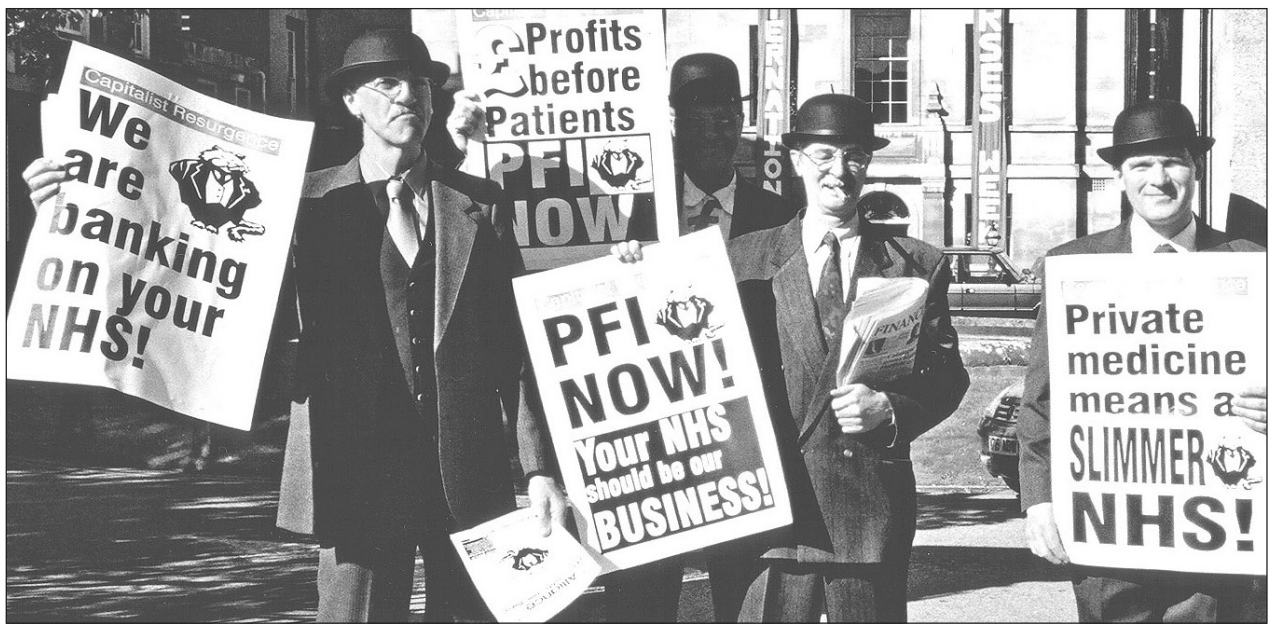


Bankers' favourite: lifting the lid on PFI

Addicted to private funding: Milburn

What is PFI?

The initials stand for Private Finance Initiative: PFI is a Tory policy, first devised in 1992, which was strongly denounced by Labour's shadow ministers until a few months before the 1997 election.

According to Tory Chancellor Kenneth Clarke, who in 1993 introduced the policy, initially for NHS projects costing £5m or more, PFI means:

"Privatising the process of capital investment in our key public services, from design to construction to operation."

Margaret Beckett, shadow health secretary in 1995, summed up what had became a common line from Labour when she told the Health Service Journal

"As far as I am concerned PFI is totally unacceptable. It is the thin end of the wedge of privatisation."

But in the summer of 1996 Shadow Treasury minister Mike O'Brien announced a change of policy:

"This idea must not be allowed to fail. Labour has a clear programme to rescue PFI."

By the spring of 1998, PFI was: "A key part of the Government's 10 year modernisation programme for the health service."

Despite its popularity with ministers, and especially with the Treasury team, PFI has incurred the increasingly vociferous opposition of the BMA, the Royal College of Nursing, almost all trade unions, local campaigners in affected towns and cities, and a growing body of academics.

So what does the policy involve?

Large-scale building projects, which would previously have been publicly funded by the Treasury, were to be put out to tender, inviting consortia of private banks, building firms, developers and service providers to put up the investment, build the new hospital or facility, and lease the finished building back to the NHS – generally with additional non-clinical support services (maintenance, portering, cleaning, catering, laundry, etc).

Lease agreements for PFI hospitals are long-term and binding commitments, normally at least 25 years. The NHS Trust involved, which (since the Tory government's "market-style" reforms of 1991) would normally expect to pay capital charges on its NHS assets, instead pays a "unitary charge" to the PFI consortium, which would cover construction costs, rent, support services, and the risks transferred to the private sector.

The big difference from capital charges is that not only are the costs much higher, but PFI "unitary payments", rather than circulating back within the NHS, flow into the coffers of the private companies, from where they are issued as dividends to shareholders.

The appeal of PFI both to the Tories and to the Labour government is that it enables new hospitals and facilities to be built without the investment appearing as a lump sum addition to the Public Sector Borrowing Requirement.

The government can appear to be funding the "biggest ever programme of hospital building in the NHS", while in practice injecting less public capital than ever. Only six major NHS-funded schemes, totalling less than £300m, have been given the go-ahead since 1997.

By contrast, the Labour government has so far given the go-ahead to 38 PFI-funded NHS schemes totalling almost £4 billion, and aims to increase this to £7 billion by 2010. The NHS Plan calls for a total of 100 new hospitals. 85% of all new capital investment in the NHS is now coming from the private sector.

But as with all borrowing, the short term benefits of PFI are outweighed by the long term costs. By 2007 the annual cost to the NHS of PFI payments involved in leasing these privately-owned, profit-making hospitals, and buying ancillary services from private contractors, will be in the region of £2.1 billion: together with capital charges, the total bill will add up to £4.5 billion a year.

These – and other, less obvious, costs are being picked up by the taxpayer, by patients, and by hospital staff struggling to keep the service afloat under mounting pressure.

The extra costs of PFI:

Increased "headline" costs of schemes

PFI hospital projects have become notorious for the massive level of increase in costs from the point at which they are first proposed to the eventual deal being signed.

The first 14 PFI deals escalated in cost by an average of 72 percent, from a total of £766m to £1,314m by the time they were approved.

This inflation has obviously had an impact on the final bill to be paid. The new Dartford Hospital was originally projected to be "at worst cost neutral", but it soon emerged that purchasers were going to have to foot the bill for an extra £4m a year if the Trust were to be enabled to pay the PFI costs.

Rate of return for private investors

PFI consortia don't build hospitals for the sake of our health. They want profit for their investment.

A BMJ article in 1999 pointed out that shareholders in PFI schemes "can expect real returns of 15-25 percent a year", and went on to explain how little actual risk is involved for the companies in PFI consortia.

In Barnet, the second phase of the new general hospital, originally tendered at £29m, went ahead at a cost of £54m, with capital borrowed at 13% over 25 years. In Dartford the rate was 11%, and the £17m annual payment represents a massive 35% of the Dartford & Gravesham Trust's revenue.

The new Worcester Royal Infirmary, a project which was originally estimated at £45m when it was first advertised for PFI tenders in 1995, was eventually given the go-ahead at a total cost of £110m.

But the annual charge of £17m is more than a quarter of the Trust's projected income. Of this, £7.2m is the "availability" charge, or lease payment on the building, giving a total cost of £216m to rent the hospital for 30 years. The scheme will cost the Worcestershire Health Authority an extra £7 million a year.

While most NHS Trusts spend around 8% of their income on capital, those with PFI schemes are spending between 12% and 16%. In part this is because the private sector has to pay more to borrow money than does the government – but the net result is that the taxpayer picks up an inflated bill, while the banks coin in an extra margin.

Margins for PFI consortium partners

But the profits flow to the private sector at every level in PFI. Building firms, banks, business consultants and other PFI hangers-on are eagerly anticipating a generous flow of profits as the first hospital schemes take shape.

An investigation in the *Health Service Journal* showed building contractors "expecting returns of up to 20 percent a year on the equity stakes they hold in the project companies". The *HSJ* article pointed out: "there is little chance of the construction industry losing interest in PFI hospitals".

An idea of the profitability of PFI is given by the figures from Balfour Beatty, which is involved in a number of PFI deals. As *Observer* journalist Nick Cohen pointed out,

"It reported last month that PFI projects accounted for 20 percent of sales, but 40 percent of operating profits. In other words, the prudent Treasury is allowing companies to take profits from the taxpayer at twice the rate they can make in a competitive market."

And once the building is finished, maintaining and providing services in the buildings will deliver comfortable, guaranteed profits of up to 7 percent for firms holding service contracts. The first two waves of PFI hospital schemes all involved the privatisation of any non-clinical support services that were not already in the hands of the contractors.

Fewer beds

The first wave of PFI hospitals became notorious for the scale of the cuts in bed numbers they represented, with reductions in front-line acute beds ranging from 20% to 40%.

PFI planners wanted to axe almost 40% of beds in Hereford (from 414 to 250) and North Durham (from 750 to 450) – and as a result the newly-opened North Durham Hospital has been plunged into an immediate beds crisis.

Two other PFI hospitals embodying large-scale bed reductions have so far opened, in Dartford and in Carlisle, and both are already struggling to cope with pressures on the depleted numbers of beds remaining.

These bed numbers were based not on the actual experience of front-line Trusts dealing with current levels of caseload, or on any actual examples of hospital practice in this country, but on the wildly over-optimistic projections of private sector management consultants working for PFI consortia.

The verdict is still awaited on one of the other big bed cuts based on this type of approach, in Worcestershire, where the Health Authority forced through plans to for a new PFI-funded Worcester Royal Infirmary which would cut 260 acute beds – over 200 of them in Kidderminster – as well as beds in Redditch – a county-wide cutback of 33%.

In Edinburgh the new Royal Infirmary involves a loss of 400 of the previous 1,300 beds, and a halving of the 6,000-strong workforce.

But campaigners in West Hertfordshire, faced with bed cuts on a similar scale, in a scheme to replace Watford General and Hemel Hempstead hospitals with a new, smaller hospital, were able to persuade their local Labour MPs to rally to the defence of local services. Ministers were forced to intervene and instruct the Health Authority to think again.

Lesser, but significant bed reductions are also involved in most of the PFI schemes currently under construction:

Bromley's new £121m hospital will have 13% fewer beds than the hospitals it replaces.

Since the findings of the NHS Beds Inquiry, commissioned by the Labour government to report on the adequacy of bed numbers, Alan Milburn has become more sensitive to the charge that PFI is further reducing frontline capacity. He has insisted that new PFI schemes must at least match the existing numbers of acute beds. This has in turn led to a further escalation in the costs of the new generation of PFI schemes.

Staffing levels reduced

The Cumberland Infirmary scheme involved a cut in clinical staff of £2.6m, and in North Durham the financial balance of the plan involved staff cuts to save £3m.

In Bromley, the Full Business Case projects savings in staff costs of £2.9m a year, which arise, among other things, from "the reduction in the number of beds and theatres. 136 jobs are expected to be axed, including 34 nurses and 8.5 doctors, while the reduction in qualified nursing is to be compensated by a higher ratio of health care assistants.

Privatisation of support services and staff

In the first few PFI hospital schemes, staff working in non-clinical support services have been routinely "sold on" to private contractors providing "facilities management" for the PFI consortium.

Since the 2001 Election, Alan Milburn – in the aftermath of nearly a year of strike action by support staff at Dudley Hospitals Trust fighting their compulsory transfer to a private contractor as part of a PFI deal – has now announced three "pilot" schemes, in which support services will be separated from the financing of the new building.

It is not yet clear whether the PFI consortia will agree to this loss of what they saw as a valuable additional income stream. It is possible they will respond by seeking to increase other charges to compensate for the loss of additional profit.

A document for the Barts and the London Trust, discussing the so-called "Soft Facilities Management" services (portering, cleaning, catering and laundry) pointed out that "Potential bidders view the inclusion of Soft FM services as important to making the Trust's Project attractive".

Squeeze on clinical staff

With all non-clinical support services covered by rigid, legally-binding "unitary payments" clinical services become the only area of Trust spending where Trust managers can seek the "cost improvements" and "efficiency savings" which they are required to make each year by government and by NHS purchasing bodies.

As the Wellhouse Trust was told in the negotiations over the new Barnet General Hospital – where even medical records have been incorporated into a PFI contract in a new computerised system:

"Part of the price … has been to agree to an indexation regime which has no in-built cost improvement and is linked to the published RPI index … The Trust will not therefore be in a position to impose Cost Improvement Programme targets across most of its support and operational services. … The scope for future mandatory CIP targets will be limited to clinical services and to the few support services remaining under the management of the Trust."

Squeeze on community and other services

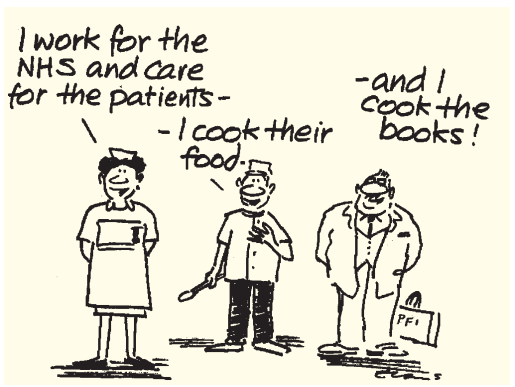
If more has to be spent in paying inflated costs of building new acute hospitals through PFI, less cash is left in the pot to finance other aspects of health care in each area.

As we have seen, many of the first wave of PFI hospitals have had to be heavily subsidised by local health authorities in order to make them affordable. The Worcestershire scheme means that an extra £7 million is being allocated to acute services to enable the Trust pay for the new WRI: this has to be found by squeezing cash allocations for mental health, community services and primary care.

How does PFI show "value for money"?

Untested assumptions

As we have shown above, the inability of the first PFI hospitals to meet pressures for emergency and elective work with substantially fewer beds has already been exposed.



In North Durham, within 12 weeks of the new hospital opening there have been calls for an additional 42 beds to be provided to prevent patients enduring 12-hour waits in A&E.

But their ability to deliver dramatic increases in efficiency has always been seen as key to the affordability of PFI hospitals, and the principal way in which they can defray the additional money they cost the Trust.

As the full financial cost of operating the new system – including the use of increased numbers of community beds and services – is counted, the underlying false assumptions will be fully revealed and the heavy price of PFI will be revealed.

The next generation of PFI hospitals, embodying Alan Milburn's call for schemes to be at least "bed neutral", or embody an increase in bed numbers, will find it even harder to show that they offer value for money.

NHS innovation excluded

Any Trust seeking PFI investment has to depend upon the private sector to suggest the best way of meeting estimated clinical activity, leaving scope for innovative developments.

By contrast, any public sector comparative scheme is required by the Treasury to be "based on the recent and actual method of providing that defined output (including any reasonable and foreseen efficiencies the public sector could make)".

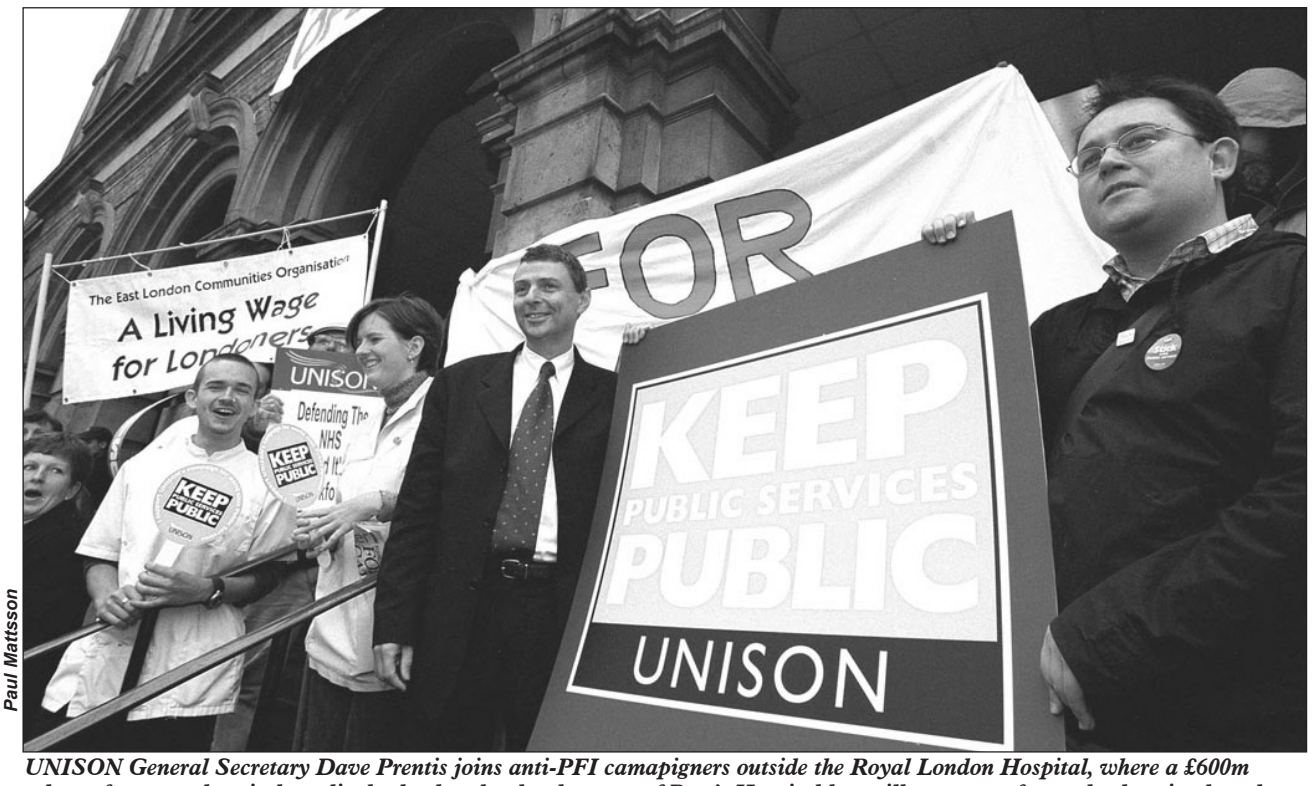
This is especially ironic when we see the quite unreasonable and unrealistic assumptions on which some of the PFI schemes have been based.

Cooking the books: "Public Sector Comparator"

Every PFI scheme is supposed to prove that it represents value for money by being contrasted with a "Public Sector Comparator.

But it is clear from the outset of such an exercise that the comparison is not between like and like: the investment of energy and commitment into selling the PFI scheme to attract the only likely source of funding will not be matched by the ritualistic development of a hypothetical and unloved alternative, whose main virtue is to appear less attractive.

Government guidance spells out that the public sector scheme is not a real plan for a real hospital but just a fig leaf to hide the blushes of the PFI plan: "The purpose of the PSC is to provide a benchmark against which to form a judgement on the value for money of PFI bids".



Paul Mattsson

UNISON General Secretary Dave Prentis joins anti-PFI camapigners outside the Royal London Hospital, where a £600m scheme for a new hospital, medical school and redevelopment of Bart's Hospital has still not got as far as the drawing board.

Discounting the future

One of the manipulative techniques that works consistently to the advantage of a PFI deal in comparison with the PSC is the calculation of the "net present costs".

This assumes that money spent now is worth more than money spent in five, ten or twenty years time – and that the full costs of a hospital development will be paid in the first few years of the scheme (when the value is highest) while the costs of a PFI deal can be defrayed over the whole life of the contract.

On one level this is true, given the effects of inflation and the costs of borrowing a large sum up front.

But the exercise is made surreal by selecting an arbitrary, and high, level of 6% per year – well above current and projected levels of inflation – as the basis for discounting the value of future payments (which in any event are index-linked, and do not diminish but increase each year to keep pace with inflation).

By this measure, £100 of expenditure in five years has a present value of £74.73, and in 20 years £31.18. Even a small (0.5%) reduction in this "discount rate" would be enough to wipe out the claimed economic advantage of the Carlisle hospital PFI.

A former Treasury advisor has suggested a much more realistic figure would be 4%: but such a discount rate would leave most PFI deals clearly more expensive than the PSC.

The rising tide of PFI costs

NHS schemes completed, under construction, or on the list for approval between now and 2006 already add up to a staggering £6.4 billion, and the sums of money committed in terms of annual payments are far larger than that, with most deals lasting 25 years or more.

The combined unitary payments on the six PFI hospitals which are already operational adds up to £83m a year, giving a total payable of £2.4 billion – SIX TIMES the capital value of £423m.

The annual fees on the next 14 schemes in the queue for which details are available add up to £250 million a year, giving a total cost of £7.9 billion – over FIVE TIMES the capital value of £1,507 million.

If these deals are replicated in subsequent PFI schemes, the NHS could wind up paying between £32 billion and £38 billion in real terms (index linked payments) to private consortia over the next 25-30 years.

The argument that support services are included in this overall cost falls flat when we contrast this cost of financing a project through PFI, in which every £1m of capital eventually costs £5-£6 million, with a standard 6% mortgage.

Every £1m could be financed this way over 25 years for just £1.94 million, less than double the amount borrowed, and with no obligation to buy any other services, and freehold tenure of the assets at the end of the deal.

But how does all this represent value for the public sector? While the costs of the large schemes are big enough to cause long-term dislocation to the finances of the NHS, the cumulative costs of financing some of the smaller schemes (less than £20m) through PFI can be ludicrously large.

Some small scale deals – which ought to be affordable from one-off capital funds – are to be paid off over 25 or 30 years, with a resultant cost as high as 24 times the value of the scheme.

- Queens Medical Centre catering: value £1m total cost £23.8m
- North Birmingham Mental Health: value £12.4m, total cost £163.5m
- North Bristol Brain Rehab unit: value £4.9m, total cost £42m

The more money that is squeezed out of the NHS in PFI payments to bankers and private providers, the less that remains to treat patients, pay clinical staff and develop modern, appropriate services.

■ The full text of this dossier on PFI, which was commissioned by from LHE by the GMB, can be found on the GMB web site www.gmb.org.uk