Debate about the Private Finance Initiative is usually confined to its effects on the acute sector. Allyson Pollock puts PFI in the context of the recent White Papers and shows how a primary-care-led NHS could soon become a profit-directed NHS

It's not too late to save the NHS

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Just as community care heralded the privatisation of long term care provision and ultimately the privatisation of its method of funding, the primary care-led NHS heralds privatisation of the remainder of the NHS. What will the new Government do to reverse the trend?

The introduction of private capital through the Private Finance Initiative (PFI), in combination with the recently passed primary care legislation, poses the greatest threat to the NHS since the introduction of the internal market — a market that has already fragmented care, eliminated patient choice and destroyed the planning framework for service delivery.

Building new hospitals with private cash

Managing any type of PFI is divided into three complex phases: planning, procurement and contracting. The responsibility for managing each of these phases rests with the organisation seeking capital investment. In the case of new NHS hospitals this falls to the individual NHS trust. During the planning phase the NHS trust has to produce an outline business case and put together a project team. Having done so it then enters the procurement phase where a specification of service requirements is developed, bidders are shortlisted, an invitation to tender is drawn up, preferred bidders are shortlisted, a full business case is produced and the contract awarded. The cost of this process to the NHS and the private sector can run into several million pounds. Trusts are not obliged to consult on changes to hospital services. But they cannot carry out a major PFI development without the support of the local health authority. When the trust has chosen its partner for the scheme it is obliged to seek health authority approval for it. The health authority has a statutory duty to consult with the community health council.

The last Conservative Government's aims for the health service were to replace the powerful public sector with the private sector, and to transfer funding of health care from the public to the private purse. Yet it could not privatise funding until it had privatised provision. In the 1980s this began with privatisation of the provision of long term care, and with the privatisation of ophthalmology and dentistry. Funding of long term care is now about to be completely privatised, through long term care insurance and means-testing.

PFI was launched in 1992 for funding capital projects in the public sector. The Government's stated objective was to transform public sector organisations from being owners of assets and direct providers of services to being purchasers of services from the private sector. The private sector thus becomes the provider of capital and of services. The types of project funded under PFI range from the building and operation of trunk roads, computer systems, town halls, office accommodation and vehicle fleets, to the construction of hospitals and delivery of support systems for front-line NHS staff.

As the *BMJ* has shown[1], the use of the PFI for whole new hospitals is well underway — the 18 NHS trusts aiming to sign PFI deals listed in the table. Dartford and Norfolk and Norwich have already signed contracts; the others aim to sign contracts in the near future.

Under PFI, planning of hospital services is left to the private sector consortia which operate the hospitals. In the words of Kenneth Clarke: 'Under PFI, the public sector does not buy assets, it buys

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services. The private sector is responsible for deciding how to supply these services and what investment is required to support these services.'

Under NHS Executive guidelines, trusts do not specify the number of beds they think they need to meet their clinical commitments. Instead, they specify outputs, the level of anticipated clinical activity. It is left to the private sector contractors to suggest the appropriate number of beds for the level of clinical activity.

The consortium which wins the contract decides how many beds are necessary to deal with the projected activity. Moreover, the consortium will have flexibility to reduce beds still further. Health authorities and trusts will lose the control they currently have over the number of hospital beds and levels of service required for the population. Hospital and service planning is left to the dictates of the commercial sector.

The most notable feature of all the first wave PFI hospital schemes under negotiation is the reduction in bed availability (table). The 26-30 per cent decrease is out of line with national trends for England and Scotland (figure).

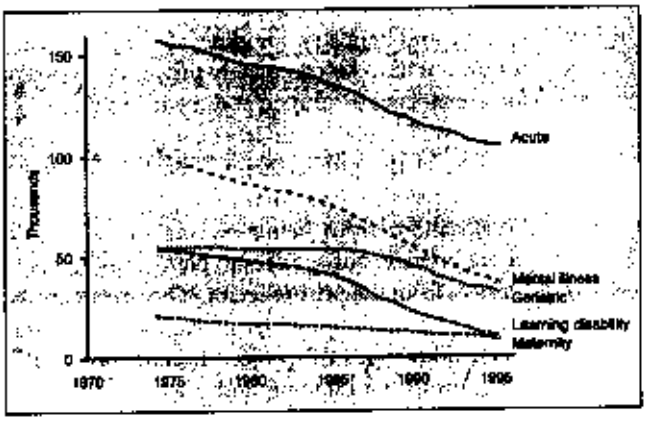
In Scotland the average number of beds in acute and supraregional specialties available daily fell from 19,969 in 1982 to 14,904 in 1996 — a 2.1 per cent average annual decrease. In England the average number of acute beds available daily fell from 144,000 in 1982 to 100,000 in 1993-4 — a 2.5 per cent per year average annual decrease). This downward trend has levelled out at 108,000 during 1995-96. In the past two years, the number of acute NHS beds in England increased by 0.3 per cent.

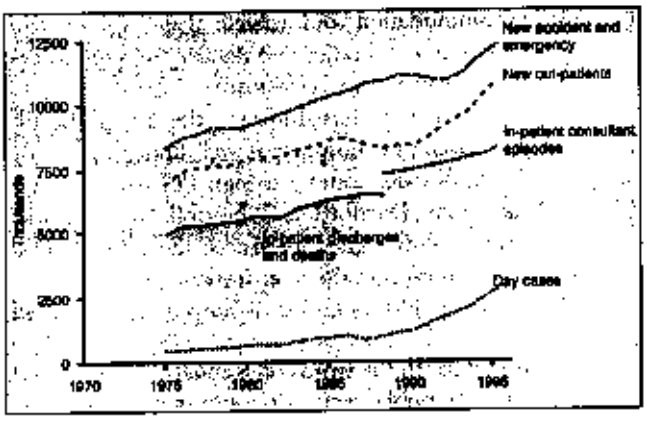
One reason why numbers of beds have not continued to decrease is the rising trend in inpatient activity (see figure). Numbers of inpatient and day case episodes for all specialties in England rose by 4.9 per cent per year from 1988/89 to 1995/96 per year and by 6.5 per cent from 1994/95 to 1995/96. In Scotland, which still has a large number of long-stay beds, in-patient discharges and day cases for all specialties rose by 3.5 per cent between 1985/86 and 1995/96.

These trends in inpatient activity suggest little scope for further reductions in numbers of beds without posing a threat to access to care and quality of care. Clinical services are affected by PFI predictions of bed activity projections and bed reductions. Their revenues will be used to fund PFI bricks and mortar. Bed reductions mean reductions in clinical services. But what if the predictions are wrong? If clinical activity rises in line with national trends then clinical services will be at risk. The PFI contract is only for a given level of activity. If clinical activity is exceeded then trusts could face penalty clauses.

Any extra money would have to come from the clinical services budget since, in effect, PFI monies are ringfenced. Doctors will be faced with stark rationing choices to provide less care or risk losing their budgets. Although the Government has said that PFI does not include clinical services, it has refused to rule out the possibility of privatising hospital staff in the next parliament.

Average number of beds available daily, England (top) and NHS hospital activity, all specialties, England 1974-1995/96 (right). Source: DHSS and DH Statistical bulletins 5/85, 1995/20 and 1996/23





So how do advocates of PFI justify these reductions? Some say that a primary care-led health service complemented by new models of community care will mean fewer beds needed. Yet few GPs, social services or hospital consultants appear to have been consulted.

But PFI investors are also concerned about GP fundholding. As fundholders will hold most of the budget in the future, what is to stop them moving contracts from PFI hospitals to other hospitals? The *Choice and Opportunity* White Paper offered PFI investors a new means of protection. Fundholding practices, or an agency on behalf of the practice, may now be able to hold combined budgets for hospital and community health services and primary care.

Moreover these agencies on behalf of the GP fundholder will be able not only to design build and operate services as now but also to operate clinical services. They will be able to employ their own clinical staff including hospital consultants and they will have the power to determine the range of services and number of staff they want to employ. Given that the more they save on patient care and clinical services the more they can reinvest in PFI deals, these could be lucrative,

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particularly if the PFI has a private hospital or a private patients unit in its grounds. The implications for planning and patient care are serious.

The White Papers move the NHS towards an insurance model where the capitated budget may be held by a single agency — in the short term by GP fundholders or possibly through salaried GPs or NHS trusts. Patients will access their purchaser and total care through their GP, and will be increasingly tied into the services the fundholder contracts for total care. This raises questions: how will patient choice and local accountability for services be ensured, and how will service monitoring and service planning be undertaken?

The effect of giving GPs greater freedom to invest savings, equity and harness PFI may well be mergers between practices, and of practices with community trusts. When PFI is taken in conjunction with the firm model, large fundholders or community trusts could become commercial partners and shareholders. Such a model operates in the US model where groups of physicians own and manage networks (with large shareholdings and profits). In turn they employ other physicians and staff or partially capitate them for care, and may also own and run buildings or subcontract for care.

If fundholders are allowed greater freedom to invest savings, and to use PFI, they could begin to own the capital of, for example, trusts and hospitals. If this were to happen the commercial for-profit sector would demand that the market be opened up. In the short term fundholders would make a great deal of money as they would be bought out by the big corporations. GPs provide access to patients and hence the budget. Once the private sector is opened up, other managed care networks would move in. There would then be greater freedom to raise and introduce charges and to use private health insurance. There will also be a greater risk of agencies limiting their risks, either through careful patient selection or through restricting access to benefits.

PFI in combination with the recent primary care legislation poses the greatest threat to the NHS since the introduction of the internal market. Doctors must ensure they are kept informed of the consequences of PFI by insisting on seeing the plans put out by health authorities and trusts relating to bed numbers, activity and clinical service projections. Look at the contracts – these concern public land and public assets and should not be secret. The NHS belongs to the public, and its disposal cannot be through a back door privatisation. ■

What happens to bed numbers under PFI

Trust	Best available bed numbers	Bed numbers under PFI	Percentage change
Barnet General*	646	411	- 36
Bishop Auckland**	565	454	- 20
Bromley Hospitals	619	507	- 18
Calderdale Hospitals	832	508	- 29
Carlisle Hospital Trust	509	474	- 7
Dartford & Gravesham*	524	400	- 24
Greenwich Healthcare	654	573	- 12
Hereford Hospitals	414	250	- 40
Norfolk and Norwich Acute Trust	1,207	809	- 33
North Durham Acute Trust	750	450	- 40
South Buckinghamshire	806	Refused	
Swindon & Marlborough*	632	450	- 29
Walsgrave & Coventry**	1,145	1,083	- 5
Worcester Royal Infirmary*	697	390	- 44
Total	9,194	6,759	- 26
Lanarkshire Health Board			
All acute	1,482	1,286	- 15
All geriatric assessment	226	200	- 12
Lothian Health Board			
All acute	2,234	1,442	- 35
All geriatric assessment	661	415	- 37
Total acute	3,716	2,698	- 27
Total geriatric	887	615	- 31

Bed numbers on Trusts marked with an * are taken from NHSE, Bed Availability for England, 1995/96 (London: DoH/NHSE, 1996). All others were supplied by the Trusts themselves. Caveat 1: Some of the percentage decreases will underestimate the true loss as data were unavailable for smaller hospitals due to close as part of the PFI agreement. Caveat 2: The total percentage of bed losses was calculated by excluding hospitals where PFI projections were unavailable. Trusts marked ** are in the process of merger and reconfiguration — new data will become available.

This table has previously been published in the *British Medical Journal*.

REFERENCE

Pollock AM, Dunnigan M, Gaffney D, *et al*. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. *Br Med J* 1997; **314**: 1266-71.