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Private finance for the public good?

Still no sign of evidence based policy making

Early promotion of the British government's private finance initiative (PFI) suggested that everyone would benefit. The initiative is an extension of the government's contracting out policy. A hospital requiring new operating theatres or a scanner must seek competitive tenders from private sector companies both to build and to run these facilities. Under the initiative, an NHS trust does not purchase a scanner, it signs a contract to purchase, say, 1200 scans a year for 10 years. The NHS does not own the scanner so the cost of purchasing the equipment does not appear as a public expenditure. The result, so the enthusiasts predicted, would be that politicians could take credit for higher capital spending, doctors and patients could move from semiderelict buildings to modern facilities, and construction companies in the doldrums of a property recession would have extra work. The initiative would substitute private finance for public funds, and the NHS would have the use of more and newer hospitals, scanners, and incinerators.

But life is full of illusory free lunches. The initiative will not bring new money to the NHS. The services provided by privately financed capital projects will have to be paid for out of the cash limited, tax financed budget of the NHS. Public expenditure plans for the next three years show real NHS funding constant or falling. Capital projects funded by the private finance initiative are not subject to the public sector borrowing requirement, which puts limits on public spending. However, the ongoing costs of providing and maintaining the service, including repayment of the capital cost, will have to come out of public funds.The government assumes that private sector ownership of hospitals, scanners, or incinerators will lead to lower future costs, and therefore that the fixed (or declining) NHS budget will be able to purchase extra services for patients.

The initiative is a radical change for the NHS. But the Treasury admits that there is no central system for monitoring or control. Treasury evidence to the House of Commons Treasury Committee stated that the initiative is decentralised, "for example, health authorities around the country are entering into contracts, and I do not think we can produce information on individual schemes. That would be the responsibility of individual departments and authorities."[1] Douglas Hogg, head of the Treasury's private finance unit, noted that the NHS had a database of private finance initiatives, but while "trusts are encouraged to register ... I am not aware that they are actually required to or there is a means to require them."[1]

The private finance initiative creates genuine risks for the NHS that need monitoring and evaluating. Schemes to generate income by selling services to non-NHS purchasers are an integral part of the initiative. Many major income generation schemes involve the setting up of private patient facilities on NHS sites. Through these, the government is in effect reducing direct capital investment for NHS patients, facilitating improved provision for private patients, and using the profits generated to fund new facilities for NHS patients. The outcomes of this convoluted system need evaluating and quantifying. Is encouraging trusts to stimulate demand for private health care the most cost effective way of financing services for NHS patients?

There is also the risk that providers will see the initiative as an opportunity to indulge in quality inflation. In the United States, hospitals compete on the quality of their facilities. New technology is vigorously marketed regardless of its cost effectiveness. In Britain, providers must gain approval from purchasers for projects set up as part of the private finance initiative. Purchasers must decide if new technologies and higher quality services are "affordable" in light of forecasts of their future tax financed budgets. Problems will arise if purchasers do not rigorously evaluate projects and yield to the pressure from providers to support schemes, or from politicians who want projects approved quickly to generate votes. Future tax revenues would then be mortgaged to fund, at best, higher quality services for fewer patients or, at worst, non-cost effective diagnostic procedures and treatments, reducing the quantity and quality of NHS services.

There is also a major worry about what happens in the next economic downturn, when public expenditure is reduced. NHS trusts are currently signing contracts committing future tax revenues to fund private finance initiative projects for the next 10 to 30 years. When scientific change or population movement or public expenditure cuts make particular facilities redundant, will the cost of premature termination of these contracts be greater or less than the cost of rationalising health care services under existing NHS procedures?

Many questions remain unanswered due to political haste to implement the initiative and the pressure to retain confidentiality of commercial contracts. We presume that government ministers will instruct the director of NHS research and development, Professor John Swales, to evaluate the initiative carefully, particularly as the present secretary of state for health has indicated that all "experiments" must be evaluated.[2] In the end these questions will be answered empirically, based on whether or not private sector finance does produce health care services for NHS patients at acceptable financial risk and at a lower cost than public sector management. If it does, in the face of the inordinate bureaucracy associated with the initiative—one trust has spent over £1m preparing the tender specification, which is 1700 pages long—tax revenues will buy more health care and this is to be welcomed. At present there is no evidence to confirm or refute the hypothesis on which the private finance initiative is based, that private sector management is superior. As ever, evidence based policy making in the NHS is notable by its absence.

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