Is this the end of the road for the PFI?

The initiative that led to more than 100 new hospital schemes in Labour's boom years is looking increasingly unaffordable in this era of austerity, finds **Peter Davies**

What prospects await the private finance initiative (PFI)—that unlikely emblem of Labour's boom years when hospital building (and investors' profits) flourished as never before? In an era of austerity, with a Conservative and Liberal Democrat coalition government, will PFI remain "the only game in town" for NHS capital development or be seen as increasingly unaffordable? Has it left a legacy to be proud of or merely mortgaged a huge chunk of the NHS's income for generations to come?

Currently 76 large PFI contracts are operating in the English NHS, costing £890m (€1bn; $1.4bn) a year.[1] Since 1997 more than 100 new hospital schemes have opened, with over 90% of the £12bn invested coming from PFIs.[2] But the golden age has long since peaked. By 2005 a survey found big falls in the number of bids from the private sector,[3] and in 2006 the Department of Health halved the value of 15 schemes approved two years earlier.[4]

Today's economic climate is harsher than anything foreseen five years ago. According to Carl Emmerson, deputy director of the Institute for Fiscal Studies: "If the private sector is still finding it harder to borrow than before the financial crisis, that may mean PFI is more expensive and less likely to be the value for money option. So for the more marginal cases, conventional finance may be more attractive to government."

But as Mr Emmerson points out, the coalition's emergency budget stated that funds for all conventional public investment would be cut from £49bn in 2009-10 to £20.6bn by 2014-5. The result is much less public sector capital development of any kind, he says. This could mean that although there may be fewer new PFI projects, they form a larger share of the whole.

Evidence so far supports this. None of the last eight major NHS PFI schemes approved by Labour has yet been axed, but the £460m publicly financed North Tees and Hartlepool Hospital has—and its trust is now investigating PFI as an alternative. "That would suggest if there are going to be any new major building projects, PFI will be the way," says Sean Boyle, visiting research fellow at the London School of Economics. "But the question in the next five years is whether there will be room for any capital expansion as opposed to just dealing with day to day running and depreciation."

Inflexibility

Indeed, the cost of existing PFI contracts in a health service tasked with saving £20bn by 2014 looks set to become a flashpoint. The medical profession has always been suspicious of PFI, perceiving it as foisting lengthy, expensive, and inflexible commitments on the NHS for political reasons often difficult to reconcile with clinical judgment or economic sense.

Hamish Meldrum, chairman of the BMA council, can scarcely hide his exasperation that the NHS should continue to be dogged by a concept promoted by a former government to preserve a "golden rule" it eventually violated in spectacular fashion—keeping public borrowing below 40% of gross domestic product. He particularly laments the lack of flexibility in PFI contracts, which some see as having "hardwired" existing forms of provision into the system. Inflexible PFI contracts can be enforced to an absurd degree. For example, when the Scottish government wanted to abolish hospital car parking charges, it was able to do so everywhere except three hospitals where the car parks were covered by PFI contracts, Dr Meldrum points out.

"The medical profession has always been suspicious of PFI, perceiving it as foisting lengthy, expensive, and inflexible commitments on the NHS"

"We're not necessarily against some sort of public-private partnership arrangements, but we feel there are better ways," he says, adding: "They have to look at the possibility of renegotiating PFI contracts. How easy or expensive that's going to be is another matter."

It is certainly a matter that has already attracted government attention, beginning under Labour. In 2009 the Department of Health asked management consultants McKinsey to examine how the NHS could improve productivity. One suggestion was to renegotiate interest charges on PFI schemes, most of which were agreed when rates stood at 6-8% though by last year they had fallen below 1%. McKinsey argued this could save up to £200m a year.[5]

Recently the National Audit Office exhorted the Department of Health to use its "leverage" to persuade PFI contractors to share efficiency savings with the NHS. Currently they are not obliged to do this, although they must share windfall gains from refinancing deals. "Investors and contractors will naturally seek to maximise their profit margins, and we have seen examples where this is at the expense of the trust," the audit office said, noting this could seriously hamper trusts' ability to achieve savings targets and jeopardise PFI contracts' value for money.[1] It acknowledged, however, that the health department lacked performance and cost data to use as ammunition.

Any way out?

So how easy would it be to renegotiate PFI contracts? Economists are cautious. "I've never thought it realistic to get more savings once a contract has been signed," says Mr Boyle. "Contractors have not been willing to discuss it. Their line has been, if you want to play hard ball we won't be going for future contracts."

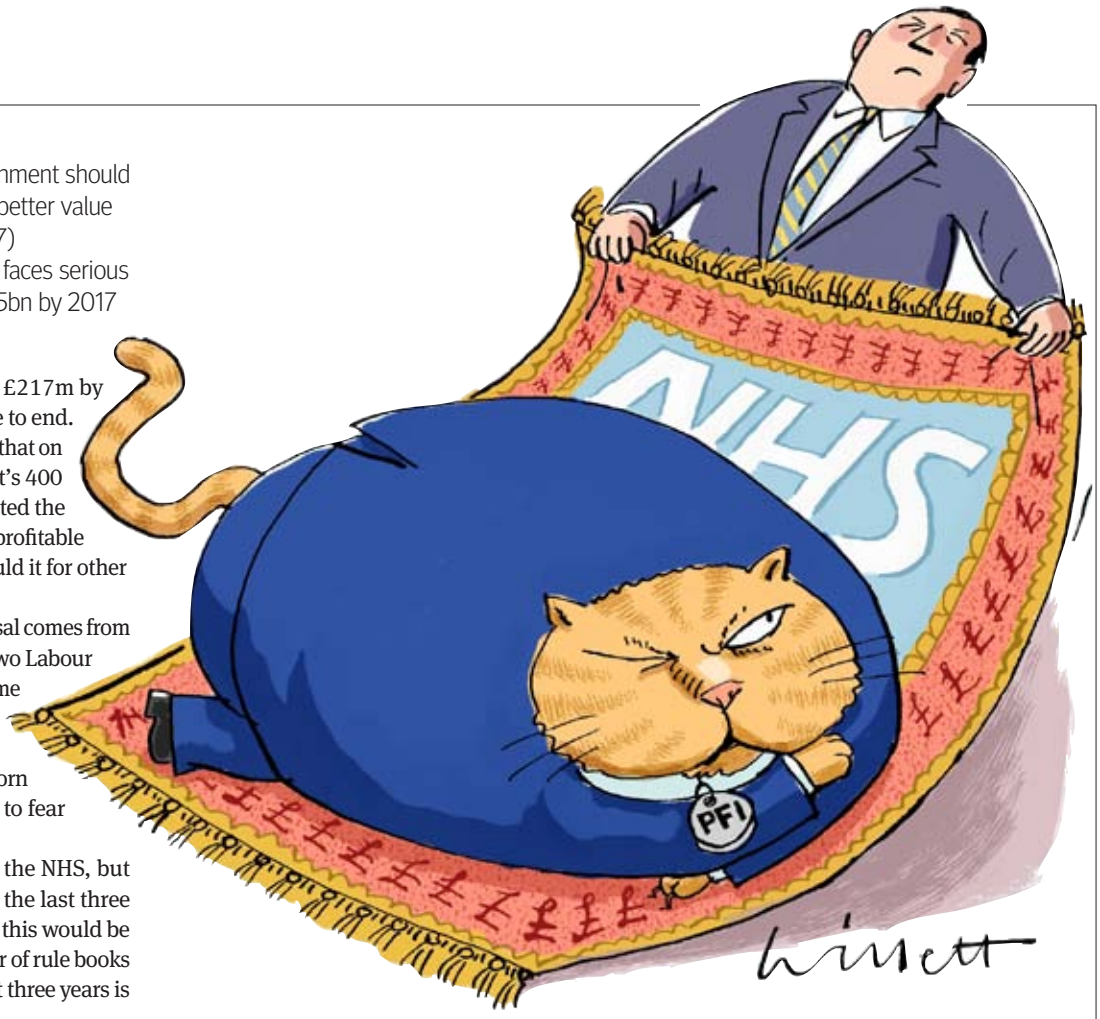
Mark Hellowell, research fellow at Edinburgh University's global public health unit, says the government has used its purchasing power as the contractors' biggest customer before, when it persuaded them to them to share savings from refinancing deals. "They'd been realising an equity windfall and pocketing it. The government convinced most of them this was creating so much political controversy it threatened to slay the golden goose."

Now, however, the goose may appear less golden. "Financiers and contractors would regard the NHS as an important market, but much less important than it used to be as the pipeline of forthcoming schemes is much diminished." Instead they may see a future in exporting PFI, with British companies now setting up missions in Mexico and Brazil to promote public-private partnerships in health care, Mr Hellowell says.

If renegotiation proves tricky, could the NHS simply buy itself out of costly contracts? Dr Chris Edwards of the University of East Anglia floated this proposition last year based on a study of Norfolk and Norwich University Hospital's PFI contract.[6] He calculated a buy-out would cost

bmj.com archive

- News: Audit office says government should renegotiate PFI contracts to get better value for money (*BMJ* 2010;340:c3277)
- News: London health service faces serious financial problems and cuts of £5bn by 2017 (*BMJ* 2010;340:c3937)



£300m but would save the trust £217m by 2037, when the contract was due to end. However, Dr Edwards now reports that on closer examination of the contract's 400 pages of legalese he underestimated the cost, and a buy-out would not be profitable after all—nor, by implication, would it for other NHS PFI agreements.

Perhaps the most radical proposal comes from Paul Corrigan, former adviser to two Labour health secretaries and the then prime minister, Tony Blair. He advocates simply tearing up PFI agreements. In a world where agreements are torn up every day, the NHS ought not to fear this as controversial, he says.

"PFI is a big sum of money in the NHS, but against the debt restructuring of the last three years it's weeny. You might think this would be breaking the rules, but the number of rule books ripped up in banking over the last three years is astronomical."

Debt has become highly fluid, subject to frequent restructuring, with its price and value changing rapidly, Professor Corrigan says. PFI debt is the conspicuous exception, but it too must be made fluid to reflect changes in the assets to which it relates. It is imperative that the NHS can restructure services and income flow through PFI institutions, and that trusts' debt reduces accordingly. "The nature of healthcare buildings will change dramatically over time. It's odd to treat a building as if it would stay the same for 30 years when intellectually you knew it wouldn't."

The Department of Health should seek help from the Treasury in putting its PFI agreements on a different footing, Professor Corrigan says, as the Treasury is "involved hourly in renegotiating hundreds of billions of pounds." If left in isolation, the NHS could only "negotiate clumsily from a position of weakness."

But any such request may be rebuffed. "Revisiting the costs of contracts would have to be on a case-by-case basis and I wouldn't expect we'd see huge reductions as a result," says a Treasury source.

Before the election George Osborne, now chancellor, said: "Labour's PFI model is flawed and must be replaced. We need a new system that doesn't pretend that risks have been transferred to the private sector when they can't be, and which genuinely transfers risks when they can be."[7]

What progress has been made? The Treasury source seems keen to dampen expectations. "No doubt it's something the government will be looking at, but I'm not sure we're quite there yet." And although PFI is included in the new Office for Budget Responsibility's remit, it is to examine issues of transparency not policy fundamentals.

If PFI remains unreformed, the consequences for clinical services may be dire. In their search for savings, trusts with PFI contracts will be unable to reduce the cost of their support services so may have to squeeze clinical budgets instead. Ironically, to avoid controversy government policy has always deliberately excluded clinical services from PFI contracts.

According to Mr Hellowell, PFI trusts allocate more of their budget to maintenance and ancillary services than other trusts but are reimbursed only the national average. This puts clinical services under immediate pressure, he says. "There's a really strong correlation between the presence of large PFI contracts and significant annual deficits. It's therefore reasonable to have some concerns about clinical services."

What has PFI achieved for the NHS? "Enormous change in hospital plant," says Professor Corrigan. 'There's no way public funding could have done it that quickly, and if it hadn't been done quickly it would have been stopped: look what's happened to schools."

PFI's excessive rewards for investors in return for minimal risk make no economic sense, says Mr Hellowell, but the policy may have made political sense: "The Treasury may simply never have provided the Department of Health with the budget for such schemes otherwise."

Mr Boyle says: "From a political point of view it enabled a Labour government to show it was friendly to business, but from an economist's viewpoint I can't see any evidence of benefits."

Peter Davies is a freelance journalist, London
petergdavies@ntlworld.com

Competing interests: None declared.
Provenance and peer review: Commissioned; not externally peer reviewed.

1 National Audit Office. The performance and management of hospital PFI contracts. 2010. www.nao.org.uk/publications/1011/pfi_hospital_contracts.aspx.
2 Department of Health. Rebuilding the NHS: a new generation of healthcare facilities. DH, 2007.
3 O'Dowd A. Private sector is losing interest in PFI projects. *BMJ* 2005;331:1042
4 Hellowell M. Is PFI on the critical list? *Public Finance* 2008 Aug 29. www.publicfinance.co.uk/features/2008/is-pfi-on-the-critical-list-by-mark-hellowell/.
5 McKinsey. Achieving world class productivity in the NHS 2009/10-2013/14: detailing the size of the opportunity. Department of Health, 2009.
6 Edwards C. Private gain and public loss; the private finance initiative (PFI) and the Norfolk and Norwich University Hospital (NNUH); a case study. University of East Anglia, 2009.
7 Helm T, Inman P. We'll bring a new model PFI, vows George Osborne. *Observer* 2009 Nov 15. www.guardian.co.uk/politics/2009/nov/15/osborne-replace-pfi.

Cite this as: *BMJ* 2010;341:c3828

Expert witnesses above the parapet

Clare Dyer reports on the problems facing doctors acting as witnesses in child protection cases and attempts to overcome them

"My feeling was 'why take the risk of losing my livelihood?'" This is how Terence Stephenson, president of the Royal College of Paediatrics and Child Health, explained why he decided five years ago to turn down requests to be an expert witness in cases where parents are suspected of making up or causing their child's illness.

He made the disclosure in a statement for the judges hearing the appeal of fellow paediatrician David Southall, who was appealing against being struck off by the General Medical Council for accusing a mother of murdering her son.

Professor Stephenson told the court that in the 14 years before his decision he had given advice in 30 such cases. "What changed? In 2005, I was asked by the Medical Defence Union to assist in the preparation of the defence of Roy Meadow. In the same year I was reported for the second time to the GMC regarding a case of fabricated or induced illness."

The GMC ordered Roy Meadow, a former president of the royal college and a pioneer in the recognition of fabricated or induced illness, to be struck off for straying outside his expertise and giving misleading statistical evidence in the case of solicitor Sally Clark. She was jailed for murdering two of her babies but later freed on appeal. Although the High Court subsequently allowed Professor Meadow to stay on the medical register, his reputation among the general public has never recovered.

"Both Meadow and Southall have been vilified in the media. No wonder other doctors are keen to stay below the radar"

In the years before the GMC took action against them, Meadow and Southall, the leading experts on fabricated or induced illness—then known as Munchausen syndrome by proxy—were targeted in a hate campaign mounted on behalf of parents who claimed they had been falsely accused. Dr Southall, who finally won in the court of appeal in May and is now back on the medical register, has been subjected to a barrage of inquiries and investigations and taken to the GMC three times.

Loss of anonymity

Both have been vilified in the media. No wonder, then, that other doctors who give evidence in difficult care cases are keen to stay below the radar. Could a recent high court judgment and new legislation making it clear that expert witnesses in care cases cannot count on anonymity mean that fewer still will want to take on the work?

Tim David, a consultant paediatrician and professor of child health, is in strong demand as an expert witness in complex court cases where parents are accused of deliberately harming their children. If he and many of his colleagues were to withdraw their services from the courts, local councils would be hamstrung in their role of protecting children.

Professor David recently waged an unsuccessful court battle to keep his name under wraps after he acted as an expert witness in a case about a baby whose parents were accused of breaking his leg. The couple ultimately won their son back after the judge found there was no cogent evidence they had harmed him.

Professor David, along with a paediatric radiologist who also appeared in the care proceedings, asked for the injunction then in force barring anyone from naming them to be extended until 2025, although three other experts in the case decided not to join in the attempt.

In a statement for the High Court Professor David said: "When I agreed to assist in these care proceedings, it was on the clear understanding that the normal rules of engagement were in operation—namely, that all correspondence, reports, and evidence would be treated as confidential to the court, as has always been the case in care proceedings."

He added: "I regard the confidential nature of the work to be a fundamental principle, and I would not have agreed to assist or become involved in this case had I known that there was (or would be) any intention to disclose details of my involvement, or my evidence, to the media."

Another paediatric radiologist, who was instructed by the police to advise on a possible prosecution of the parents and later withdrew his bid to keep his identity secret, told the court: "I am very concerned at the prospect of being named because I felt, and feel, that my professional reputation and, more importantly, my professional credibility and, therefore, eligibility to continue to assist as an expert witness in future cases, whether on behalf of a child or an authority, would be compromised by what I have reason to believe would be a one-sided account of my involvement . . . any allegation that I am in some way 'anti-parent' would be grossly unfair and inaccurate."

None of the doctors who sought anonymity was criticised by the judge who presided over the care proceedings; indeed, she described Professor David's paediatric overview as of "tremendous assistance."

The parents, who had kept a video diary, wanted to be free to tell their story to the BBC after the case ended and applied to the High Court for the anonymity covering the expert witnesses, treating doctor, and social workers to be lifted. Lord Justice Munby weighed up the parents' right to tell their story against the doctors' fear of vilification and the shortage of experts, and came down in favour of openness.

"When all is said and done, it seems to me to be a very strong thing to say that the identities of expert witnesses giving evidence in care cases—

bmj.com archive

- News: Southall faces being struck off for a second time (*BMJ* 2010;341:c3799)
- News: Child abuse experts "astonished" that convicted doctors' critic is in guidance group (*BMJ* 2010;341:c3788)
- News: Southall plans new career as expert witness in child protection cases (*BMJ* 2010;340:c2529)
- News: Paediatrician David Southall is restored to the medical register (*BMJ* 2010;340:c2448)

RCPCH FEATURES

Terence Stephenson, president of the Royal College of Paediatrics and Child Health, now turns down expert witness work

MARK ST GEORGE/REX

Sally Clark, the British solicitor acquitted of the murder of her two sons, at the High Court, London, January 2003

BOB COLLIER/REX

Roy Meadow's reputation among the general public has yet to recover since acting as an expert witness in the Sally Clark case

REX

David Southall has been subject to a barrage of investigations and taken to the GMC three times. He is now back on the medical register

cases where the consequences for both child and parent are potentially so serious—should be concealed from the public," he declared.

The experts considered appealing but decided not to, perhaps because the rule that experts may be named was about to be enshrined in legislation—in the Children, Schools and Families Act, which was one of the bills rushed through in the dying days of the last parliament. The legislation is not yet in force and the new government has not yet taken a final decision on it. But Lord Justice Munby's judgment makes it clear that no expert witness can count on anonymity.

So will Professor David, now that he won't be able to be sure he can keep his identity secret, withdraw his services as an expert witness? He declined to answer the question, saying only that he could not comment on the case and did not wish to comment on the wider issues involved.

New approach

In 2004 the government, concerned that doctors were shunning expert witness work, asked the then chief medical officer for England, Liam Donaldson, to come up with ideas to tackle the shortage of medical experts, particularly paediatricians, willing to give evidence in care cases. His 2006 report, *Bearing Good Witness*, suggested that NHS trusts with sufficient expertise should set up multidisciplinary teams, with doctors doing the work as part of their NHS job plans.

Little has been heard of the proposals since then, but a low key pilot began in April 2009 and an evaluation by a team at Cardiff Law School is due to be published in June 2011. As of April 2010, 21 cases had been referred through the pilot, run by the Legal Services Commission—which pays for legal aid—with the Department of Health. Of the six multidisciplinary teams that have joined the pilot at different times, one is a private organisation and one, from Great Ormond Street Hospital, has been in existence for 20 years. And although it was the shortage of paediatricians that inspired the report, the teams are comparatively light on paediatricians and heavy on psychiatrists and psychologists.

In Dr Southall's former area of North Staffordshire, the contract for the pilot that began in April 2010 is with the mental health trust, and the team comprises a clinical psychologist, a psychiatrist, and an independent social worker. Consultant paediatrician Martin Samuels, a former colleague of Dr Southall and experienced expert witness, was unaware of the pilot and questions whether paediatricians would be able to do the work as part of their job plan. "I don't see the trust giving me time to do this sort of work. There would have to be a real sea change in attitude. Most people who do this sort of work do it outside their job plans in their own hours. It's a very, very time consuming activity."

A spokesman for the Legal Services Commission said a review of a sample of cases found that psychologists and psychiatrists were the most frequently used experts in children's cases, so teams taking part in the pilot were required to have representatives from those disciplines. "All teams can and should call upon paediatricians and experts from other disciplines as and when they need to," he added. Three of the six core teams have paediatricians but "the others can bring this expertise into the team should a particular case demand this."

In the wake of Dr Southall's successful appeal, the GMC has set up an expert group to review the problems paediatricians face in doing child protection work. Chaired by Lord Justice Thorpe, deputy head of family justice, it also includes Professor Stephenson; Rosalyn Proops, child protection officer for the Royal College of Paediatrics and Child Health; Keith Brent of the BMA's central consultants and specialists committee; and Heather Payne, associate dean of the Wales Deanery. Non-paediatricians include a child psychiatrist, a general practitioner, a lawyer, and Penny Mellor, a parent advocate who says she has played a role in about 50 complaints about doctors to the General Medical Council. Dr Payne supports the Bearing Good Witness pilots but doubts that expert witness work could easily become part of the NHS job for paediatricians. She is participating in an alternative pilot that the local family justice council expects to launch in south east Wales in September.

The idea is to raise standards by using the techniques of clinical audit. Lawyers are supplying confidential papers from past cases, anonymised and with consent from the parties, judge, and experts. "It's a quality improvement, it's an educational approach, it's non-threatening, and it also says 'am I practising to a certain standard?' We will look at them as a peer group of doctors and lawyers and say 'what are the standards for a paediatric report?'"

Of the GMC expert group, she says: "It's imperative that we move forward and that we look for better ways of doing all this. I'm enthusiastic and optimistic."

Clare Dyer is legal correspondent, *BMJ*
ClareDyer@aol.com

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2010;341:c3672