Mark Hellowell, research fellow at the Centre for International Public Health Policy, University of Edinburgh, and Allyson Pollock, director of CIPHP, examine whether PFI is proving a good model for funding primary care in Scotland

PFI: friend or foe of primary care in Scotland?

For over a decade, the private finance initiative (PFI) has been the chief means of providing capital investment in Scotland's NHS. Contracts have been signed for a total of 46 PFI projects, most of them delivering new hospitals or new hospital departments. The Royal Infirmary of Edinburgh and the new district hospitals at Hairmyres and Wishaw were all delivered through this financing method, but PFI is now also being used to fund primary care projects in Scotland.

Although private finance costs more than public finance, the Executive argues that PFI is better value for money because the private sector's own money is at risk. The extra cost of PFI is attributed to the extra risks that private investors and their banks claim to carry. However, recent reports from the National Audit Office show that the returns to the private sector are out of proportion to the amount of risk being taken. With the Norfolk and Norwich Hospital, for example, the capital cost of the scheme was £158m, but the cost to the public will be at least £1.3 billion over 34 years. The consortium anticipates making a total profit of £335m over the life of the contract.

Unlike traditional procurement, responsibility for servicing debt under PFI is devolved by the Treasury and the NHS to local level: health boards in Scotland and NHS trusts in England. Research has shown that the additional costs of private finance create an 'affordability gap' which can only be met by scaling back the scope or quality of clinical services (for example, by reducing the number of beds and staff), selling land and closing facilities. Even where these cuts are made, however, they have not always provided boards with the necessary savings.

In Scotland Ministers plan to raise a total of £1bn through private finance for the hospital-building programme, with huge new hospital projects planned for Fife and the Forth Valley. And here, too, private finance is to be extended to the primary and community care sectors. The result is that the private financing of NHS infrastructure and the influence of the companies involved are becoming much more significant in Scotland.

Following in England's footsteps, Scotland is planning a programme of new, privately financed primary care centres. Dozens of these centres have been procured in England under the Local Improvement Finance Trust (LIFT) initiative, run by the Department of Health. So far, half of all primary care trusts in England have entered into LIFT contracts and the rest are expected to joint them over the next five years.

The Scottish Executive has lifted the model wholesale from England, with an initial wave of six to eight schemes, accounting for between £20m and £30m each in private finance, currently being planned. The legislation required to develop the 'Hub' initiative – Scotland's version of LIFT – was hidden away in last year's Smoking Bill and received little attention. But Hub requires proper scrutiny. Like PFI and LIFT, Hub will generate an affordability gap – meaning that resources will have to be diverted from other capital works and clinical services to pay the charges.

During an inquiry into England's LIFT programme, the Public Accounts Committee heard evidence from Dr Bhupinder Kohli, a GP whose premises in Newham, East London, were the first to open under LIFT in 2004. Dr Kohli's data provides clear evidence that LIFT is leaching resources away from the rest of the local health economy. He found that the average spend per patient by his primary care trust on premises was £8, but the average spend for Newham's two LIFT buildings was £43.40 These LIFT facilities treat just eight per cent of the PCT's population, but account for 32 per cent of the total facilities budget for Newham. The National Audit Office has noted "the common perception" among pharmacists, dentists and local authorities "that the higher cost of LIFT, compared with current rent payments, outweighs the benefits of new, purpose-built premises".

But the problems go well beyond the financial. Important questions need to be raised about PFI's effect on democratic accountability and patient access. The Hub approach will involve the creation of new public-private companies that take on important responsibilities – such as health investment planning – that used to be the preserve of the NHS. Local NHS bodies hold shares in these profit-making entities and take seats on the board of directors, raising obvious questions about potential conflicts of interest.

In England, the LIFT model is being quietly 'enhanced' so that it can play a more pivotal role in the privatisation of clinical services. Under new plans, LIFT companies are to become involved in commissioning or directly providing clinical services. Initially, this will involve a greater degree of private sector involvement in primary care. But as LIFT moves into diagnostics and elective care, large private corporations are moving to provide a range of healthcare services. LIFT LOBI, an organisation representing companies involved in LIFT, is backing the expansion, aware that the profit-making opportunities will be considerable. The lobby group is pushing for the new facilities to take the form of 'health malls' in which a range of private providers will plan and deliver services, with the NHS's role in healthcare reduced to that of funder. There is scant protection in the current regulations for the public interest, let alone the public health.

To what extent will Scottish Ministers choose to follow England's route? Andy Kerr, the Health Minister, has said in the Scottish Parliament that there is currently "no policy intention for joint venture companies established to provide clinical services". However, some initial steps are being taken towards the English model of 'diverse' markets in healthcare commissioning and delivery. The Scottish Executive's recent policy paper, *Delivering for Health*, outlined a variety of ways in which the private healthcare sector would be used to "support our objectives for a greater separation of elective and emergency work and for faster access to diagnostic services". The SEHD has earmarked £45m over three years to develop independent sector treatment centres (ISTCs) – an exact carbon copy of the English model.

From its inception, the ISTC programme's stated function was to establish additional clinical capacity in specialities that traditionally suffer from long waiting times, such as orthopaedics and ophthalmology. But, as the BMA demonstrated in evidence to the Commons' Health Select Committee recently, the ISTC programme – far from adding capacity – has simply seen activity and scarce NHS funds transferred from NHS organisations to the for-profit health sector at higher cost and with few guarantees as to quality.

Those who care about safeguarding an efficient, equitable and universal healthcare system in Scotland would be well-advised to watch what is happening in England. First PFI, then LIFT, and now private clinical provision have crossed the border and with each new import, Scotland's NHS moves a step closer to being broken up and privatised.

■ The Centre for International Public Health Policy carries out research into the growing importance of markets and non-state parties in national and international contemporary public health policy. From September 2006 it will be running two new MSc programmes, Public Health Policy (Global Health) and Public Health Policy (Public Private Partnerships). For more information, please visit www.health.ed.ac.uk/ciphp or contact mark.hellowell@ed.ac.uk

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