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

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 conjunction 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, the use of the PFI for whole new hospitals is well underway. The NHS trusts aiming to sign PFI deals listed in the table. Bradford 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 Clark: 'Under PFI, the public sector does not buy assets, it buys...'

Medical Interface May 1997
The most notable feature of all the first wave PFI hospital schemes under negotiation is the major reduction in bed availability.

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 28-30 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 106,000 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 6.1 per cent from 1991/92 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 privatizing hospital staff in the next parliament.
Doctors must ensure they are kept informed of the consequences of PFI by insisting on seeing the plans relating to bed numbers, activity and service projections.

What happens to bed numbers under PFI

<table>
<thead>
<tr>
<th>Trust</th>
<th>Best available bed numbers</th>
<th>Bed numbers under PFI</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet General*</td>
<td>640</td>
<td>471</td>
<td>-36</td>
</tr>
<tr>
<td>Bishop Auckland*</td>
<td>360</td>
<td>454</td>
<td>-29</td>
</tr>
<tr>
<td>Bradley Hospitals</td>
<td>590</td>
<td>450</td>
<td>-24</td>
</tr>
<tr>
<td>Calderdale Hospitals</td>
<td>832</td>
<td>573</td>
<td>-12</td>
</tr>
<tr>
<td>Carlisle Hospital Trust</td>
<td>569</td>
<td>479</td>
<td>-40</td>
</tr>
<tr>
<td>Darlington &amp; Gracelands*</td>
<td>354</td>
<td>400</td>
<td>-12</td>
</tr>
<tr>
<td>Greenon Healthcare</td>
<td>604</td>
<td>559</td>
<td>-9</td>
</tr>
<tr>
<td>Hereford Hospitals</td>
<td>414</td>
<td>250</td>
<td>-50</td>
</tr>
<tr>
<td>Norfolk and Norwich Acute Trust</td>
<td>1,257</td>
<td>809</td>
<td>-33</td>
</tr>
<tr>
<td>North Durham Acute Trust</td>
<td>720</td>
<td>450</td>
<td>-39</td>
</tr>
<tr>
<td>South Buckinghamshire</td>
<td>806</td>
<td>Reduced</td>
<td>-38</td>
</tr>
<tr>
<td>Swindon &amp; Marlborough*</td>
<td>622</td>
<td>450</td>
<td>-29</td>
</tr>
<tr>
<td>Walney &amp; Coventry**</td>
<td>1,145</td>
<td>1,083</td>
<td>-5</td>
</tr>
<tr>
<td>Worcester Royal Infirmary*</td>
<td>897</td>
<td>390</td>
<td>-44</td>
</tr>
<tr>
<td>Total</td>
<td>9,194</td>
<td>6,759</td>
<td>-26</td>
</tr>
</tbody>
</table>

Lancashire Health Board
- All acute: 1,482, 1,286, -15%
- All geriatric: 226, 200, -12%

Leeds Health Board
- All acute: 2,234, 1,447, -35%
- All geriatric: 661, 415, -37%

Total acute: 2,916, 1,898, -35%

Total geriatric: 807, 615, -37%

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. Case 1. Surveys of the percentage decreases will underestimate the true loss as data were unavailable for smaller hospitals due to closure as part of the PFI agreement. Case 2: The true 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