the advantages to the NHS of transferring the risks of capital costs to the private sector. They cite delays in completion of NHS capital projects—as long as 30 years from the design stage. Nevertheless, most delays are not contractor-driven but financial, stemming from a stop-go mentality on the part of regional health authorities anxious to ensure that books balance at the end of each financial year. Moreover, since the state continues to guarantee free health care at the point of delivery, it is hard to see how the government could avoid underwriting the risks involved. To do so would amount to withdrawing hospital services from particular populations, and the government has not yet signalled a willingness to do that. Indeed its guidance for financial institutions trading with NHS Trusts states that the "concepts of bankruptcy and insolvency as generally understood in the private sector are therefore not strictly applicable to trusts".

Lancet 1995; **346**: 683–84

Department of Public Health Sciences, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, UK
(A M Pollock MPhM)

In the light of these considerable benefits, what are the risks to the private sector? The NHS is, after all, a £32 billion, recession-proof, inflation-proof business, with a 0.75% real growth annually. One might envisage risks in the competition that would ensue from any move by the UK government to transfer responsibility for healthcare provision to the private sector. Until then, PFI is a licence to print public money. The government seems prepared to increase long-term public debt in order to encourage more private sector involvement in health care, secure in the knowledge that rising costs will enhance the financial case for state withdrawal from an increasingly expensive welfare service.

The UK population, however, cannot afford the costs of handing health care over to the private sector. The provision of long-term residential care illustrates the point. Between 1985 and 1989 the number of beds in the private nursing home sector grew from 26 900 to 194 800. Between 1982 and 1993, public sector provision lost 148 000 free long-term care NHS beds and 40 000 local authority long-term care supported places.⁶ The massive switch to private care was brought about by a change in the law which allowed residents of private nursing homes to claim full income support to pay the costs of care. The change did not cover patients in NHS and local authority places. In the past 7 years, the private sector has grown by 260%, and now represents 57% of the total market in residential and nursing home care in terms of annual revenue. Many operators of residential care homes make a trading margin of around 30% per bed, or £5000 on an average annual fee income of £16 000. If one assumes a capital cost of £30 000 per bed, this is a trading return of 17%.

Capital costs and central overheads vary. Large operators incur overheads of 5.7-5% of total fees, which leaves ample margins for profit. Two leading operators, Westminster and Takare, make profits of 25% of turnover. Takare, which increased its profits by 41.2% this year, is publicly financed to 86% of total fees: 65% is funded by the Department of Social Security and social services and 21% is contracted out on a long-term basis from the

NHS.⁷ Thus about 80% of the profits come directly from taxpayers' money. The cost of long-term care to the public is estimated to be £8 billion, of which private residential and nursing home care accounts for £4.6 billion. If providers show the same profit margins as Takare, £1 billion of taxpayers' money is diverted from services into shareholders' pockets. The private nursing home sector is expected to grow by 30-40% over the next 2 years and by 72 000 beds over the next 6 years. On current trends and changing sociodemographic projections, this may reach 1 million beds by the year 2050. Currently the market is fragmented because of the large number of small providers. The fourteen major companies own only 12% of all beds: smaller homes drive up costs with higher overheads, but with Takare set to meet 22% of total forecast requirements, market consolidation looks likely in the near future.

PFI is an extension of the government's 1980s policy on long-term care. Then, private investors were granted a monopoly of state business at an inflated rate to look after a cross-section of society. Now the principle will be extended to cover whole hospitals (and the populations depending on them). The costs to the public purse, to public accountability, and to the founding principles of the NHS—equity, comprehensiveness and universality—are likely to be heavy.

References

- 1 Anon. A great deceit: the private finance initiative. *Public Policy Rev* 1995; 2: 45-46.
- 2 Corry D. Public and private partnerships. *Renaissance* 1995; 3: 41-48.
- 3 Newchurch and Company Ltd, and NHS Executive. Private finance in the NHS Update (newsletter), May, 1995. (Available from Newchurch and Company Ltd, 12 Charterhouse Square, London EC1M 6AX, UK.)
- 4 NHS Executive. HSG(95)15. Private finance and capital investment projects. Leeds: NHS Executive, 1995.
- 5 Willets D. The opportunities for private funding in the NHS. London: Social Market Foundation, 1993.
- 6 Pollock AM. Where should health services go: local authorities versus the NHS. *BMJ* 1995; 310: 1580-84.
- 7 Takare plc. Interim report, 1995. (Available from Takare plc, Takare House, Whitechapel Way, Priorslee, Tetford, Shropshire TF2 9SP, UK.)