

Finance Committee

Inquiry into methods of funding capital investment projects

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Summary

- This report focuses on the Private Finance Initiative (PFI) model, which was introduced by the previous Conservative administration in 1992.
- PFI has played a bigger role in Scotland than any other part of the UK. As of October 2007, the total capital value of PFI contracts signed across all public services in the UK was £56.9 billion.
- Of this, £5.2 billion was spent in Scotland. PFI creates a debt which public authorities must repay. This £5.2 billion of investment has created a public sector cash liability of £22.3 billion.
- Ministerial support for PFI is premised on its ability to deliver good value for money. But the validity of VfM appraisals has been questioned by academics and auditors.
- Meanwhile, the government's claim that PFI delivers to time and to budget is not supported by valid evidence. PFI's performance in this regard has in fact never been compared to that of modern public procurement.
- The flaws in the evidence base regarding value for money are a significant problem as PFI costs are a significant burden on the public authorities responsible for meeting them. The debt created by PFI has a significant impact on the finances of public bodies.
- In the NHS, for example, research shows how services are downsized in order to bridge the 'affordability gap' prior to contracts being signed. New research shows that, despite these cuts, PFI remains a leading cause of NHS deficits, and further cuts are now being considered.
- With a number of successful public procurement methods available to public authorities, the case for PFI playing a role in investment programmes is questionable, and its dominance in public procurement is certainly unjustified.

1. Introduction

The Centre for International Public Health Policy carries out research on global health and healthcare policy, with a focus on access, equity and universality. The purpose of this report is to give evidence on public private partnerships (PPPs) to the Finance Committee of the Scottish Parliament. We focus on the Private Finance Initiative (PFI) model, which is by far the most common form of PPP used in Scotland and the UK. We provide a description of the PFI model, a short critique of the economic rationale for the policy and case studies of the impact of PFI on the NHS in Scotland and England.

In this report, we have not considered here the various constraints facing the Scottish Government in terms of capital expenditure. Neither have we examined the Non Profit-Distributing variant of PFI, nor the recent proposals concerning the Scottish Futures Trust. We aim to submit a further note on these matters when the Scottish government's proposals are clearer.

2. What are public private partnerships?

As noted, this report focuses on the PFI model, under which public facilities or infrastructure are leased by a public authority from a private sector Special Purpose Vehicle (SPV) for periods of 30 to 60 years. The SPV is a company owned by a number of private sector shareholders, typically a building contractor, a service provider and an institutional investor. This company provides around 10% of the investment cost of the PFI project through equity and subordinated debt, with the rest coming from banks or the capital markets. The SPV also manages the design and construction

works required for the project, and manages a variety of facilities management services upon completion.

In return for the investment and management of the various works, the SPV is paid an annual fee for the duration of the contract from the day the capital asset becomes 'operational'. PFI contracts usually combine two types of transaction: the provision of *assets* such as buildings and equipment; and the provision of *services* such as buildings maintenance, cleaning and catering. The fee for the provision of assets is called the *availability charge*; the payment for the provision of services is called the *service charge*. Together, these are known as the *unitary charge*. This is paid by the public authority (though, in the case of local authorities, this cost is subsidised by central government), for periods of between 30 to 60 years, occasionally more.

The availability charge

On average, this accounts for 60% of the unitary charge (though this varies according to the area of public service and the specification and scope of the PFI contract). It is a fixed cost which the authority can only alter if new requirements outside the terms of the contract arise, or if the consortium is penalised for failing to meet performance standards. The charge covers three types of cost. First, it funds interest and principal payments on the debt taken out by the PFI consortium. This claim takes precedence over all others, and accounts for a significant proportion of the availability payment.

Second, the consortium has to build up cash reserves in order to meet "lifecycle" costs - expenditure that may be required in the later years of the contract in order to maintain the condition of the facilities. This reserve is the consortium's property and will only be spent to the extent that is deemed necessary. Any unused funds will be passed to SPV shareholders. Finally, the availability payment funds returns to SPC shareholders in the form of dividends. Under normal financing arrangements (which are subject to change if schemes are refinanced), an increasing proportion of the availability payment funds profit to shareholders of the PFI consortium as debt is paid off over the contract period.

The service charge

The service charge meets the cost of the services provided by the private sector contractor. All PFI contracts include the contracting out to the PFI provider of so-called 'hard' facilities management services, such as routine building maintenance work. The majority of PFI contracts also involve the outsourcing of 'soft' services, such as catering and cleaning.

3. Origins

The PFI has dominated capital investment in Scotland's public services since 1992 when it was introduced by the Conservative government of John Major. As privately financed investment did not score against the Public Sector Borrowing Requirement (PSBR) PFI was widely seen as a means of updating public infrastructure while appearing to keep within macro-economic constraints. In the early 1990s, demand for new capital investment in the public sector was high after 20 years of insufficient spending. Total net annual capital expenditure fell in real terms from £28.8b in 1974 to £3.3bn in 1998.¹ In the NHS, for example, much of the estate was widely regarded as unfit for the provision of modern patient care².

As in many European countries, the PFI model was initially used in the transport sector, notably in providing new roads and bridges. However, the Conservative government was committed to transferring the model to other sectors, including education, defence, housing, waste management, leisure, government accommodation and healthcare. The Labour Party abandoned its opposition to PFI in 1994, when a Party 'joint consultative paper' backing the policy was produced by the then Shadow Chancellor Gordon Brown along with Robin Cook and John Prescott³.

¹ HM Treasury. *Financial statement and budget report 1999-2000*. London: Stationery Office, 1999. (Table B28: Historical series of government expenditure.)

² Pollock, A. M, Dunnigan, M. G, Gaffney, D., Price, D., Shaoul, J. (1999). The private finance initiative: Planning the "new" NHS: downsizing for the 21st century. *BMJ* 319: 179-184

³ Brown, G, Cook, R, Prescott, J, 'Financing infrastructure investment: Promoting a partnership between public and private finance', February 2004, The Labour Party, London

By May 1997, when Labour took office, few PFI contracts had been signed outside of the transport sector, and legal and bureaucratic obstacles remained. The new administration introduced to Parliament a number of Acts designed to stimulate the progress of projects in health and local government. Simultaneously, a PFI Taskforce was established in the Treasury to act as a focal point for the policy across government. Its main roles were to increase standardisation of the procurement process; prioritise projects; and train staff throughout government, especially in the departmental Private Finance Units.

The TTF was set up in July 1997 with a policy arm of five civil servants, and a projects arm, which employed eight middle-ranking executives from the private sector with experience of PFI. This latter element was led by Adrian Montague, formally co-head of Global Project Finance at the merchant bank Dresdner Kleinwort Benson. In 1999, the policy arm was transferred to the Office of Government Commerce (though it has since been transferred to the Treasury) while the projects arm was part-privatised and became Partnerships UK (PUK), a public-private company majority owned by leading PFI investors, with the Treasury retaining a 49% 'golden share'.

This agency is now staffed almost exclusively by private sector procurement specialists (corporate lawyers, financiers, management consultants etc), and is both the leading advocate for PFI/PPP in government and in control of the policy's implementation. In Scotland, the agency works closely with the Government's Financial Partnerships Unit, which is headed by Sandy Rosie.

4. PFI in Scotland

PFI has played a much larger role in public capital investment in Scotland than in any other nation of the UK. As of October 2007, the total capital value of PFI contracts signed across all public services in the UK was £56.9 billion⁴. Of this, £5.2 billion was spent in Scotland, or £1,028 per head⁵. This compares to £50 billion invested in England (or £1,017 per head), £1.1 billion in Northern Ireland (£631.4 per head) and £618 million in Wales (£213 per head). Over the lives of contracts for all PFI projects located in Scotland, the public sector liability is £22.3 billion (£4,500 per head) in nominal terms.

5. PFI and Value for Money

While PFI has offered an advantage to successive governments in allowing capital investment to occur without scoring against fiscal measures such as the PSBR and now Public Sector Net Debt, the current British government does not justify its use of PFI on macro-economic grounds. Rather, it claims that its support for PFI is premised on the model's ability to deliver good value for money. According to the government, PFI is selected as the method of procurement for investment projects only where it will deliver best value for money - and this is tested on each scheme through an options-based appraisal exercise, carried out by the relevant public authority.

While developing PFI proposals, contracting authorities are obliged to construct a theoretical alternative to their PFI proposal - a 'public sector comparator' (PSC) - which compares the value for money of a private versus publicly financed scheme. While the appraisal system was amended in 2004, the project-level PSC remains a fundamental part of the appraisal exercise⁶. In principle, where a PSC exercise concludes that PFI does not represent value for money over public financing, the latter procurement method should be chosen. In practice, however, this outcome is very rare and researchers have examined the reasons.

Gaffney et al⁷, for example, suggest in their evaluation of PFI in the health sector, that appraisal processes are intrinsically biased in favour of the PFI option.

⁴ HM Treasury, Signed PFI Projects list – October 2007. (Available at http://www.hm-treasury.gov.uk/documents/public_private_partnerships/ppp_pfi_stats.cfm)

⁵ Office of National Statistics, Census 2001, The Stationery Office, London.

⁶ HM Treasury, 'Meeting the Investment Challenge', The Stationery Office, London.

⁷ Gaffney, D., Pollock, A., Price, D., Shaoul, J., (1999), 'PFI in the NHS – is there an economic case?' *British Medical Journal*, 10 July; 319; pp. 116-119.

i. Risk transfer

Gaffney et al suggest that the PFI appraisal system involves highly subjective assessments of the value of risk being transferred to the private sector through the PFI contract (and not through the publicly financed option). This subjectivity is a cause of concern because the PSC is not, in reality, fundable. The authors note "a tendency" for NHS Trusts to ascribe risks to PFI consortia that they will never be asked to bear. For example, at one project, one of the risks supposedly transferred was that targets for clinical cost savings would not be met. The cost of this risk was estimated in the PSC at £5 million.

However, the researchers show that the consortium had no responsibility for ensuring such savings would be made, and faced no penalty if they weren't. This "risk transfer" was "spurious", they conclude.

This analysis has been supported by Jeremy Colman, former deputy general of the National Audit Office and the current Auditor General for Wales. In comments made to the *Financial Times* newspaper, Mr Colman notes that many appraisals were guilty of "spurious precision", while others were based on "pseudo-scientific mumbo-jumbo". Some were simply "utter rubbish". He also noted the perverse incentive facing contracting authorities to manipulate their appraisals in favour of the PFI route: "If the answer comes out wrong you don't get your project. So the answer doesn't come out wrong very often."⁸

ii. The discount rate

In addition to the potential for manipulation by contracting authorities, Gaffney et al show that the design of the appraisal process itself favours PFI. In particular, the process "exploits" the fact that under public financing all the costs of public procurement are paid in the first few years, whereas under the PFI they are spread over 30 years or more. To calculate the economic consequences of spreading capital payments evenly throughout the contract period (under PFI) or paying them all in the first few years (under public financing) a discounted cash-flow analysis is carried out. Cost comparisons are expressed in terms of net present values (NPVs) and the option with the lowest NPV is said to offer the best value for money.

In 1999, when Gaffney et al was published, the discount rate used in investment appraisal was 6%. The authors found that slight variations in the discount rate were often enough to swing the appraisal in favour of the PSC. The 6% discount rate did not at this time reflect interest rates on government borrowing. According to Treasury guidance extant at the time, "the practical choice of 6%, from the top of the range...is an operational judgement, reflecting, for example, concern to ensure that there is no inefficient bias against private sector supply."⁹ Thus, Gaffney et al conclude, the discount rate "favours private finance and obscures the central characteristic of private finance: the higher cost of capital. Therefore, economic appraisal assumes from the outset what it is held to prove: the economic advantage of private finance." (p.118).

The current appraisal regime

In 2003, the Treasury revised the discount rate from 6% to 3.5% in new appraisal guidance¹⁰. The new rate, intended to reflect "social time preference rate" (the interest rate society charges for not consuming its available wealth immediately), had the immediate effect of significantly increasing the present value of a stream of future payments.

This was widely welcomed among academics. However, the Treasury simultaneously introduced two adjustments to the appraisal calculation which were in favour of privately financed options. The first of these related to tax treatment. Previously, all taxes were as far as possible stripped out of economic appraisals on the grounds that they were merely transfer payments and the cost to the Exchequer was neutral. Now it was argued that the PFI industry creates new taxable wealth, as tax is payable by both the shareholders benefiting from profits on PFI contracts and by recipients of interest payments, such as senior lenders and subordinated debt holders. The PSC cost would

⁸ Timmins, N, (2002), Warning of 'spurious' figures on value of PFI, *The Financial Times*, 5 June. Available at www.ft.com

⁹ HM Treasury. "*The Green Book*": appraisal and evaluation in central government. London: HMSO, 1992.

¹⁰ HM Treasury. "*The Green Book*": appraisal and evaluation in central government. London: HMSO, 2003

henceforth be adjusted by adding on the tax generated by the PFI option. According to the head of PFI/PPP at business accountants Grant Thornton, this could add 30% to the cost of the PSC.¹¹

A second change required all estimates of construction costs in non-PFI schemes (including the PSC) to be inflated for 'optimism bias': that is, the "demonstrated, systematic, tendency for project appraisers to be overly optimistic about risks" of schemes going over budget or being delivered late. The 2003 Green Book guidance, which includes estimates of optimism bias in PFI and conventional procurement, requires estimates for standard buildings procured under the conventional route to be increased by between 2% and 24% of the original estimate for construction costs, and between 1% and 4% of the original estimate of works' duration (and these percentages are much larger for non-standard buildings).

The revised estimates of the cost of the PSC are then compared with the PFI cost estimates, which are not revised upwards in this way. A report by PFI consultants Mott MacDonald, *A Review of Large Public Procurement in the UK* (June 2002) is cited as the authority for the optimism bias adjustments listed in the revised Green Book. The aim of the MacDonald study was: "...to gather a representative sample of projects procured traditionally and through the Private Finance Initiative (PFI) and implemented over the last 20 years [in order] to assess the past delivery of major projects in the UK procured by the public sector over the last 20 years and from the lessons learned provide best practice guidance for reducing optimism in project estimates for current and future projects."

A main objective was to measure 'optimism bias' in a sample of both PFI and conventionally procured schemes. The results are summarised in Table 1 below, which shows the numbers of projects included in the study by one of five categories (non-standard building, non-standard engineering, standard building, standard engineering, other), and the cost and time overrun data. The table shows the small number of studies and the absence of data on some schemes.

Table 1. Time and cost overruns as percentage of original estimates by type of procurement and project reported by Mott MacDonald

Project type of total	Number of schemes		Percentage	Time overrun	Cost overrun
	opt. bias (%)	opt. bias (%)			
Non-standard buildings	PFI	0	-	-	-
Trad. 7	(18)	39	51		
Non-standard engineering	PFI	0	-	-	-
Trad. 13	(33)	15	66		
Standard buildings	PFI	3	(30)	16	2
Trad. 14	(36)	4	24		
Standard engineering	PFI	4	(40)	No info.	No info.
Trad. 3	(8)	34	44		
Other	PFI	4	(40)	28	No info.
Trad. 2	(5)	54	214		
Total	PFI	11	(100)		
Trad. 39	(100)				

Pollock et al evaluated¹² this study, looking specifically at the basis of comparison, representativeness, sample size and measurement bias. The authors found that the Mott MacDonald study did not include an account of the sampling methodology used, nor the representativeness of the samples studied. Although 80 projects were selected for inclusion in the study, 60 by the Treasury and 20 by Mott MacDonald, neither the populations nor the time periods involved were described. Furthermore, 29 projects had to be excluded from the sample because of insufficient data, but the characteristics of the excluded projects are not indicated. The PFI sample contained only 11 projects, although 451 PFI construction schemes were completed by April 2003.

¹¹ Cutler, P, (2002), The new Green Book reviewed, *Public Private Finance*, 9 September, London. Available at: <http://www.publicprivatefinance.com/Document.aspx?ID=45414>

¹² Pollock, AM, Price, D, Player, S (2007), 'An examination of the UK Treasury Evidence Base for Cost and Time Overrun data in UK Value for Money Policy and Appraisal', *Public Money and Management*, Vol.27, April 2007; pp.127-33.

This compares with 39 schemes included in the non-PFI sample, although by 1999 there were very few non-PFI deals.

Pollock et al also point to “clear evidence” of selection bias. The conventionally procured project sample included projects commissioned under different conditions, and different policy guidance, from those governing PFI projects. Most conventional procurement projects predated procurement reforms of 1999; some predated the introduction of PFI by more than two decades. There was also evidence of selection bias through over-representation of atypical schemes in the conventional procurement sample and under-representation of them in the PFI sample.

The PFI sample also did not include any of the numerous failed PFI IT projects, such as those for National Insurance Recording System 2 (NIRS2) and the Passport Office. This is important, the authors note, as non-standard projects usually involve more cost increases because of their complexity. The paper also notes that sample sizes were too small. There were only 11 projects in the PFI arm. Three were ‘standard’ buildings and two were standard engineering. The numbers of standard schemes in both the PFI and non-PFI samples were too small to allow statistical tests to be conducted.

The study samples were: not representative of projects procured either traditionally or under PFI; non-comparable; and too small to be significant. One especially problematic weakness in the Mott MacDonald report was measurement bias, in particular, the fact that cost changes were measured from different baselines under PFI and under conventional procurement. In PFI projects, change was measured from the full business case stage (FBC) to completion, whereas cost change in conventional procurement was measured from either the earlier strategic outline case (SOC) or the outline business case (OBC) stages to completion. Thus, cost escalations included in conventionally procured projects were omitted from PFI projects.

The impact of this omission is potentially very large. To take one example, the average cost increase for major PFI hospital schemes in England between OBC and FBC is 74.5%, and in fact this increase has got even higher in more recent schemes.¹³ These cost increases would not have been picked up in the Mott Macdonald study and the effect is to inflate significantly the cost changes under conventional procurement relative to those under PFI. The authors conclude that the evidence base for optimism bias is highly questionable.

It is important to consider the broader evidence base for the Treasury’s common claim¹⁴ that PFI delivers ‘on time and to budget’ more reliably than conventional procurement. Pollock et al note that, in addition to the Mott Macdonald report, four studies are cited by the government when making such claims. The first study was undertaken by the Treasury in 2002, and results were published in the 2003 Treasury document, *Meeting the Investment Challenge*. In this document, it was stated that the research would be published on the Treasury’s website in the following autumn.

However, publication failed to occur and requests for the data made by the authors (and subsequent attempts by the present authors) have proved unsuccessful. The Treasury now claims that no such research report exists.¹⁵ The Treasury also draws on data apparently contained in two National Audit Office reports: *Modernizing Construction* (2001) and *PFI Construction Performance* (2003). But neither of these studies, Pollock et al note, compares performance under different procurement routes.

The first report is based on interviews with the industry about the scope for improved construction performance. The second is a census of 38 PFI project managers. Neither study examines the relative performance of PFI and conventional procurement. A fourth source of comparative data is cited by the Treasury in *Meeting the Investment Challenge*, namely the 1999 *Agile Construction Initiative: Benchmarking Stage Two Study*. This study, Pollock et al note, was designed to develop

¹³ Hellowell, M, Pollock, AM, (2007), ‘Private finance, public deficits: a report on the cost of PFI and its impact on health services in England’. Available at: http://www.health.ed.ac.uk/CIPHP/Documents/CIPHP_2007_PrivateFinancePublicDeficits_Hellowell_000.pdf

¹⁴ HM Treasury (2003), *PFI: Meeting the Investment Challenge* (HM Treasury, London).

¹⁵ Treasury response to Freedom of Information request from Mark Hellowell, received 3 June 2007

a method for comparing performance, not to evaluate performance. Although it is cited by the Treasury as the source for the claim that, historically, time overruns occur in 70% of conventionally procured projects, and cost overruns in 73%¹⁶, no data bearing on these claims are provided in the report.

While the Treasury's evidence base is unsound on time and cost overruns, it is important to note that comparing PFI and non-PFI projects for post-contractual price increases is in any case not very meaningful. Contract price in traditional procurement is obtained at a particular stage of project design and specification that is equivalent to a much less advanced procurement stage than financial close. Thus, 'contract price' in PFI has price and risk control mechanisms built into it that 'contract price' in traditional procurement does not, and these are factored into the PFI price *ex ante*.

In accepting the validity of price certainty as a key measure of overall performance, it is necessary to be sure that the benefits of price certainty will lead to better value for money. In failing to do this, the Treasury's claims about the time and cost advantages of PFI are not just based on flawed evidence, they are also irrelevant to the value for money issue.

6. Case Study: PFI and the NHS in England

The evidence on value for money is crucial, not only because VfM is the central rationale for the policy across the UK, but also because the liabilities that PFI investments give rise to are such a significant call on resources for the public authorities involved. This section looks at the impact of PFI expenditure for NHS organisations in Scotland and England.

Research demonstrates^{17, 18, 19, 20} that, for NHS organisations across the UK, the cost of PFI has been greater than historic cost. In response, authorities have made attempts to close the affordability gap prior to projects being signed. This has involved funds being diverted from clinical budgets, the selling of assets and reductions in bed capacity and staff in hospitals and other services – all prior to PFI contracts being signed. Recent work by CIPHP²¹ demonstrates that, despite attempts made to close the affordability gap *ex ante*, PFI costs are a central cause of financial difficulties among health boards in Scotland and NHS Trusts in England.

Scotland

As of October 2006, the total capital value of signed PFI contracts in Scotland's NHS was £602 million, while the total liability accruing to these deals was £4 billion (in nominal terms), of which circa £2.4 billion is the availability charge. In excess of 80% of this debt was borne by just two Health Boards in Scotland: NHS Lothian and NHS Lanarkshire. These two are the only boards with 'major' PFI schemes in operation, and they paid annual fees of £46 million and £41 million respectively in the year 2005/06.

Lothian and Lanarkshire must divert a much greater proportion of their revenue to buildings than Boards without major PFI schemes – around 4% of total revenue, compared to an average of less than 2.5% for other Boards (excepting Orkney which has unusually high capital costs owing to its extreme rurality). As a result, both Lothian and Lanarkshire are experiencing financial difficulties.

¹⁶ HM Treasury (2003), *PFI: Meeting the Investment Challenge* (HM Treasury, London)

¹⁷ Heald D, Scott D. Lessons from capital charging in the UK national health service. *Int Assoc Management J* 1996;8:29-45.

¹⁸ Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative: expansion or contraction? *BMJ* 1999;319:48-51.

¹⁹ Gaffney D, Pollock AM, Price D, Shaoul J. PFI in the NHS: is there an economic case? *BMJ* 1999;319:116-9.

²⁰ Hawksworth J. Implications of the public sector financial control framework for PPPs. In: *The private finance initiative: saviour, villain or irrelevance?* London: Institute of Public Policy Research, 2000.

²¹ Hellowell, M, Pollock, AM, (2007), 'Private finance, public deficits: a report on the cost of PFI and its impact on health services in England'. Available at: http://www.health.ed.ac.uk/CIPHP/Documents/CIPHP_2007_PrivateFinancePublicDeficits_Hellowell_000.pdf

Lothian reported a £15.9 million overspend in its financial statement for the six months to September 2006. NHS Lanarkshire's accounts in 2005/06 also showed a recurrent deficit of £21.66 million.

Despite its extra costs, current plans (which may be amended by the new administration) are that the PFI programme will be significantly expanded. Major schemes for Forth Valley (capital value: £300 million) and Greater Glasgow (£180 million) have already been signed. A £152 million scheme is close to financial close at Fife, and there are less advanced plans for major schemes for the Glasgow Royal Infirmary, Glasgow Southern General and Edinburgh Sick Kids, among others.

England

We have examined the relationship between PFI, NHS Trust deficits and a new DRG-based system of resource allocation for England's NHS. Under this system, Payment by Results (PbR), Trusts receive the bulk of their income through a standard tariff for each patient that receives treatment. This tariff is based on the average cost of providing the treatment across the NHS,²² and includes funds for capital charges in an amount equal to the average cost of finance and depreciation across all NHS Trusts in England.

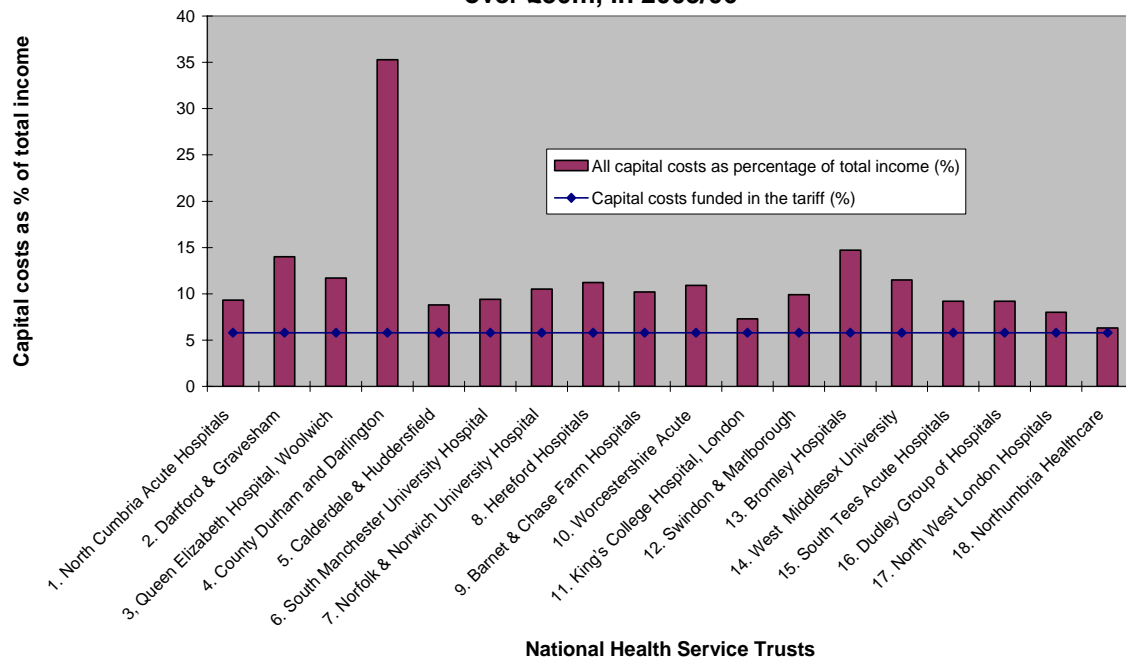
Trusts with higher than average capital costs receive less money than the cost of their capital charges, and will tend to incur a deficit on their income-expenditure accounts.²³ The aim of this work was therefore to discover whether, and the extent to which, Trusts with PFI schemes in operation have higher capital costs than their non-PFI counterparts, and are therefore particularly exposed to financial difficulties under the PbR regime. We studied capital costs, including public dividend capital, depreciation and the availability charge (as noted, this is the part of the PFI charge related to capital, rather than service payments) for all Trusts for the year 2005/06. Data on capital charges (depreciation and public dividend capital) and Trusts' total income was provided by the Department of Health through a response made under Freedom of Information laws. This showed that, on average, Trusts must allocate 5.8% of their income to pay capital charges. This figure is the basis on which funding for capital costs is allocated through PbR.

An analysis of the data provided by the Department of Health shows that, on average, NHS Trusts with PFI schemes operational and incurring charges in 2005/06 had capital costs of 8.3% that year – some 2.5% higher than the average of 5.8% and the amount covered by the PbR tariff. The average Trust with one or more operational PFI schemes is therefore subject to 'excess' capital costs of 2.5%. However, this understates the seriousness of the problem for Trusts with larger schemes. For the 18 Trusts that were, in 2005/06, paying charges on schemes with a capital value of over £50m, the difference between the capital costs funded in the tariff and real capital costs was more marked (see Figure 1, below). For these schemes, average capital costs were 10.2% of total income in 2005/06 – 4.4% over tariff funding.

²² Department of Health, Payment by Results Guidance, Version 1, December 2006. Available at: <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH063684>

²³ Further explanation of this point is given in Palmer K (2006), 'NHS Reform: getting back on track', King's Fund Discussion Paper.

Figure 1 Capital costs for Trusts with PFI schemes with a capital value of over £50m, in 2005/06



This analysis explains a widely observed problem: that Trusts with new hospitals seem to encounter financial problems to a disproportionate extent. The Audit Commission has noted a “marked correlation” between the presence of large new building projects and deficits in the NHS.²⁴ The Commission suggests that this may be caused by the amount of management time devoted to managing the process of constructing and moving into new facilities. However, the figures presented above suggest a much more straightforward analysis: the “marked correlation” between new hospitals (almost all of which have been delivered through PFI since 1997, as outlined above) and deficits is due to the high cost of the PFI contracts.

The Commission itself appears to acknowledge this in a separate section of its report, which also provides a neat account of how contracting authorities may come to sign up to schemes which in practice they cannot afford: “The attraction of the big building project, both to local NHS management and across the wider community, makes it difficult to withdraw from negotiations or reshape the vision once strategic approval has been gained and detailed discussions are underway. This carries a clear risk of commitment to spending levels based on optimistic future income assumptions, ambitious savings arising from improved operational efficiency, or both” (p.28).

This problems that result from this are significant from a public health perspective. In a policy context in which ensuring NHS trusts are ‘in the black’ is privileged over the capacity of services to meet local health need, trusts are diverting resources from expenditure on clinical services to expenditure on facilities and equipment. For example, Worcestershire Acute Hospitals NHS trust overspent its budget by £4.9 million in 2005/06 and recorded an underlying deficit for that year of £20 million²⁵. The trust has attributed £7 million of this to the “additional costs” of their PFI hospital, which are “not reflected equitably in the national tariff” and “for which the Trust does not receive sufficient income” (Volume II, p.152).

In response to budgetary pressures, the trust has developed a ‘recovery plan’, which involves a reduction of staff numbers by 675. It has also warned that achieving recurrent financial balance will

²⁴ Audit Commission, ‘Learning the Lessons from Financial Failure in the NHS’, pp.27 July 2006, London.

²⁵ House of Commons, ‘Evidence submitted by Worcestershire Acute Hospitals NHS Trust’ in ‘NHS Deficits’, December 2006, Stationary Office.

not be achieved without “even more radical action”, involving “a comprehensive review of services” across its three hospitals, and “serious questions about their sustainability” (Volume II, p.153). In South East London, the picture is similar. According to a recent paper from the South East London and Maudsley Strategic Health Authority, the area’s four district general hospitals had a combined deficit of £66 million in 2005/06, with the largest outflows at the Queen Elizabeth and Bromley²⁶. Both of these trusts have operational PFI schemes with capital values in excess of £50 million.

According to an SHA document, the deficits of both trusts arise “because the cash costs of the PFI availability charge exceed funding for capital charges in tariffs” (p.5). Both trusts had capital cost/income ratios (all capital charges, plus the PFI availability charge) of over 10%, against the 5.8% funded in the tariff. The SHA also noted that Lewisham’s ratio would rise from 5.3% in 2006/07 to 8.2% after its PFI hospital scheme becomes operational in 2007/08. As the SHA explains, these trusts “incur recurrent [income/expenditure] and cash flow deficits even if they operate as efficiently as the average hospital trust in England (p.7). The Authority suggests that achieving “financial balance” in the area cannot be achieved without significantly reducing “controllable costs”, including “further substantial reductions in staff costs and staff numbers.” (p.10)

8. Conclusion

Scotland’s PFI programme and the associated liabilities are currently very large – and there are significant risks to expansion. The value for money claims on which the case for PFI are poorly evidenced, relying on subjective appraisal exercises and flawed comparisons. This is a significant flaw in the policy as it stands, since PFI costs are a significant call on the resources of the public authorities involved, and it is essential that they are not paying more than is necessary for their facilities. Our case studies of the NHS in Scotland and England show that the high cost of PFI, relative to non-PFI, buildings is impacting severely on authorities responsible for paying unitary charges, despite cuts and closures made to bridge gaps in affordability.

With a number of demonstrably successful public procurement methods available to public authorities (in the sense of being approved by the Office of Government Commerce, the British government’s expert purchasing body), the case for PFI playing any role in investment programmes in the UK is open to question, and its overwhelming dominance in large-scale capital procurement is certainly unjustified.

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²⁶ South London and Maudsley Strategic Health Authority (2007), ‘Acute Sector deficits in SE London’. London.