

Public–private partnerships and the Private Finance Initiative

The November 2006 *Bulletin* paper by Martin McKee et al., *Public–private partnerships for hospitals* (84(11):890–96), makes several valid and useful points about the Private Finance Initiative (PFI) in the building of new United Kingdom of Great Britain and Northern Ireland (UK) hospitals. In particular, the emphasis on the failure of the UK government to undertake a rigorous evaluation of the PFI is welcome, as is the coverage of ministers' attempts to discredit the work of scholars whose research has disproved many of the claims made in favour of it.^{1,2}

At the same time, the paper has some serious weaknesses. First, at several points it treats the key issues raised by the PFI as if they were still open, when from a scientific viewpoint this is unjustified. The paper fails to draw attention to an extensive and detailed empirical literature dealing with the affordability problems created by PFI and their impact on public expenditure and the scope of service provision.

Given the quantity of detailed research devoted to this and related issues over a period of more than ten years, not least by my own research team (previously at University College London and now at the University of Edinburgh)^{3–9} and the failure of any PFI supporter to refute the findings, it is surprising to see the debate as a whole described by fellow scientific researchers as “ideological”.

The paper's concluding statement that “it is impossible to say whether the model underlying public–private partnerships is flawed or whether the difficulties ... are the result of mistakes in its execution” is not even consistent with the authors' own apparent conclusions in the body of the paper.

Second, the authors seriously underestimate some of the problems they acknowledge that the PFI presents. There is no reference to the systematic failures of risk transfer, which underpins the

government's justification for using private financing, rather than less costly public financing. The paper claims that PFI investments are high-risk and near “junk bond” status, suggesting extensive risk transfer. The paper cites the Office of Government Commerce (OGC) in this context.

But the OGC's claim does not relate to the risks borne by investors, which are generally triple A, and only refers to bonds (www.hm-treasury.gov.uk/media/6066B/ppp_Guidanceon-CertainFinancing.pdf). It is true that the underlying credit strength of PFI projects is usually in the range of BBB– to BBB+. However, most PFI bonds to date have been “wrapped” by a monoline insurer, allowing the bonds to benefit from an AAA rating. The cost of this insurance is borne by the public. Therefore, risk transfer in bond financing is paid by the public through the costs of private finance and the insurance costs.

The paper acknowledges that the very low risk actually transferred to the private consortia has enabled the latter to enjoy “significant benefits”. But the scale of the profits made through refinancing – in the case of the Norfolk and Norwich University Hospital project giving returns of 70% on the contractors' original investment – is surely more than a “significant benefit”: it is a misuse of public funding that fundamentally undermines the risk transfer argument.

Third, the authors overlook further research that has demolished “the one positive finding” they claim has been established concerning the PFI: the government's often-repeated assertion that it reduces the cost and time overruns of hospital procurement relative to the traditional system. A study of the evidence for this claim shows that it rests on a single erroneous report by a consultancy with a major interest in PFI projects (http://www.health.ed.ac.uk/CIPHP/publications/unison_2005_pfi_a_policy_built_on_sand_pollock.pdf, <http://society.guardian.co.uk/societyguardian/story/0,1600183,00.html>).¹⁰

The focus of this report was on price certainty after contracts are signed – a method that is bound to favour the PFI. A more valid comparison between PFI and traditional procurement pricing would involve increases from the Outline Business Case (OBC) stage, not post-contract increases. The PFI process from OBC to Final Business Case (FBC) is relatively longer than that in traditional procurement, and there are bigger differences between OBC and FBC figures for price and delivery time. Department of Health figures show that the average cost increase between OBC and financial close for “prioritised” PFI projects is 74.5%. Therefore, the paper's statement that “compared with the traditional system, PFI facilities are more likely to be built on time and within budget” is unfounded. ■

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Response to *Public-private partnerships and the Private Finance Initiative*

Allyson Pollock suggests that we have been unduly lenient on the Private Finance Initiative (PFI), even though we made very clear that this policy, which continues to underpin the British Government's approach to capital procurement, has many flaws. Specifically, Pollock criticizes our suggestion that the jury is still out. We sympathize with her argument, as will be clear from our earlier paper entitled "Is the private finance initiative dead?"¹ in which we suggested that it was. However, notwithstanding our views, some people seem determined to keep it alive, a decision that is now even more surprising given growing evidence of how it is distorting planned reconfigurations of hospital services.² We felt it was important to reflect the reality that not everyone was convinced by the evidence. Furthermore, it is important to recognize that the available evidence relates almost exclusively to the models adopted in the Australia and the United Kingdom, and we cannot exclude the possibility that models employed elsewhere might be more successful.

We must clarify our description of the debate as ideological. In the following sentence we noted the fierce personal attacks that had been made by some British politicians on one PFI critic and, although we did not name her, the victim was Pollock. The juxtaposition of these sentences was intended to make clear that the ideology was emanating from successive British governments. We agree entirely that the wealth of evidence that Pollock and her team have produced has not elicited any meaningful response from the government, who have consistently declined to engage on the issues.

We disagree that we failed to address the failure to transfer risk from the purchaser to the contractor. While we welcome Pollock's additional information, we did discuss this in the section on cost. Although we might debate the precise wording that was used, we do

not argue that the profits made by some private consortia have been, by any standards, excessive.

We do, however, concede Pollock's final point about timeliness. We did address this partially in relation to the failed development in west London but we should have made clear that when the overall project duration is considered, beginning with the outline business case, then the duration, as well as the cost, is often much greater than with conventional procurement.

We welcome this opportunity to have an open debate on the British model of public-private partnership. We agree with Pollock that this is a flawed model, even if we focus on different aspects of it. It is only a pity that its strongest supporters are unwilling to justify their position publicly. ■

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Contraception counselling and compliance

The editorial on inequality and unwanted fertility in developing countries in February's *Bulletin*¹ reminds us all that maybe this is the time to achieve the goal – all pregnancies should be intended, consciously and clearly desired at the time of conception.

Unwanted pregnancies are not only the major cause of maternal mortality and morbidity, but are also a great social and financial burden on societies and countries. According to WHO statistics there are an estimated 200 million pregnancies around the world each year, and a third of these, 75 million, are unwanted. Unintended pregnancy also is a major health problem in the United States of America. In the 2002 National Survey of Family Growth assessment, 1.22 million, or 31%, were reported as unintended. When

abortions were included, unintended pregnancies increased to 2.65 million, or 49% of all pregnancies.

These pregnancies contribute to women's health problems in two ways. First, unwanted pregnancy can threaten a woman's health or well-being because she may have existing health problems or lack the support and resources she needs to have a healthy pregnancy and raise a healthy child. Second, where women do not have access to safe abortion services, many resort to unsafe procedures that can lead to their death or disability. It is estimated that nearly 80 000 maternal deaths and hundreds of thousands of disabilities occur around the world because of unsafe abortions. Due to the political nature of women's health care, implementation of healthy public policy has been most difficult to achieve. Appropriate preventive, curative and community care have central roles in the pursuit of the health-for-all targets.

Availability, accessibility and perspectives towards contraception are complex social, political and economic issues. Contraception is a women's health issue. It is about choices and human rights, not fear, guilt and shame. The negative images and concepts perceived regarding family planning and contraception in some religious and social arenas are the major factors responsible for noncompliance and meagre usage of birth control methods in many areas of the world. A fundamental tenet in ethical, female-centred care is that women have a right to participate in their choice of contraceptive method. A woman who has actively chosen a method is more likely to use it consistently and correctly. Responsible sexual behaviour and family planning should be part of men's health checks as well. This will increase users' compliance with various birth control methods. It takes two people to conceive.

With such a wide range of contraceptive options available, health-care providers face the challenge of matching each patient with the method that is best for her. Proper evaluation of the woman's individual reproductive desires, medical complications and other

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health concerns is a necessary first step. Consideration should also be given to lifestyle issues and patient preferences regarding form and route of administration. Ultimately, education is the key to compliance, long-term use and success. Women's contraceptive needs change throughout the reproductive life-cycle and must be re-evaluated over time. It is important to address specific concerns of young women to promote compliance. Counselling is essential to provide accurate information about the mechanisms, efficacy and safety of available options. Understanding the needs and characteristics of the individual patient can help the health-care provider to direct her towards the method that will best suit her needs in terms of efficacy, safety and ease of use.

There is no magic pill or quick-fix solution to the population explosion. Governments, health-care providers and religious leaders, working together, can contribute substantially towards a healthy future for families around the world. As women live longer than men, the quality of their longer life becomes of central importance. Women and men have different circumstances, challenges and health concerns as they age. Enhancing health potential depends on preventing and reducing premature mortality, morbidity and disabilities. We are slowly learning one of life's most important lessons: not just how to live longer; but also how to stay longer in good health with less dependence on others. The desire for a healthier and better world in which to live our lives and raise our children is common to all people and all generations. ■

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