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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References

1. Atun RA, McKee M. Is the private finance initiative dead? *BMJ* 2005; 331: 792-793.
2. Moore A. Service cuts urged at non-PFI hospitals. *Health Serv J* 2007; 14 June: 7.

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 economical 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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