PFI in England: from humble beginnings to major problem. Lessons for Ontario: May 2013

By John Lister for Ontario Health Coalition

In 1981, under Margaret Thatcher, 98% of UK spending on infrastructure, including hospitals, was financed by the state. But this consensus has long since been broken, not least with the Private Finance Initiative in England, equivalent to PPPs in many other countries and P3s in Canada.

Yet after almost 20 years of attempts to make the notion of PFI work in England, it has resulted in inflated costs, inflexible contracts, unsuitable and inadequate, high-cost buildings, cash crises requiring government and other bail-outs, cuts in other services and closures or surrounding hospitals.

A growing share of the profits that have been made through PFI are being appropriated by off-shore companies which pay little if any tax, and which have spotted the weakness of half-hearted government attempts to renegotiate unaffordable contracts: the private sector knows that the political cost of closing hospitals and publicly accepting that the schemes have failed is too great for politicians of the two main parties responsible for PFI, and so the consortia have been able hang tough and force continued payment – at the expense of other services and health care.

Origins

The notion of PFI seems to have originated in John Major's government in the early 1990s: it was described as a means to "privatise the provision of capital" which up until then had been a responsibility for the Treasury.

Although there were early, improbable, claims that PFI projects could be cheaper than those funded through conventional public finance, and of course there was the usual salesmanship seeking to promote an image of the private sector as somehow more 'innovative', NHS trusts were only persuaded to take PFI seriously by a combination of carrot and stick.

The stick came in the form of a rapid reduction in the allocation of Treasury capital to fund new hospital development – sufficient to halt almost all new hospital schemes from 1992 through to 1997 when New Labour signed off the first PFI projects.

The carrot was the alluring (largely empty) promise that the private sector would shoulder all of the risk involved in the construction phase of the project, and that it would deliver 'on time and to budget'.

What was not said was that the NHS would be charged handsomely for handing over the risk, in the form of a 25, 30 or 35 year rigid contract, during which time the hospital building itself was the property of a private consortium and a guaranteed, index-linked profit stream for private shareholders. And the public sector still effectively still wound up stuck with the bill if anything substantial went wrong: penalty

payments for failures in the contract have always been pitifully small, complex to claim, and easy to evade.

Even though both carrot and stick were waved by John Major's Tories, and PFI was initially attacked by Labour as the "thin end of the wedge to privatisation", by 1997 the Tories had failed to finalise a single hospital contract, and it was left to New Labour, which in the six months before the election had dropped its principled line and embraced PFI, to sign the first PFI deals in the NHS.

From the Labour government's point of view it appeared that one attraction would be that PFI schemes, by delegating the borrowing to private sector "partners" would effectively be "off balance sheet" for the government, and therefore not count as public borrowing – allowing Gordon Brown to build new hospitals even as he continued with his line of "prudent" borrowing. In practice this, too, has turned out to be a short-term illusion, since at the insistence of EU accountants many of the schemes have now had to be put back onto the government's balance sheet as the scam failed to convince.

The first wave of PFI hospitals were signed off at the end of 1997 and completed new hospitals began to open up from 2000: most were significantly smaller than the hospitals they replaced, both in terms of footprint and in capacity, with an average 25% reduction in numbers of beds in the first wave.

Many also were obliged to squeeze down numbers of front-line staff, while in early PFIs non-clinical support services were part of the income stream for the consortium, and so once contracts were signed, non-clinical budgets and staff have effectively been removed from the Trust's control.

New build = privatisation

Labour's 2000 NHS Plan looked forward to at least 40% of the value of the NHS estate being less than 15 years old by 2010. But since there was little if any public sector capital available, this was effectively a commitment to privatise 40% of the £22 billion asset base of the NHS – through PFI.

They may have achieved this target: certainly much of the NHS has been transformed from landlord to tenant. **There are now over 100 hospital PFIs in England**, with a combined **capital value of £11 billion**, but with a combined **cost in excess of £65 billion** over the lifetime of the PFI contracts. Scheduled **payments in 2012-13 totalled £1.6 billion**, although many will have been further inflated by inflation.

The average cost of a new hospital has also been rapidly driven up under PFI. In 1997 **the average cost of a new first-wave PFI hospital was less than £100 million**. But since then there have been new planning guidelines increasing the amount of space that must be allowed per bed and for patient areas, and the projects have become much larger and more elaborate: **many of the more recent schemes are now in excess of £300m** – with an inflated payments to go with the higher cost.

As a result, Trusts desperate to secure new facilities have been persuaded by PFI consortia, by ministers and by conniving financial advisors to sign up for expensive contracts that have turned out to be unaffordable. **PFI has become a major factor undermining the financial viability of a number of Trusts, with 22 admitted in 2011 to be facing PFI-related financial problems.**

Early in 2012, Conservative Chancellor George Osborne set up a £1.5 billion bail out fund to help ten of the most troubled, but payouts were subject to rigorous conditions, requiring the hospitals to already be making drastic cuts, and it is not clear how much of this money, if any has been distributed and to which trusts.

PFI "unsustainable"

In May 2012 the Commons Public Accounts Committee, having taken evidence from the Treasury that it too was engaging in a "rethink," declared that the current model of PFI is "unsustainable". The Committee was also highly critical of the lack of transparency on PFI contracts, leaving the taxpayer in the dark on how much the public sector was paying in interest and other charges and what level of profits were being creamed off by investors, several of them offshore institutions paying little if any tax on the money they make.

In too many cases, the Committee argued, investors appeared to be making "eye-wateringly high" profits while taxpayers were footing the bill for inflexible and expensive contracts and NHS trusts were forced to seek deeper cuts in other budgets to maintain PFI payments.

And despite the fact that the Treasury had been reviewing PFI for 6 months, and Chancellor George Osborne had promised in opposition that the Tories would stop using PFI, over 40 new PFI contracts had been signed by the coalition government in its first two years in office, with another 30 being negotiated.

One explanation for this is that Osborne, like Gordon Brown before him, has set a tough target for borrowing, committing the coalition to ensure the public sector net debt is falling by 2015-16: so he, too, is drawn to PFI by the fact that a proportion of the borrowing is manipulated to be "off the books" – even at an inflated long-term cost.

Unreformable

Osborne has claimed that the government has already "driven changes in existing PFI projects", but no details of these changes have been published, and the efforts so far to renegotiate reductions in contract costs have been largely fruitless.

In the summer of 2012, Health Secretary Andrew Lansley invoked the draconian powers of the "Unsustainable provider regime" and dispatched a "special administrator to deal with the soaring £200m-plus debts of South London Healthcare Trust, a merged trust with TWO unaffordable PFI hospitals (Queen Elizabeth and Princess Royal).

The administrator decided to throw the net far wider than the stricken trust itself, and reorganise services right across South East London. His proposals, which were subject to just four week's pretence of "consultation" were to break up SLHT and slash back its staff numbers, to write off its accumulated £207m debts, and subsidise the two PFI contracts to the tune of over £22m per year for the next 20 years.

But he also decided to CLOSE the remainder of the third hospital in SLHT, and, worse, to CLOSE acute services and 60% of the buildings at the highly successful and solvent Lewisham Hospital, which is not part of SLHT at all. The plans all hinged upon the assertion that an "urgent care centre" could replace 77% of the work of Lewisham's busy A&E, and that community health services would somehow reduce the need for hospital care.

Despite huge local protests and evidence-based critiques of the proposals which underlined the complete absence of convincing or practical plans to put alternative community based healthcare into place, the cuts were rubber stamped in February 2013 by Lansley's successor, Jeremy Hunt.

In August 2012 "hit squads" of lawyers and accountants were sent in to seven of the most indebted hospital trusts to seek to renegotiate their PFI contracts before the financial pressures drove them into bankruptcy: However once again there appear to have been few if any successes from the high-profile interventions, not least because health minister Simon Burns made clear from the outset that the government would not walk away from any of the contracts, for fear of years of legal disputes.

With the PFI consortia convinced that any government threats are empty, they are sitting tight on copper-bottomed contracts that guarantee them a long-term profit stream.

PFI rides again

In December 2012 Osborne unveiled another approach, with the announcement of a new form of PFI, to be known as "PF2". It would create contracts in which the public sector would become a minority shareholder, and therefore in theory share in any profits that are to be made – from the public purse.

Details of one of these schemes have now emerged; the new Royal Liverpool Hospital plan has been scaled down in size to a £335m project, to be financed over 30 years by a combination of public and private capital. The public sector share is a £124m stake for the Department of Health: the remaining £221m is to be raised by the private sector. This keeps the overt payments to the private sector to below 6% of the hospital trust's income, although of course the total outgoings and capital charges for the new buildings will be much higher: **the trust itself also has to come up with another £94m for associated schemes including a multi-storey carpark, equipment and demolition work.** The contract for support services in the new building does not seem to be included in the calculations and therefore is another additional cost.

The private capital is expected to be borrowed at 7.44%, compared with the current UK 30-year bond rates available to the government, currently 3.03%: as a result, the PFI component of the scheme is expected to cost at least £1015m compared with £691m if it were publicly funded – 46% more expensive.

Payments are indexed to the Retail Price Index, which is assumed to stay at 2.5%, although official projections suggest it will rise to 3.7% by 2017. The project also assumes further "cost savings" to be generated by the trust, another 600 fewer jobs, and almost £50m of "transitional funding" to cover double running costs.

As can be seen from this example, the public share of PF2 represents a not inconsiderable hidden cost – and requires public money to be invested up front as part of the capital for the project, alongside private sector risk capital. And any "profits" from this and similar schemes will be derived entirely from the public purse, in the form of inflated payments by the hospital trusts.

The only game in town

However it's clear that Osborne intends the new scheme, whether improved or not, to remain the "only game in town", leaving trust bosses at the mercy of ruthless and skilled private sector negotiators. It seems that the costs of investing this way may actually go up, although there is still no guarantee at all that the private sector will be minded to invest in this way if there is any potential risk involved.

The attached table indicates the financial burden of a sample of the PFI hospital schemes in England (equivalent to about half the £11 billion schemes signed off and in progress so far). It shows that while three quarters of the total capital cost has been paid off already, continuing payments continue to mount up, with payments equivalent to 6.5 times the total still to be made, and a cumulative bill averaging 7.3 times the capital cost.

Even if we assume that an average 33% of the cost of PFI is for non-clinical support services and maintenance which might have been required without PFI, this still means that the buildings are costing almost 4.9 times the capital cost, before inflation and index-linking is taken into consideration.

Phony figures and fictitious risk

One justification for these inflated costs is that the private sector is taking on the various "risks" involved in constructing the hospital to a tight schedule: but the assumptions on which these risks are itemised, and more controversially on which they are given a largely imaginary financial value, are far from transparent. The process has been described by the auditor general of the UK National Audit Office as ranging from "spurious" to "scientific mumbo-jumbo" and "utter rubbish": he told the Financial Times:

> **"If the answer comes out wrong, you don't get your project. So the answer doesn't come out wrong very often".**

The hypothetical financial value of the risk is added to the estimated cost of the so-called "public sector comparator" – although the comparator itself is also largely spurious, since it represents a plan for a hospital that nobody really wants to build, and is therefore made to seem as unappealing as possible in order to justify the PFI plan.

Only when these often very large risk payments are added to the PSC does PFI appear even comparable in price, and it seldom even them appears to be cheaper than public funding.

In fact it is widely acknowledged that the principal risk element in a PFI hospital is in the construction phase: once this is completed, the scheme is little other than an income stream for the consortium,

which is why the shares in these schemes are now often traded, and new investors, often from offshore companies, seek to exploit this.

At each stage the financial projections and the assessment of them is in the hands of the leading private sector accountants, financial advisors, lawyers and others, who manage to play a role on both sides, and have an interest in schemes proceeding. The (often heavily redacted) details that are eventually published appear long after any deal has been signed , and therefore offer little if any genuine transparency or scope for independent evaluation. Billions in taxpayers' money is paid out, signed away and put at risk with minimal scrutiny. There is ample scope for conflict of interest and even corruption, with little hope of redress.

PFI-driven crises and failures

Among the higher profile problem PFIs not mentioned so far are:

Queen's Hospital Romford, part of Barking, Havering & Redbridge Hospitals Trust, which has cumulative debts of over £150 million, and is seeking to balance its books by closing most services at the neighbouring King George Hospital, despite the fact that closing KGH's busy emergency services would further inundate the already struggling services at Queen's.

Peterborough & Stamford Hospitals Foundation trust, which defied two letters from the regulator Monitor urging the Trust board not to sign the PFI, is facing recurrent deficits in excess of £40m per year – almost exactly the same as the unitary charge for the £311m hospital, and has been surviving only on hand-outs of extra money from elsewhere in the NHS. A team of high powered accountants has yet to come up with realistic plans for cost savings to balance the books.

Mid Yorkshire Hospitals, which has been repeatedly bailed out in previous years, is seeking to drive through a cuts package that would strip complex surgery and emergency medicine from the non-PFI Dewsbury Hospital within the Trust, in order to centralise services in its PFI-funded Pinderfields Hospital, which is already desperately short of beds – and adding an extra fifth bed to each of its state of the art 4-bed bays to boost capacity. Even the full cuts package would still leave the Mid Yorks trust £10m a year in the red by 2017.

Portsmouth's Queen Alexandra Hospital was forced to cut 700 jobs in 18 months while the company that picks up all the profits from the PFI payments,a subsidiary of HSBC, is located in the tax haven of Guernsey –and paid just £100,000 tax on more than £38m profit from its 33 PFI schemes -- less than half of 1%. The firm - previously known as HSBC Infrastructure Company Limited - bought an 89.9% stake in the Queen Alexandra Hospital (QAH) project in 2010.

Worcestershire Royal Infirmary, the £87m PFI hospital that triggered the closure of services at the neighbouring **Kidderminster Hospital**, has remained mired in deficits since it opened with too few beds, and its continued crisis is now forcing cutbacks at another neighbouring hospital, Queen Alexandra in Redditch.

Hereford's modest £64m PFI hospital is at the centre of a major centralisation of services in the rural Wye Valley Hospital Trust aimed at saving £32m over four years: the trust has only been kept afloat by extra handouts of cash, and is now seeking a merger or franchising out its management.

Coventry's £397m University Hospital of Coventry and Warwickshire has been plagued by financial problems as one of the most expensive PFI deals (costing over ten times the capital value of the hospital): but is also desperately short of capacity to deal with emergencies, and recently hit headlines for having almost all of the West Midlands fleet of ambulances waiting outside to hand over emergency patients, delayed by the shortage of beds. The hospital is now delaying and cancelling elective treatment as it struggles to cope, with no solution in sight to its financial plight.

The giant **970-bed Norfolk & Norwich** hospital, the biggest first-wave PFI, is also under pressure: the bed numbers were always inadequate, and with lines of ambulances waiting to hand over emergency patients, moves were made recently to erect a marquee in front of the hospital to receive patients for whom there was no room inside the building.

West Middlesex and **Central Middlesex** Hospitals, two early PFI hospitals, are each threatened by plans in West London to cut 28% of acute hospital beds as part of the government's drive for £20 billion cash saving sin the NHS by 2014. Bed closures would reduce capacity (and therefore income) while leaving PFI liabilities unchanged, and therefore seriously undermine the already shaky finances of the trusts involved.

See table, page 8 (based on latest figures available as at May 2013)

Hospital Trust	Capital cost £m	Paid so far 2013 £m	Still to pay £m	Total payable £m
Queen's Hospital, Romford	**304**	288	2,024	**2,312**
Bart's	**1149**	435	6,708	**7,143**
Amersham ***(Ist wave)***	**45**	103	351	**454**
Calderdale ***(Ist wave)***	**65**	148	541	**689**
Durham ***(Ist wave)***	**61**	128	382	**510**
Darent Valley ***(Ist wave)***	**94**	159	616	**775**
Derby	**312**	229	2,271	**2,500**
Swindon ***(Ist wave)***	**125**	179	601	**780**
Chelmsford	**148**	41	725	**766**
Mid Yorkshire	**311**	92	1,484	**1,576**
Hereford ***(Ist wave)***	**64**	92	286	**378**
Cumberland Infirmary ***(Ist wave)***	**67**	120	437	**557**
Central Middlesex ***(Ist wave)***	**69**	42	242	**284**
Norfolk & Norwich ***(Ist wave)***	**158**	329	1,197	**1,526**
Oxford x 3	**300**	264	2,031	**2,295**
Peterborough	**336**	41	1,922	**1,963**
Portsmouth	**256**	169	1,940	**2,109**
King's Mill	**326**	134	2,249	**2,383**
Princess Royal ***(Ist wave)***	**118**	236	1,216	**1,452**
Queen Elizabeth ***(Ist wave)***	**96**	175	738	**913**
St Helens & Knowsley	**338**	142	3,655	**3,797**
West Middlesex ***(Ist wave)***	**60**	75	358	**433**
Birmingham Queen Elizabeth	**627**	119	2,606	**2,725**
Coventry & Warwickshire	**379**	483	3,508	**3,991**
Worcester ***(Ist wave)***	**87**	161	554	**715**
Totals	**5895**	**4384**	**38,642**	**43,026**

(Source: core figures extracted from HM Treasury website, PFI signed projects list).

More details:

Case studies of specific PFI projects at **http://www.healthemergency.org.uk/challengingpfi.php**

Staff experience of working in some of the first-wave PFI hospitals (2004)
http://www.healthemergency.org.uk/pdf/PFI_experience.pdf