The reference in the guidelines to patient self-administration devices is of particular importance to general practitioners who may find that using the patient's own syringes is more efficient than trying to open their bags and prepare an adrenaline injection. The Epipen device, for example, has been shown to give more consistent and rapid adrenaline absorption than that obtained with subcutaneous adrenaline.[3] Finally, the guidelines give due recognition to the importance of prevention through reducing exposure to suspected allergens. Preventive measures include, for example, the removal of peanuts from in flight refreshment menus; rapid identification of sufferers from anaphylaxis, who should wear appropriate information bracelets; and their assessment at a specialist allergy clinic.

These guidelines are welcome. They offer sound and pragmatic advice that will enable doctors to prescribe adrenaline and intravenous fluids with more confidence. We are sure that the guidelines will soon be seen adorning the walls of emergency departments, general practitioners' surgeries, and outpatient clinics, just as cardiac resuscitation guidelines now do.

Geoff Hughes *Clinical director*

Emergency Services, Wellington Hospital, Wellington, New Zealand (wemgh@mash.wnhealth.co.nz)

Penny Fitzharris *Clinical immunologist and allergist*

Department of Medicine, Wellington School of Medicine, Wellington, New Zealand (pfitzharris@wnmeds.ac.nz)

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PFI: perfidious financial idiocy

A "free lunch" that could destroy the NHS

> "I see the private finance initiative in very simple and personal terms. At the moment I own a beautiful but outdated home in a prime position in Edinburgh, one of the world's loveliest cities. Now I'm going to 'give it away' at below market value in exchange for a smaller, unglamorous modern house on the edge of the city that doesn't have enough bedrooms and is hard to reach by public transport. Worse, I'll have to pay for it for 30 years—without any option of moving elsewhere. Worse still, we will have to reduce how much we do around the home in order to pay for the new building. Worst of all, my children will find themselves years from now in an outdated building in an awful position. They won't be able to afford either a new home or the services of the home. They'll have to buy them privately."

This is the view of one doctor in the Royal Infirmary of Edinburgh of what the private finance initiative (PFI) means to him, his colleagues, and his successors. His view may simplify some of the complexities of the initiative, but it's more true than untrue. The private finance initiative is a "smoke and mirrors" policy that may destroy the NHS.[1–8] The complexity of it all has left many electors bemused, and the English media (unlike their Scottish equivalents[9]) have not managed to put this issue before the public in a way that grabs their attention. But we must wake up to the profound implications of the private finance initiative before it's too late. And this is not just some local dispute: public-private partnerships, of which the private finance initiative is one form, are being used worldwide and in sectors other than health care—such as education and criminal justice. Poor people in the developing world may suffer much more than the people of Edinburgh.

The *BMJ* has already published extensively on the private finance initiative,[1–8] and the BMA has campaigned against it.[10] In Scotland the whole policy is falling into disrepute,[11 12] but in the rest of the United Kingdom the debate about private finance has not had the intensity and urgency it deserves. This week we begin a series on the private finance initiative that we hope will contribute to changing policy (p 48).[1–4]

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The private finance initiative has its roots in governments everywhere wanting to reduce public expenditure and in the desperate need in many places, certainly in the NHS, to replace outdated infrastructure. Electorates are unwilling to elect governments which are explicit about increasing taxation, and there are legitimate economic arguments that public expenditure creates less value than equivalent expenditure in the private sector. Hence the mantra is to reduce public expenditure, even though governments as market oriented as that of Margaret Thatcher usually fail to do so. The private finance initiative is presented as using private money to pay for the infrastructure developments that are needed for public services, but it is still paid for through the public purse—so it is not new money. Unfortunately the schemes produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital.[2 5]

Much evidence is accumulating to show that private finance initiative schemes are costing much more than traditional public funding of capital developments.[1 2 7 10] The £2.7bn ($4.3bn) Scottish private finance initiative programme, for example, will cost some £2bn ($3.2bn) more than it would have done if the Treasury had acquired the assets directly.[2] Trusts embarking on private finance initiative projects thus have a considerable gap to fill. The first way they try to do so is by reducing the proposed capacity of the new hospitals—possibly, even probably, to a point where they won't be able to do the job. Hereford's plans, for example, began with a requirement for 351 beds.[1] This proved unaffordable. The latest scheme envisages around 250. Funds also have to come from reducing service delivery, meaning fewer staff. Because no

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scheme funded through the private finance initiative is yet fully up and running we must wait to see how much staffing will be reduced to meet the extra costs. What's more, the NHS as a whole is having to underwrite these extra costs, meaning that resources shift from providers who remain in public ownership to those privately owned,[1] undermining still further the goal of greater equity in the NHS.

One way that trusts can fill the affordability gap is through increasing "income generation," which mainly means increasing the number of private beds. In areas with private finance initiative schemes both the number of private beds and the proportion of all beds that they represent is increasing.[3] Private finance initiatives may inevitably lead to an increase in the private sector and user charges, providing one way for the NHS to shrink to a rump service for the poor. This is almost certainly not the intention of the government, but it may be starting a process that will lead inevitably to that end.

The extra cost in a cash limited system is the biggest problem with the private finance initiative, but there are others. One is the closed nature of the planning process.[6 7] An important part of NHS planning is in effect being done by private companies without adequate accountability. Bed numbers are reduced to make plans affordable without any thought of what the knock on will be for other parts of the NHS. A second factor that infuriates many of those working within the NHS is the complete absence of evidence for the private finance initiative.[5 8] In fact all the evidence we have suggests that it's a very bad idea. 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.

All these arguments against the private finance initiative are becoming familiar. Why, then, does the government persist? Partly, as always, it's the problem of saving face, but more important may be the lack of sufficient imagination (and commitment) to think of an alternative. Direct public support for capital projects would be much better than the private finance initiative, but there are other alternatives—like a health development bank, proposed by the King's Fund.[13] The great minds of the Treasury should abandon the private finance initiative and come up with an alternative that will allow the modernisation of the NHS, not oblige it to shrink to a rump service. The electorate wants modernisation not destruction.

Richard Smith *Editor, BMJ*

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Magnesium sulphate and pre-eclampsia

Trial needed to see whether it's as valuable in pre-eclampsia as in eclampsia

Magnesium sulphate has been used for treating eclampsia in the United States for much of the 20th century.[1] The international collaborative eclampsia trial confirmed that this anticonvulsant is indeed more effective, and safer, than alternative drugs.[2] British obstetric practice has changed rapidly in response to these findings,[3] and standard treatment of eclampsia in the United Kingdom now much more closely corresponds to that of the United States, although some controversies remain about optimal dosage.

Is treatment of pre-eclampsia also better in the United States? As many as 5% of all pregnant women in some US centres receive magnesium sulphate in the belief that this prevents eclampsia and thus improves the outcome of pregnancy.[4] In contrast, some UK experts advocate never using anticonvulsants for pre-eclampsia[5]; many clinicians would use anticonvulsants only in women with severe pre-eclampsia.[3] Such enormous differences in attitude are mirrored by practice in other countries[6] and reflect uncertainty about the best treatment of "the disease of theories."[7]

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The central issues are:

- Even for women with severe pre-eclampsia, the risk of eclampsia is low—around 1%.[3]
- The risk of eclampsia is probably reduced by magnesium sulphate, but, even if this reduction is by as much as 50%, very large numbers of women will need to be treated to prevent a single fit.
- Therefore, if prophylaxis with magnesium sulphate is to do more good than harm it must be very safe for both the woman and her child and should have few side effects.

Pre-eclampsia is a complex, multisystem disorder and how magnesium sulphate may prevent eclamptic convulsions is unclear. Magnesium may have localised effects, producing cerebral vasodilatation with subsequent reduction of cerebral ischaemia,[8] or blocking of