UN Committee on the Rights of Child

Day of Discussion on

THE PRIVATE SECTOR AS SERVICE PROVIDER AND ITS ROLE IN IMPLEMENTING CHILD RIGHTS

Friday, 20 September 2002
Office of the High Commissioner for Human Rights
Palais Wilson, Geneva

Submission by

**Health Policy and Health Services Research Unit,
University College London**

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Public private partnership in the UK – the private finance initiative

This note summarises the Health Policy and Health Services Research Unit's research into private sector participation in public service provision, with special reference to hospital services.

Public private partnerships (PPPs) are an important part of the UK government's public service modernisation programme. Within the programme it is generally assumed that the question of who provides services is unimportant. For example, the private finance initiative (PFI), a PPP tool for funding public investment and services through the private sector, is described by government as a neutral procurement tool.

Our research into PFI tests this claim and shows the effects of increased private sector participation on health service costs, planning and access, and accountability and governance.

Background to the introduction of private investors - principles of the NHS

The founding principles of the NHS are comprehensive care and services free at the point of delivery, delivered on the basis of equity. As a national health service it has neither local tax raising nor income generating powers. Indeed such powers would contravene the spirit of the NHS, returning health services to the inequitable situation which pertained pre-1948 - relying on the wealth of local areas and introducing regressive elements to its funding.

The goal of equity is achieved by using the mechanisms of risk pooling and cross subsidisation. Risk pooling and cross subsidisation were embedded in the structures for the funding and organisation of services. These structures have until 1991 shielded the NHS from the adverse consequences and extra costs of market forces.

From 1948 until 1991 funding for NHS capital investment was distributed as government grants, and planning structures were evolved to link planning, population needs, and funding. However, the NHS inherited badly run-down estate with enormous inequities in the pattern and distribution of services across the country.[1] From the outset, capital funding was inadequate and the new hospital building programme did not start until 1962 and was never completed.[2] In recent years net expenditure on capital investment has been negative, indicating that the NHS was consuming itself (selling assets) in order to pay for capital investment.

The NHS brought all hospitals and health service facilities apart from GP practice premises under public control and ownership. No charge was made on capital as to do so would have aggravated the inequities in distribution.

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[1] Webster C. *The National Health Service: a political history*. Oxford: Oxford University Press 1998.
[2] Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative - expansion or contraction? *BMJ* 1999;319:48-51.

In 1992 charges for capital ('capital charges') were introduced to the NHS in order to facilitate the involvement of the private sector. The introduction of capital charges ended the era of funding NHS investment using government grant. The government switched to debt finance, requiring NHS services to make a return on capital employed and paying the government as banker and shareholder.

Under the private finance system (PFI), the government borrows indirectly by raisings funds for capital investment through an intermediary of businesses and banks. In the case of hospitals, a consortium of bankers, builders and service operators known as a special purpose vehicle raise the finance for capital investment, in return for which they design build and operate the buildings and receive an annual fee which covers the cost of capital, interest and services.

Effects on hospital costs

PFI costs more than traditional procurement because private sector sources of finance are more expensive than government borrowing and because PFI financing costs not payable under traditional procurement add 25%-35% to hospital construction costs. The revenue impact of the additional capital costs are substantially above existing NHS capital charges paid by the PFI trust and above the NHS capital charges that would be paid under traditional procurement. We draw your attention to the following reports and articles where the relevant evidence is set out.[3]

Financial advisers have argued that extra costs will add to public sector liabilities unless a PFI deal brings in new third-party payers such as service users.[4] However, with some qualifications (see governance section below) charging has been ruled inappropriate for NHS investment although it is being considered for roads in the form of tolls. Thus the extra costs of PFI investment in the NHS have to be met from within existing public finances.

Effects on access to healthcare

The higher cost of PFI creates an affordability gap in the NHS that leads to reductions in service provision, acute bed capacity, and clinical staffing. The service reductions are greater than those that would occur under traditional procurement because the debts are greater.

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[3] Rowland D, Pollock AM, Price D. *The school governor's essential guide to PFI*. London: UNISON, October 2001.
Pollock AM, Shaoul J, Rowland D, Player S. *Public services and the private sector: a response to the IPPR Commission.* London: Catalyst 2001.
Pollock AM, Vickers N. Private pie in the sky. *Public Finance*, 14 June 2000: 22-4.
Pollock AM. PFI is bad for your health. *Public Finance* 6 October 2000: 30-1.
Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative – expansion or contraction? *BMJ* 1999; 319: 48-51.
Gaffney D, Pollock AM, Price D, Shaoul J. PFI in the NHS – is there an economic case? *BMJ* 1999; 319: 116-9.
Gaffney D, Pollock AM, Price D, Shaoul J. The politics of the private finance initiative and the new NHS. *BMJ* 1999; 319: 249-53.
Gaffney D, Shaoul J, Pollock AM, Vickers N. *Public services, private finance: affordability, accountability and the two-tier work force.* London: UNISON 2001.
Gaffney D, Shaoul J, Pollock AM. *Funding London Underground: financial myths and economic realties.* London: Listening to London 2000.
Gaffney D, Pollock AM. *Downsizing for the 21st century. A report to UNISON*. Second edition. London: UNISON 1999.
Price D, Pollock AM. *Debts, deficits and service reductions: Wakefield Health Authority's legacy to primary care trusts*. London: UNISON 2002.
[4] Middleton N. Experience of privatisation in the UK. PwC, 1999.

Attempts to keep costs down have seen dramatic average bed losses of 30% in the first 11 PFI hospital schemes and reductions in clinical budgets of up to 20%, the relocation to cheaper land sites in order to offset the higher costs by land sales, and the removal of equipment from the schemes.

It is maintained by the government that service reductions are in line with clinical trends in the NHS and are not financially driven. However, this is not borne out by trend data. Service reductions that are against trends in clinical productivity frustrate Government health care objectives. We draw your attention to evidence of financially driven reductions in acute sector capacity as a result of the shift to debt financing and private financing.[5]

Effects on healthcare planning

The relationship between new investment and service configuration raises questions about the planning process: who is making decisions on future services, and on what basis? Until 1990, planning priorities were set by regional health authorities and were based on service needs. Regional planning departments estimated bed capacity by using population based measures of utilisation and service provision. The evidence from PFI business cases is that these methods have been abandoned and that new hospitals have been planned not on the basis of healthcare needs but on the basis of local affordability and the need to make cash savings on the revenue budget.[6]

Thus the system of debt financing operates against NHS objectives of universality based on needs-based planning and is therefore an inefficient instrument for NHS aims.[7]

Effects on governance

While individual providers have more control over service levels because of the abandonment of traditional health care planning, they are now also responsible for their own investment and their own revenue. The government has introduced new guidelines and powers which will for the first time in 50 years introduce a time limit to NHS care through the creation of an intermediate care sector. Trusts will have the potential to redefine some NHS care as personal care and to introduce charges for it.[8]

This has major implications for accountability and transparency. Under these conditions, it will become increasingly difficult for the public to understand what is going on, how care is being paid for, and how it is being redefined. This has the potential to increase inequalities in access and will invariably lead to increasing fragmentation and loss of coordination in planning and providing care.

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[5] Gaffney D, Pollock AM, Shaoul J. Capital investment and the NHS workforce. House of Commons Health Select Committee. Future staffing requirements, 1999; 3: appendix 52-3.
Pollock AM, Price D, Dunnigan MG. *Deficits before patients: a report on the Worcester Royal Infirmary PFI and Worcester Hospital reconfiguration.* London 2000.
Pollock AM. Evidence to House of Commons Health Select Committee. Capital investment in the NHS under the 1990 NHS and Community Care Act: the impact of moving from government grant to debt finance in an under-funded system, 10 December 2001.

[6] Pollock AM, Dunnigan MG, Gaffney D, Price D, Shaoul J. Planning the 'new' NHS: downsizing for the 21st century. *BMJ* 1999; 319: 179-184.

[7] Pollock AM. Evidence to House of Commons Health Select Committee. Capital investment in the NHS under the 1990 NHS and Community Care Act: the impact of moving from government grant to debt finance in an under-funded system, 10 December 2001.

[8] Department of Health Health Service Circular / Local Authority Circular. HSC 2001/01: LAC(2001) 1 Intermediate care.

Table 1 Cost of capital as a percentage of income, pre and post PFI

Trust	Pre PFI	Post PFI
	Capital as % of income	Capital as % of projected income
Norfolk & Norwich	0.7	18.9
South Tees Acute Hospitals	3.9	10.0
Dartford & Gravesham	7.5	27.2
Greenwich Healthcare	3.7	13.3
Swindon & Marlborough	3.3	14.3
Bromley Hospitals	7.0	10.7
Calderdale Healthcare	3.0	11.3
North Durham Healthcare	2.9	9.9

Sources: Fitzhugh Directory 1999; Health Committee, *Public Expenditure on Health and Personal Social Services 2000. Memorandum received from the Department of Health containing replies to a written questionnaire from the Committee*. London: the Stationery Office 2000; NHS Trusts Annual Accounts, 1998-99, 1999-2000.

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