The Private Finance Initiative
John Lister

The private financing of new hospital and health care projects through the Private Finance Initiative (PFI) has become a major contentious issue in the “modernisation” of the British National Health Service – and British-based consultancy firms such as PriceWaterhouseCoopers and British-led consortia are now at the forefront of efforts to promote this approach on an international level.

According to the trade press1 and other sources PFI hospital schemes are taking shape or already operational in Canada, Australia, South Africa, Italy, and Portugal. The EU early in 2004 changed the rules of the Stability Pact underpinning the euro, in order to encourage the use of PFI for public works, by excluding such investment from the total of public debts (as long as the private sector can be shown to be carrying the investment risk).

PFI first emerged in Britain in 1992 in the aftermath of the Conservative government’s market-style reforms, which established the principle of NHS hospital Trusts paying “capital charges” on the value of their property and land assets and on any new capital borrowing from the Treasury. This policy was initially seen as a device to encourage Trust managers to sell off any unused or partially used land or buildings at the first opportunity, rather than incur capital charges: but more fundamental was the notion of the NHS as tenant rather than landlord, occupying buildings for which it had to pay rather than simply regard as a “free good”.

Conservative Chancellors began a two-pronged approach, which combined a steep reduction in the annual allocation of capital to the NHS with the requirement that any substantial development (initially £5 million or more) had to be advertised and “tested” in the market under PFI, to investigate whether any private consortium might be prepared to put up the capital, build and operate the hospital, and lease it back to the NHS for a long-term (25-30 year) contract. It was described by the Treasury as changing “public sector organisations from being owners of assets and direct providers of services into purchasers of services from the private sector.” (HM Treasury 1997, cited in Pollock et al 1997)

For various reasons the private sector could not be convinced to sign such contracts in the NHS until after the change of government in 1997, when New Labour, having first denounced PFI as “the thin end of the wedge of privatisation”, came to office pledged to “rescue PFI”, portraying it as “a key part of the government’s 10-year programme for modernisation”.

21 PFI-funded hospitals have now been completed in Britain, with a total value of around £1.5 billion. The next ten are in the process of construction, at a capital value of £1.9 billion: and a new round of PFI schemes are currently being debated around the country, three of which total £1.7 billion. The government aims to have established £7 billion worth of PFI hospitals by 2010: 85% of all new capital investment in the NHS (and 94% of new hospitals) now come via PFI, with public funding largely restricted to smaller scale and refurbishment schemes.

1 Public Private Finance magazine, and PFI Intelligence Bulletin are both linked with organisations promoting regular conferences exploring possibilities for international extension of new PFI deals.
As a result an increasing share of NHS property assets are being privatised: PFI also means that an ever-growing share of NHS funding is flowing straight out of the public sector into the private sector and its shareholders, for whom (despite the rhetoric claiming a ‘transfer of risk’) completed PFI hospitals are seen as a virtually risk-free income-stream.

NHS Trusts, once they have become PFI lease-holders commonly retain financial control only over those services excluded from PFI – clinical services and the payroll for nurses, doctors and other professionals. Any further financial constraints are therefore more likely to impact directly upon patient care.

PFI maintains the appearance of a publicly-funded, publicly-provided service while in practice diverting very substantial capital and revenue resources into the private sector. The notion that PFI hospitals represent “value for money” despite their inflated costs has been questioned. The experience of poor quality, poorly-designed and inadequate-sized buildings, with poor quality privately-provided support services has been highlighted in many brand new PFI hospitals: a number have been obliged to begin extensions to add extra beds and facilities not properly planned into the original building. Management in some (such as the new Edinburgh Royal Infirmary) are still attempting to solve problems of ventilation and temperature control.

Meanwhile the question of value for money has been overtaken in some of the larger PFI schemes by the issue of affordability: health commissioners in Greater Manchester were warned in 2003 that the combined effects of the various capital development schemes in the area, including several high-cost PFI schemes, add up to almost £1 billion and are simply “unaffordable”: several projects have been scaled back, and others, including the largest, a new £400m hospital for Central Manchester, have been delayed (CMMH 2003).

The combined cost of health and other PFI schemes in Britain has been estimated as rising towards £30 billion per year, while the value of publicly-owned assets falls back (Lister 2001). It remains to be seen how many other governments wish to follow Britain down the road of renting the core infrastructure for key public services from the private sector.

(From Health Policy Reform: Driving the Wrong Way? by John Lister, pub Middlesex University Press www.mupress.co.uk)

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Will soaring costs scupper PFI deals?
(From Health Emergency #61, www.healthemergency.org.uk)

There are mounting rumours that ministers are about to call time on a number of large-scale hospital projects to be funded through the Private Finance Initiative. Patricia Hewitt and top DoH officials have warned of the danger of investing in costly “monuments” which will quickly outgrow their usefulness.

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2 Likewise schemes to merge two specialist hospitals and a teaching hospital onto a single “Paddington Health Campus” has escalated in cost from £370m to more than £1 billion, and is also being challenged as unaffordable: in East London the planned rebuild of the Royal London and Bart’s Hospitals has also escalated in cost from £600m to £1.05 billion before the final negotiations begin.
So far only the ill-starred Paddington Health Campus has been put out of its misery by an increasingly irritated Strategic Health Authority, with an unbridgeable affordability gap in excess of £40 million a year. The soaring cost of PFI schemes, running well beyond the bounds of affordability, have raised questions of whether Trusts could implement the latest schemes and stay viable, especially when the NHS institutes fixed reference costs and payment by results from next year. When the first wave of PFI hospitals were signed off in the late 1990s the average capital cost of a new hospital was £75m: this has since spiralled into the stratosphere, with a number of schemes now above, or close to, £1 billion, and several more in excess of £400 million. The costs are staggering. Annual payments on a £420m scheme in Central Manchester came out at £51m per year, index-linked, over 38 years, £30m of which was the ‘availability charge’ for the building itself. The combined costs of PFI payments, residual NHS interest charges and facilities management was to total £64m a year – almost 20 per cent of the Trust’s total revenue. The latest figures for the super soaraway Barts and London project suggest a total capital cost of at least £1.89 billion – almost £500m of which is comprised of interest and fees. The annual payment starts off at £115m a year, index-linked, with £67m of this being the ‘availability charge’. This means that the taxpayer will have forked out well over £5 billion for the two hospitals in the next 40 years, while the Skanska Innisfree consortium picks up guaranteed profits from legally-binding payments which currently equate to 23 percent of the Trust’s annual turnover. This type of increased overhead costs – and restricted capacity – have already helped to force most of the operational PFI hospital Trusts deep into deficit. They face restricted options for economies, since all support services are incorporated into legally-binding, index-linked, contractual payments to the PFI consortium, and Trusts retain discretion only over clinical budgets. Hence the nonsense of Greenwich’s £120m Queen Elizabeth (PFI) hospital running with wards closed, as Trust bosses wrestle with a £10m deficit. With the prospect of a new system of Payment by Results that will offer only a fixed tariff for each item of treatment, PFI hospitals from next April will be at a huge disadvantage, with bloated, fixed overhead costs, and inadequate capacity. Where new PFI hospitals do proceed, they are likely to drain vital resources from community health care and mental health budgets, leaving a lop-sided pattern of care for a generation to come. These economic facts of life were clearly a factor in the belated decision to axe the flagging Paddington Health Campus project – and seem likely to bring the demise of several more lumbering giants. PFI for the NHS remains a high-cost, high-risk way of building facilities which unlike previous NHS buildings, are not public assets but liabilities weighing down on the local health economy.

**Will Liverpool top the (PFI costs) league?**

Costs appear to be running out of control in the plans for a new mega-hospital to be shared by the Royal and Alder Hey hospitals – latest estimated cost £835m and rising.

University Hospitals of Leicestershire Trust has also put another, far higher price tag on the ever-more expensive PFI hospital project which started out at a projected £150m.
By the end of March this year this had risen more than five-fold – to a staggering £761m, while the numbers of beds in the scheme are now being whittled back down. Although the Trust has chosen a preferred PFI partner, Equion, no final deal has yet been signed and all the smart money from local punters will be on another massive upward hike in price before the Full Business case is published. In February 2001, managers drew gasps of astonishment when the projected cost of the plan hit £286m: by today’s standards that is a bargain that should have been snapped up.

Birmingham and the Black Country SHA has come up with a plan to privatise 15 percent of elective operations and axe 20 percent of NHS hospital beds (over 1400) by 2008. Campaigners who also pointed to a growing gap between availability of GPs and planned expansion of primary care were told that a 40 percent increase in primary care activity did not mean employing 40 percent more staff, since it revolved around “new ways of prescribing, new ways of tracking patients and intervening”.

Who wants to bet against the prospect that new ways of explaining another failed policy are also on the cards in the midlands as another half-baked plan takes shape? The new 1231-bed University Hospital in Birmingham, with a capital cost of £543m, will cost the Trust £50m a year, index-linked, over 40 years, even though it is the first PFI deal that does not include “soft” facilities management. The scheme includes an assumption that the equivalent of 76 fewer beds would be required because of “best practice efficiencies”, despite the failure of such projections in other PFI hospitals.

**Edinburgh Royal PFI rip-off**

The PFI consortium behind the £180m Edinburgh Royal Infirmary has come back to demand a late increase in payments to cover its annual contract to deliver support services. Despite repeated claims by ministers that PFI deals offer a ‘fixed price’, enabling Trusts to plan their outgoings, Consort Healthcare in May demanded local health chiefs stump up an additional £1.1m a year, invoking a clause in the contract which allows them to seek an adjustment of fee levels.

**Norfolk & Norwich PFI brings profit windfall**

Octagon, the consortium that financed and built the £220m Norfolk & Norwich Hospital refinanced the deal two years ago, and scooped a bonus £115m – almost half the initial cost – in windfall gains. Just £34m of this was shared with the Trust, and that to be paid in the form of a £1.7m cut in the annual fees for use of the building and support services. The remaining £81m has no doubt been wisely invested in yachts, claret and caviare by Octagon’s gleeful shareholders.

**SEE ALSO:** two UNISON pamphlets on the practical experience of working in the first PFI hospitals – Voices from the Frontline, and Not So Great, both available for free download from UNION here.