



# PFI: Still the Only Game in Town?

By Elliot Bidgood (December 2012)

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## Introduction

In 1992, Chancellor Norman Lamont announced the intention of the Conservative government of the time to “increase the scope for private financing of capital projects”<sup>1</sup>, launching the Private Finance Initiative (PFI). This scheme is a form of Public Private Partnership (PPP), utilising private sector finance and expertise to assist in the development and management of new public sector infrastructure. In NHS PFI schemes, private sector actors design and build hospitals or facilities, after which the relevant public authority pays an annual ‘Unitary Charge’ for the use of the facility and handles day-to-day NHS operations within it, while the private firms have ownership for a period (usually thirty years) and are in charge of estate management and ‘soft services’ such as cleaning, catering, security and maintenance. Despite an initially mixed stance on the issue, Labour subsequently became strongly supportive of PFI post-1997, due to perceived fiscal necessities. Indeed, the National Health Service (Private Finance) Act, which reformed PFI to ease the authorisation of new schemes, was the first Act of Parliament passed by the Blair government. As of 1997, no PFI projects had been completed, but the 1997 act saw a vast expansion in the number of PFI schemes in place. In addition to being used in the NHS, PFI was also used for schools, prisons, defence contracts and transport infrastructure, although it has been the role of PFI in the NHS that has often been the most controversial.

There were two main theorised benefits of PFI. Firstly, it allowed the government to make massive investments in infrastructure while including only the costs of the unitary charges on the national balance sheet, and thereby avoid either breaking fiscal requirements or raising taxes to fund new direct spending. Chancellor Gordon Brown's Golden Rule (the imperative to retain a budget surplus over the lifetime of an economic cycle) and Sustainable Investment Rule (the pledge to borrow only to fund capital spending and infrastructure investments) created additional fiscal constraints and therefore increased the attractiveness of PFI. It is commonly claimed that these circumstances led Tony Blair's second Secretary of State for Health, Alan Milburn, to describe PFI as “the only game in town” for new NHS infrastructure investment<sup>2</sup> (Milburn himself has to some extent denied this characterisation of his view, though he also said “when there is a limited amount of public-sector capital available, it's PFI or bust”).<sup>3</sup> Somewhat more recently in 2009, Health Secretary Alan Johnson similarly stated that “PFIs have always been the NHS's 'plan A' for building new hospitals...There was never a 'plan B'”.<sup>4</sup>

Secondly, it was hoped that the unique staged payment structure of the PFI contracts and the efficiency of the private sector would mean that more construction projects would be completed on time and under budget, which was commonly observed to be a problem with conventional procurement, and would transfer the financial risks associated with such ‘project failures’ to the private sector. It was also hoped that estate management and soft services would be provided at a higher standard, thereby increasing care quality, and that PFI contracts would establish more stable funding streams for capital-intensive projects than traditional public funding.



Figure 1: UCH Hospital, part of University College London Hospital Trust, is a “state-of-the-art” £422 million hospital built in 2005 under PFI (Source: UCLH<sup>5</sup>)

However, PFI has long had its critics, and stories of recent budget crises in the NHS hospitals built under PFI have intensified this criticism. There is a perspective that PFI is in effect a means of large-scale 'off-balance sheet' spending which will have to be paid off down the line at high rates of interest, with some going as far as to compare it to 'never-never' Hire-Purchase schemes<sup>6</sup> or describe PFI as like "putting a mortgage on a credit card".<sup>7</sup> Further, it has become apparent in recent years that at least some PFI projects were ill-advised and that PFI repayment rates are eating into the budgets of NHS trusts, putting certain trusts in acute financial difficulty and raising fears of damage to frontline care standards. Some of these difficulties have been blamed on the 'off-balance sheet' nature of the schemes, as this may have created a perverse incentive towards PFI among politicians and public sector managers. As a result, the Public Sector Comparator (PSC) assessments used to measure the suitability of PFI relative to public procurement for the same project may have been skewed, so as to ensure that potential PFI looked preferable to the 'on-balance sheet' public approach. It is also now argued that it is far cheaper for the government to borrow money than it is for private firms to do so, especially since the 2008 financial crisis. This potentially outweighs any relative project or service efficiency gains that may result from the use of the private finance and expertise.

Moreover, the arguments about private sector efficiency are also debatable. While there has been evidence cited in favour of the proposition that PFI is superior to public procurement in some areas, such as cleanliness<sup>8</sup> and project construction<sup>9</sup>, there has also been evidence of lower quality services, lower bed capacities due to private sector designs and gross overcharging for basic support services in some instances, such as £333 charges for lamp replacements<sup>10</sup>.

PFI therefore remains controversial. Some observers effectively regard it as a costly, inefficient, irresponsible and unsustainable system of accounting, and believe that either direct public procurement or fresh models of public-private partnership should replace it. However, others continue to defend PFI, at least in principle and despite acknowledged mistakes, for its claimed efficiency relative to public provision and for delivering needed NHS infrastructure. The aim of this report is to explore whether PFI has been a worthwhile project, the exact nature of its problems and what potential alternatives are available to us.

## Background Evidence

In February 2003, the National Audit Office (NAO) assessed the hypothesis that PFI "will deliver price certainty for departments and timely delivery of good quality assets", and specifically whether it resulted in on-time and on-budget delivery, whether it encouraged a longer-term approach and whether expert opinion at the time supported this view. Based on a census of all English PFI construction projects completed in 2002, the NAO concluded that this hypothesis was generally correct, and that project price certainty and on-time delivery were better than they had historically been. Further, it was found that most project managers were satisfied with the results of PFI projects. However, crucially, the report also concluded that "it is not possible to judge whether these projects could have achieved these results using a different procurement route", noting that certain changes within the construction industry may have been responsible for improvements, even if the project had not been delivered under PFI.<sup>11</sup>

Evidence from multiple sources has suggested that PFI hospitals may be cleaner on average than non-PFI hospitals, which if correct would suggest that private control of soft services is a positive from a perspective of standards and patient care. An April 2010 report by the auditor KPMG and

University College London, for example, found that in most years of the study (2005 to 2008), PFI hospitals had better cleanliness and patient environment ratings than “conventionally procured hospitals of comparable age” despite similar cleaning costs.<sup>12</sup> Another 2010 report, for the Health and Care Infrastructure Research and Innovation Centre (HCIRIC), similarly found that despite there being no statistically significant differences in cleaning costs, PFI hospitals performed better on environment and cleanliness<sup>13</sup>, and a third report, conducted by The Infrastructure Forum (TIF) of the UK-based European Policy Forum, also appeared to confirm this apparent cleanliness strength.<sup>14</sup> Further, the HCIRIC found that food quality was better in PFI facilities. However, this report also warned that maintenance backlogs were equally common in PFI and non-PFI facilities and crucially cautioned against reaching definitive conclusions that “PFI hospitals are better because they are PFI” even when they perform better, as PFI hospitals tend to have other related characteristics that may instead be the cause of the improvement.<sup>15</sup> The Infrastructure Forum report also found that PFI was relatively efficient at transferring risk and that there was “strong evidence that PPPs have a better record of on time and on budget delivery than traditionally procured projects”, though it also noted that public sector managers in charge of traditional procurement had perhaps learnt lessons from PFI procurement, thus “narrowing the gap” between the two methods.<sup>16</sup>

In February 2010, Civitas raised some issues with PFI, noting that while PFI had facilitated the construction of hospitals that would not otherwise have been built, some of the facilities built were inappropriate in light of the arguable need for a more community-based model of healthcare and that there were problems with inflexibility and poor negotiation on some contracts.<sup>17</sup> Similar concerns about the programme were also voiced by Nick Seddon in his 2007 book for Civitas, *Quite like Heaven?*:

“Serious concerns are, however, being raised about the sustainability and appropriateness of these projects, and a fierce debate is raging about the long term implications and cost benefits of PFI. The Audit Commission has found ‘capital building projects being blamed for driving unaffordable long-term expenditure levels’, and there is evidence that PFI schemes have cost overrun where the initial cost increases considerably, in some cases over four times as much. Notable examples include a £432 million overrun (82 per cent increase) at Barts & The London and a £405 million overrun (139 per cent increase) at University Hospitals Birmingham.”<sup>18</sup>

Seddon also quoted an architect who described a common preference for shared accommodation among PFI hospital designers as “regrettable”, from a standpoint of patient privacy.<sup>19</sup>

In July 2011, the Commons Treasury Committee reported on PFI and was sharply critical in key regards. While the committee acknowledged that it had delivered assets that would have been “difficult to finance conventionally” and that there was some evidence of cost-efficiency relative to conventional procurement, they also found that cost of credit was high under PFI (and had increased since the financial crisis), that there was a lack of thorough evaluation as to whether some PFIs were genuinely value for money for the taxpayer and that complex long-life PFI contracts sometimes hampered the flexibility required in public services.<sup>20</sup> Further, it was said that:

- “The use of PFI has the effect of increasing the cost of finance for public investments relative to what would be available to the government if it borrowed on its own account...financing costs of PFI are typically 3-4% over that of government debt”. Interest rates on government-issued gilts are currently around 4%, compared to rates of around 8.5% on private borrowing<sup>21</sup>

- “Assuming that PFI does not deliver efficiencies in construction, maintenance and/or services then, for the same present value of finance-related payments, the government could have secured 71% more investment by borrowing on its own account”
- Current Value for Money (VfM) assessment criteria were flawed and needed reviewing, as “evidence we have seen suggests that the high cost of finance in PFI has not been offset by operational efficiencies. Much more robust criteria governing the use of PFI are needed. These should take precedence over the current VfM assessment”
- “PFI is less suitable for services that need to flex significantly over time to reflect changes in public service delivery, demographics or technology”, a category in which we can certainly include health
- “The most straightforward way of dealing with current PFI contracts is for the government to buy up the debt (and possibly also the equity) once the construction stage is over...it would become more affordable to service the visible government debt rather than the hidden PFI debt”<sup>22</sup>
- In August 2011, committee chair Andrew Tyrie MP also identified bias in PFI assessments, while reiterating that all debts should be brought onto the national balance sheet (although it has been warned that since this would add billions to the national debt, the UK's AAA credit rating would potentially be affected<sup>23</sup>)

The Commons Public Accounts Committee also issued a report in September 2011 that was similarly critical of PFI in terms of whether it represented value for the taxpayer<sup>24</sup>:

- The committee argued that the government “assumes tax revenue for Government from PFI investments, but one of the largest PFI investment funds told us that 72% of the shareholders of its management company are registered offshore” and that “at present, PFI deals look better value for the private sector than for the taxpayer”
- The committee claimed that “although PFI has delivered many new public buildings and services, it has been far too easy for the Government to use it as the only form of financing available without clearly proving whether it is value for money” and that “the public sector has failed to make best use of commercial skills”
- During a separate investigation by the Public Accounts Committee into the resilience of NHS trusts in September 2012, Monitor Chief Executive Dr David Bennett stated that only one Foundation Trust was failing financially as a direct result of PFI (Peterborough, where PFI debts make up more than 40% of its deficit), although one more identified as “potentially at risk” (Sherwood Forest) has since deteriorated. Further, it was noted that an additional six non-foundation trusts had been reported to be in trouble by the DH earlier in the year and that 51% of hospitals had reported being concerned about PFI debts<sup>25</sup>

## Current Government Position

The current coalition government argued in 2010 that PFI has left the Department of Health (DH) with a total of £65 billion of PFI-related debt, part of a total PFI debt figure of over £300 billion across all government departments.<sup>26</sup> In 2012, the DH figure was reported to be over £79bn.<sup>27</sup>

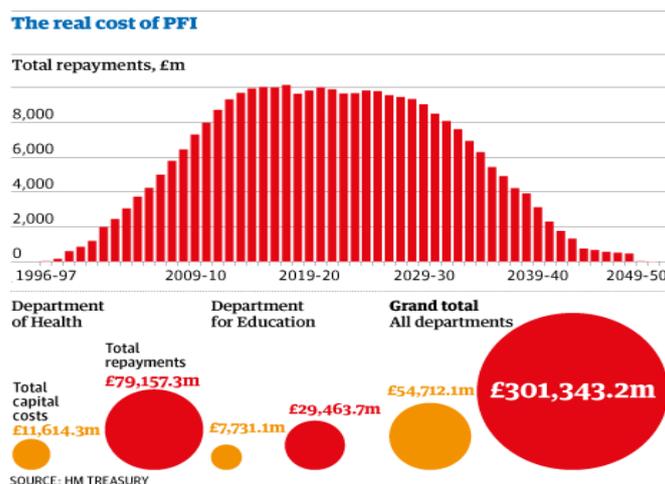


Figure 2: Cost of PFI Repayments (Source: *The Guardian*<sup>28</sup>)

The DH has also named specific trusts that it believes to be at financial or clinical risk as a result of PFI debts, including trusts in which PFI debts account for more than 10% of their revenues.<sup>29</sup> However, while emphasising that they believe Labour's PFI deals were often costly or ill-considered, departments in the coalition government (including the DH) have continued to authorise PFIs<sup>30</sup>, while at the same time the government has also been making moves towards investigating and reforming the scheme:

- Six months before the election in November 2009, then Shadow Chancellor George Osborne pledged to reform the “discredited” PFI model, announced that the Conservatives were exploring alternative models of public sector financing and were planning on reforming accounting to make it more transparent and to remove “perverse incentives” for the use of PFI<sup>31</sup>
- In May 2010, Chancellor Osborne announced a review of the affordability of PFIs as part of the Comprehensive Spending Review. This review concluded in October 2010 and included plans to transfer the “responsibility for the revenue costs of local government Private Finance (PFI) projects from local government to the sponsoring department to remove perverse incentives for projects to be delivered through PFI”<sup>32</sup>, consistent with Mr Osborne's pre-election promises
- In February 2011, Commercial Secretary to the Treasury Lord Sassoon launched a new project to accrue additional savings for taxpayers from PFI contracts, initially focusing on Queen's Hospital in Romford, northeast London as a pilot.<sup>33</sup> In July 2011, initial findings suggested that energy consumption, public sector sharing of savings on insurance, subletting excess space and, notably, reviewing soft service requirements to prevent overspending could allow for savings in current PFI contracts<sup>34</sup>
- The Chancellor then announced a more specific “fundamental reassessment” of PFI in November 2011, and in September 2012 initial indications as to the results of the review were announced. It was suggested that new reforms would involve removing soft services from contract to reduce costs and making small-scale direct public investments in PFI schemes, to ensure government representation on project boards and thus increase accountability for taxpayers and ensure them a small share of profits. However, while industry leaders were said to be pleased that relative continuity was being maintained, Public Accounts Committee chair Margaret Hodge MP observed that core problems with transparency, lack of risk transfer and excessive costs would remain, and the *Financial Times* characterised the announced changes to PFI as “minor”, as the “main elements of the new PFI projects look set to remain the same”<sup>35</sup>

- In August 2012, the DH announced that 7 hospitals were at risk of insolvency or would have to make severe cutbacks to basic patient care as a result of PFI debts, and therefore provided £1.5bn in emergency funds to these trusts (Barking, Havering and Redbridge; Dartford and Gravesham; Maidstone and Tunbridge Wells; North Cumbria; Peterborough and Stamford Hospitals; St Helens and Knowsley NHS trusts, along with South London Healthcare Trust, which is already in administration)<sup>36</sup>
- Then Secretary of State for Health Andrew Lansley claimed in September 2012 that 22 trusts, totalling at least 60 hospitals, were in a state of financial risk due to PFI, although King's Fund chief economist John Appleby and former NHS Chief Executive Nigel Crispin have warned that it is an oversimplification to blame PFI solely for financial problems in NHS trusts (both have noted that PFI debts amount to only 1% NHS turnover)<sup>37</sup>

On December 5<sup>th</sup> 2012 as part of his 2012 Autumn Statement, Chancellor George Osborne confirmed the reforms to PFI previously indicated by the Treasury and rechristened the scheme 'PF2' (Private Finance 2). This included direct public investments of up to 49% to ensure representation on project boards and a taxpayer share of any profits, although the magazine *Construction Inquirer* reported that smaller investments (perhaps 20%) will be more common.<sup>38</sup> The reforms also include requirements for increased openness from contracts about profits and liabilities, 18-month limits on project negotiations, the removal of soft service requirements from contracts and new contract clauses to allow renegotiation. Mr Osborne also announced the first round of 'PF2' projects in the form of a £1.75bn school construction programme, although plans were also announced for it to be used in health as well.<sup>39</sup> However, several of these reforms are consistent with what was previously indicated in September 2012 and the schemes will still be funded 80% by debt<sup>40</sup>, and so some criticisms made then still appear valid.

## Interviews

In order to gain a direct insight into different viewpoints on PFI, I conducted telephone interviews with staff from organisations that have taken a key interest in the debate over PFI.

I spoke with Stephen Ratcliffe, Director of the UK Contractors Group (UKCG), a representative body for contracting companies, many of which have been involved in PFIs. Ratcliffe noted that some of these companies also operated multinationally and were involved in PFI/PPP projects in Europe and Canada. UKCG argues that PFI is value for money for taxpayers and spares them risk by transferring project risks to private contractors, and that it has been subject to excessively negative portrayals in the press, which prompted UKCG to publish a 'Facts & Myths' factsheet to push back against some common criticisms of PFI.<sup>41</sup> Ratcliffe also argued that:

- Current coalition policy represented a "tweak" of PFI and perhaps a more limited usage of it than before
- PFI has led to an "evolution" and an important "learning process" in public-private relationships, with both sectors gradually improving their skills in negotiating good contracts and forging relationships over the past 10 to 15 years. In some respects, the government's current localism agenda could disrupt this, however, if central government authorities experienced in negotiating PFI deals have to hand this responsibility to less-experienced authorities
- On the differences between PFI in the NHS and other areas, Ratcliffe observed that the volume of NHS construction was far higher, which created a greater body of experience in this area, although there is currently less new activity

- Bidding costs in the UK are high, the process can be onerous and can take several years. By contrast, UKCG members with PFI contracts in Canada and Europe have found that the bidding process is much shorter abroad, Ratcliffe said. This has also been highlighted as a problem by the Treasury Select Committee, as it substantially raises entry costs to the PFI market<sup>42</sup>
- UKCG is concerned about the capacity of private providers to deal with changes as a result of the evolving government policy on PFI, such as the standstill in PFI school construction seen in the education sector, which they mentioned in the formal response they submitted to the Treasury consultation on PFI<sup>43</sup>

Howard Catton, head of policy for the Royal College of Nurses (RCN), outlined how in the late 1990s, when PFI was first becoming a matter of high-profile public debate, the RCN conducted surveys of members working in PFI hospitals and gave evidence to the Health Select Committee on the issue. Among its membership, the RCN found two broad viewpoints about new PFI hospitals. On the one hand, some members found that NHS staff were actively included in the process of helping to design their hospitals, facilitating better layouts and planning, higher standards of patient care in new PFI hospitals and better consideration of health and safety. Some new PFI facilities were therefore better than older facilities, some of which dated to the Victorian era. On the other hand, some NHS staff experienced a failure on the part of private contractors to include them in planning. This led to less appropriate hospital designs, cost-cutting and other severe problems. Basic maintenance procedures could also be onerous or unnecessarily expensive in new PFI hospitals. Further, in the 1990s the RCN raised several potential issues about PFI, some of which are now commonplace concerns:

- These included concerns about the long life of the contracts, whether the repayment charges would become less “manageable” if the fiscal situation within the NHS changed or whether public sector negotiators would be able to negotiate, renegotiate or refinance contracts with private sector companies more experienced in such matters
- The RCN were also concerned that if the PFI contract was long, this may reduce flexibility to respond to changing patterns of patients’ needs and demands. A provider may find itself “locked-in” to a contract that could prevent it from developing more community based models for delivering care in the future, for example
- The RCN has found it very hard to say whether PFI represents value for money as there have been consistent concerns about the economic case for PFI. They believe that the method of costing a traditionally procured NHS hospital was over-inflated, that the argument that PFI passes financial risk from the NHS to the private sector has been exaggerated and that the total costs to the NHS over the term of a PFI contract are excessive. The RCN does not oppose PFI/PPP in principle and recognises that there have been improvements in the negotiation of PFI deals over time, but maintains that it is difficult to know whether it is value for money
- There are concerns that the difficulty of renegotiating PFI deals is making PFI repayments a “no-go area” for potential savings in NHS budgets, forcing at least some trusts to look elsewhere in their budgets for such savings. The RCN is concerned that this may affect other core budget areas, including frontline care and staff numbers

Alastair McLellan, editor of the *Health Service Journal* (HSJ), has long been reporting on issues around PFI, having conducted the first interview on PFI with then Treasury Financial Secretary Stephen Dorrell in the early 1990s. HSJ has also taken the lead on reporting about potential alternatives to PFI that are being tested, taking the view that it cannot necessarily be continually defended as “the only game in town”, although it has also published opinion pieces arguing

some of the merits of PFI.<sup>44</sup> In 2012, HSJ has covered the authorisation of the first pension-financed PPP scheme in Hartlepool<sup>45</sup>, the plans to renationalise Carlisle hospital in Cumbria<sup>46</sup> and a joint venture by University College London Hospital Trust to constrain its PFI costs.<sup>47</sup> Additionally:

- While there have been examples of both good and troubled projects delivered under PFI, both early in the history of the initiative and later on, Mr McLellan believes there likely has been a learning process and that tendering and negotiation for later PFI projects have on average been better over time
- Mr McLellan also argued that PFI is more likely to deliver good projects, such as University Hospital Birmingham, if trusts appropriately review their service models, cost base and future revenues as part of the project, ensuring future PFI payments will be affordable
- Along with the six trusts receiving £1.5bn from the DH in order to deal with PFI debts, a further four may require local support from the new NHS Commission Board or other bodies, according to HSJ's acute providers expert Ben Clover
- Due to the efforts of NHS staff, it does not necessarily follow that PFI debts are immediately affecting frontline care, and Mr McLellan stressed that it is important to take account of the huge contribution PFI has made to patient wellbeing in terms of the new hospitals that have been delivered under the initiative over the past fifteen years
- Sensible renegotiation of debt is key in the public sector, especially for trusts that have basic structural problems

The British Medical Association (BMA) submitted evidence to the Treasury Select Committee outlining the organisation's stance, which was overall critical of PFI. First of all, the BMA made clear that "BMA policy has been consistently opposed to the use of PFIs to develop healthcare facilities since [their] introduction in the early 1990s", due to "the high cost, associated low value for money, the lack of flexibility that results, and the transfer of public funds into private sector profits...their long-term affordability, and their impact on local health economies and service delivery". The report noted how the impact of PFI must also be considered in the context of additional pressures on the NHS at the current time, including population trends, the Quality Innovation Productivity & Prevention (QIPP) savings scheme and restructuring under the Health and Social Care Act 2012. The BMA further argued that renegotiation of "all health PFI contracts" was necessary and cited the Public Accounts Committee's findings about value for money with regard to PFI. Responding to a question about the strengths and weaknesses of different public procurement methods, the BMA stressed its commitment to a public NHS, to patient care and to reduced commercial involvement, favouring instead the "smart use of public procurement" and public ownership of all current PFI hospitals.<sup>48</sup> The submission also cited evidence refuting the claim that PFI is more efficient than conventional public sector procurement, in the form of a 2007 report challenging the Treasury's evidence on this aspect of PFI.<sup>49</sup> Responding to questions about accounting, the BMA criticised how the government has used PFI to keep debts off balance-sheet and the "manipulation" of Public Sector Comparator (PSC) assessments of the suitability of PFI projects in a manner favourable to PFIs, concluding that PFI projects are "expensive and short-sighted". Finally, regarding risk, the submission argued that "the structure of PFI makes it difficult to evaluate risk", as responsibility is dispersed, but cited evidence suggesting that hospitals pay a "risk premium" and that PFI fails to shift project risks to the private sector, while also making contracts inflexible and unaffordable.<sup>50</sup> I also spoke directly with Andrew Lloyd-Kendall, Senior Research Analyst at the BMA:

- With regard to alternate forms of PPP/private finance, the BMA does not oppose them per se, but believes PFI fundamentally may not be necessary and that it would be better for patients, and for taxpayers from a value for money perspective, for procurement to be handled publically
- Mr Lloyd-Kendall believes that while early contracts were often expensive, were poorly-specified and that risk was highly priced by private contractors due to uncertainty, a learning process in NHS contracts has led to somewhat better PFI deals over time
- BMA does not at this time have any specific data from members regarding the experiences of its members with PFI
- No clear, non-anecdotal evidence exists of PFI negatively affecting frontline services
- There is also no clear evidence that PFI debts are the cause of budget problems in the NHS, though it clearly doesn't help
- There is no obvious, “blanket” answer to the question of how to deal with existing PFI debts
- There need to be both individual reviews of all current PFIs and an overall evaluation of PFI, aimed at ascertaining how the PFIs have worked in practice and whether they have been cost-effective when compared to alternative models of procurement or investment, particularly public procurement. This would help us to ascertain which current PFIs are unsuitable and require contract renegotiation
- Contract renegotiations would help address the lack of flexibility in many of the current contracts, which is a significant problem. This would in particular help the trusts that are currently experiencing severe financial difficulties, as while PFI in itself is not necessarily the main cause of difficulties for many trusts, the fixed costs associated with PFIs make other financial pressures harder to address
- There is also a problematic relationship between Payment by Results (PbR) and PFI. This is because the PbR tariffs used to decide central funding for trusts are based on average and historic costs, while newer buildings in general and PFI buildings in particular cost more than these averages. Further, since PbR is essentially an activity-based funding regimen (“money following patients”<sup>51</sup>), trusts with high fixed PFI costs face difficult decisions in terms of how to balance PFI debts and cost-effective setting of care. How this could be addressed remains unclear, although it has been suggested that some payment for capital could be removed from the PbR tariffs and handled separately to ease the burden of PFI hospitals somewhat

The public sector union UNISON has been both active and critical on the issue of PFI.<sup>52</sup> In an April 2011 report, UNISON noted that the coalition had procured 61 new PFIs at that point in time, totalling £6.9bn, and outlined how in June 2010 a proposal by Tees & Hartlepool NHS Trust to develop a 91% publically-financed hospital was rejected by the government, despite the simultaneous decision to authorise a PFI hospital in Liverpool. The report also argued that the financial crisis had weakened the case of PFI in terms of value for money, as the “cost of private finance has increased as financial sector liquidity and competition have diminished, while the interest rate on UK gilts has fallen to historic lows”.<sup>53</sup> UNISON recommended regulations to control excessive returns to investors at public expense, while warning that a new code of practice announced by the government will deliver few savings in this regard and would not constitute a genuine “rebate” for taxpayers in their view. UNISON also expects that while PFI would be maintained “in the medium term”, eventually other models of capital financing will begin to replace it.<sup>54</sup> In February 2012, UNISON Assistant National Officer Sylvia Jones submitted a response on behalf of the union to the government's consultation on PFI reform, stressing that UNISON welcomed the review and had major concerns that PFI put profit over quality, that

borrowing costs were too high, that evaluation methods were flawed, that contracts were inflexible and failed to account for service requirements, that PFI buildings were inadequate and that PFI tended to leave risk to the private sector, while private backers could “pocket windfall profit”.<sup>55</sup> I was also able to speak with Ms Jones:

- UNISON advocates a more flexible model, an end to off-balance sheet accounting, the removal of soft services from existing contracts, better monitoring of the impact of existing PFI schemes on both the workforce and quality of public services, PFI being subject to Freedom of Information (FOI) law and an end to the “two-tier workforce” that can result from how PFI contracts are written
- UNISON has been campaigning against PFI for over a decade. Its current campaign is known as ‘Million Voices’, which opposes cuts, privatisation and outsourcing in public services
- UNISON also responded to the Treasury Committee investigation into PFI and to an investigation by the Lords Select Committee on Economic Affairs, the results of which were published in early 2010<sup>56</sup>
- UNISON has commissioned research into the impact of PFI on frontline services and NHS jobs
- As of yet, government announcements have not changed UNISON’s stance of PFI, as the removal of soft services and other reforms to PFI that have been announced in the course of the review are considered minor and overall would not lead to a better model, as UNISON believes PFI will remain more costly due to interest repayments and would deliver services that were not fit for purpose
- UNISON disputes that a lack of negotiating skills in the public sector was a major problem in PFI, as the basic nature of 20-30 year PFI contracts means that even when well-negotiated they are inflexible and fail to take account of future needs, making it difficult to negotiate relevant contracts in any context
- The inflexibility of PFI deals has also had a serious effect of NHS trust budgets. The worst examples of this are Hinchingbrooke, Peterborough, South London and Worcestershire<sup>57</sup>, though UNISON believes at least 22 trusts are affected
- PFI hospitals have often not met necessary requirements. For example, some have fewer beds than the old hospitals they replaced. This means that these hospitals cannot easily respond to population pressures or changing needs
- Although there may indeed have been a learning process that could facilitate better PFI agreements, this is now irrelevant, as post-crisis PFI hospitals are now twice as costly due to the clear difference between public and private borrowing rates (even when borrowing from the same markets). This creates an affordability gap for public bodies that can lead to cuts in services and staffing
- UNISON did not comment on alternative models such as pension fund investment, instead advocating a full return to traditional public procurement, though it has published reports on some other models that might be more cost-effective than PFI, such as gain sharing from equity sales and from maintenance over-spend<sup>58</sup>
- ‘Making the Connections, Contract Cleaning and Infection Control’, published April 2009, made the case that PFI cleaning services provided “no clear cost advantages over non-PFI services”<sup>59</sup>, while two further reports have outlined negative staff experiences with PFI<sup>60</sup>

The picture gained from talking with experts on the role that PFI has played in the NHS is therefore somewhat mixed. Several stressed the positive impact that the construction of many new NHS facilities under PFI had on patient care and overall NHS standards, as well as the

possibility that risk transfers and private sector efficiency may have benefited the NHS in certain instances. However, a variety of problems, potential problems and needed changes were also raised, including the excessive cost of using private finance, contract issues and concerns about detrimental impacts on patient care.

## Alternatives

As was made clear by the representatives from the HSJ and UNISON, among other sources, the view that PFI (or now PF2) is ‘the only game in town’ increasingly appears outdated, as evidence mounts that numerous alternatives to the PFI model of Public-Private Partnership exist and may in fact be preferable, in light of some of the difficulties with PFI. It is therefore worth exploring these alternatives, in order to see whether they are viable as replacements for PFI.

**Non-Profit Distribution (NPD)** First proposed in Scotland in 2007 and now routinely favoured over PFI by the SNP administration there, NPD has been touted as a potential alternative to PFI UK-wide. NPD is similar to PFI in basic design, but has contractors invest solely in project debt and it is 100% debt-funded, with no expensive private equity element. It also caps returns to investors, diverting surpluses into a non-governmental charity for the public (hence the reference to it being non-profit distributing). This is argued to increase value for money. The Scottish government has already announced £2.5bn in infrastructure spending, and during the PFI review, the UK Treasury acknowledged NPD as “one option among many that we are keeping under review”<sup>61</sup>. Arguments in favour of NPD include the following:

- The Scottish Futures Trust, the government agency in charge of infrastructure in Scotland, has claimed that contractors submit lower bids compared to previous PFIs, which they claim proves the success of capping<sup>62</sup>
- The Scottish Financial Partnerships Unit have stressed the relative similarities with PFI as a reassuring factor for investors: “The market can see many familiar features in the NPD model...the public sector governs its relationship with the NPD through a contract like any other PPP; the standard PPP form of contract is still relevant; normal profits and returns are taken by contractors and funders as in all such procurements”<sup>63</sup>
- That some of the efficiencies associated with private-sector procurement under PPP/PFI schemes can be retained, while the high costs that prevented the schemes from being cost-effective are tackled
- In 2008, NHS Tayside began using NPD to develop a £95m mental health facility. This has been touted as “the single largest single capital investment in mental health facilities in Scotland”<sup>64</sup>



Figure 3: Plan of the Tayside Acute Mental Health Developments project (Source: Morgan Sindall, contractor for the Tayside project<sup>65</sup>)

However, there have been many critics of NPD, notably University of Edinburgh PFI expert Dr Mark Hellowell, who has warned that returns, not profits, are capped under NPD. Further, Hellowell warned that it wasn't clear why investors would accept a lower rate of return for the same risks they faced under PFI and he charged that the Scottish government may have favoured the NPD model to PFI despite a lack of evidence of a difference in costs, simply because 'PFI' now carries a negative association.<sup>66</sup> Several other potential problems also exist:

- In an article on NPD, *The Guardian* mentioned the possibility that contractors will compare PPP opportunities in Scotland with those in England and in the developing international market, raising a capital flight concern if it were to be implemented in England too - "with private companies already looking at emerging opportunities overseas, the [UK] Treasury may be reluctant to drive away potential investors by threatening them with a cap on returns"<sup>53</sup>
- Out of 93 PPP projects listed by the Scottish government, only 5 are currently NPD<sup>67</sup>. Furthermore, the NHS Tayside Mental Health Development is the only health-related project out of these 5. Therefore, more evidence on its applicability in healthcare is needed

**Local Asset Backed Vehicles (LABVs)** For a number of years, Local Asset Backed Vehicles have been used by English local government for infrastructural investments of various kinds, and were promoted by the think-tank Localis as an alternative to PFI with "great potential to create both low-cost physical infrastructure and a profitable return to the taxpayer".<sup>68</sup> In local authority LABVs, the authority puts forward land as an asset, while in exchange, the private partner puts forward its skills and finances the development of it, with both parties having agreed a clear outcome that both will profit from, as well as a theoretically even sharing of risk. To ensure the plan is kept to and that the public sector retains adequate control, the two partners share representation on the board of the project. Though so far primarily a local government infrastructure tool, in July 2011 Watford Borough Council published a tendering licence for a new Health Campus, joint contracted with West Hertfordshire NHS Trust, which will provide non-acute and office facilities for NHS West Hertfordshire. The council further added that "it is expected that the re-provision of acute hospital facilities are likely to be outside of these arrangements, but it may be possible that the arrangements with the LABV support the hospital development at a future date".<sup>69</sup>

- LABVs have been claimed to avoid the cumbersome procurement process and upfront costs of PFI<sup>70</sup>
- It has been claimed that they "avoid some of the worst excesses of PFI – high start-up costs, bureaucracy and the impression that the public sector doesn't get 'good value'", prioritising partnership on "delivery, rather than wholesale outsourcing of a service or objective"<sup>71</sup>
- LABVs have had shorter contract terms than PFIs, varying between 10 and 20 years, potentially avoiding some of the inflexibility problems associated with PFI. However, the Watford NHS LABV has a 30 year contract period
- They have also been billed as allowing the public sector to "exploit and unlock the full economic potential of its existing property estate through regeneration and rationalisation", and as allowing projects to gain from private sector efficiency in a manner less "contractualised" than PFI, again perhaps avoiding the flexibility issues associated with PFI
- The Treasury Select Committee praised LABV as an alternative to PFI<sup>72</sup>
- The HSJ has argued that they will allow the "delivery of new, fit-for-purpose facilities or refurbishment of existing facilities without calling on central funding", noting that a

“number of foundation trusts have already embarked on the procurement of a private sector partner and have assessed that the LABV model is suitable for their estate”<sup>73</sup>

Issues:

- They are described as being “heavily dependent on location”, in terms of local needs and private sector demand, which sometimes means LABVs must be combined with other types of investment<sup>74</sup>
- Take-up has been slow so far, due to “perceived cost and complexity of creation, a small pool of advisors with relevant expertise, the challenges of implementing change in the public sector, the attachment that organisations have to real estate and the challenges in quantifying benefits in advance of procurement”<sup>75</sup>
- Despite being around since the mid-2000s there have been few health LABV projects<sup>76</sup>, other than Watford, so again their use on large-scale health projects may not be proven as of yet

**Growth Bonds** Growth bonds have been floated as an alternative to PFI for national infrastructure projects, including those related to housing, power, telecommunications and transport. These would work by allowing individuals, banks, building societies and investment funds to purchase special bonds from the government, in order to provide funding for such projects. While currently rare in the UK, infrastructure bonds are already common in the US, where funds have been raised and hypothecated for specific purposes<sup>77</sup>, and University of Sheffield professor Colin Hay has suggested that hypothecated bonds for the NHS should be considered if growth bonds in other areas are initially successful.<sup>78</sup> However, there have been concerns that growth bonds could be another high-interest, off-books scheme like PFI.<sup>79</sup> Moreover, there are no concrete examples of growth bonds being used to fund major health infrastructure at this time.

**Pension Funds** Linked to the idea behind growth bonds is the model of attracting pension fund investment to support the construction of infrastructure. However, in contrast to general proposals that have been floated with regard to infrastructural growth bonds and the so far largely academic suggestions that they could be used for health specifically, NHS North Tees & Hartlepool now looks set to provide a high-profile example of a major hospital project part-funded by pension fund investment. Admittedly, this project was authorised only recently and so we cannot yet fully assess its merits or wider applicability, but it could nevertheless provide an interesting test case if successful.

- Given the formal go-ahead by the local trust board in September 2012, the new hospital in Hartlepool will cost £298 million to build and will replace two existing hospitals, making this a substantial project.<sup>80</sup> The hospital will serve Hartlepool, Stockton, Easington and Sedgefield
- NHS North Tees & Hartlepool have stressed that they “are acutely aware that the funding route we are pursuing – a pension fund holder solution – is unique and it is the board’s responsibility to ensure the whole project provides value for money and is sustainable over the long term”<sup>81</sup>
- On top of the initial review already conducted, further reviews will take place after the procurement period for the project, after which a final decision will be taken, pension money will be borrowed and construction will begin under contract, with the hospital aiming for a three-year build and a 2016/2017 opening time if the project goes according to plan

- Potential risks identified by the trust include the need to make adequate efficiency savings, a lack of income growth, high transactional costs, the impact of cost improvement programmes (CIPs) once the hospital is open, the stability of the funding structure from the perspective of investors and whether the full unitary payment will be subject to the Retail Price Index (RPI)



Figure 4: Impression of the new pension-funded Hartlepool hospital (Source: NHS North Tees & Hartlepool)

**Regulated Asset Base (RAB) Models** These models have been praised by Jesse Norman MP of the Campaign for a PFI Rebate<sup>82</sup> and by the accountancy firm KPMG. Modelled on the concept of Financial Capital Maintenance, which allows investors to recover capital invested into projects, RABs attract private investment into infrastructure, while reducing investor risk and capping consumer prices. They work by encouraging investment in a “regulated asset via long-term borrowing”, with regulation minimising the risks<sup>83</sup>. They were first introduced in the UK, but are now “spreading across Europe” for use on infrastructural projects<sup>84</sup>. For governments, it is argued that RABs ensure long-term investment and thus a degree of project stability, as well as “fairly deep capital resources”, while also transferring risk to investors<sup>85</sup>. However, there are again some issues:

- RAB models “do not really ‘guarantee’ a return as recovery is based on a regulatory contract”, making confidence in this regulatory contract and the governmental regimes that support it crucial if projects are to be successful. As a result, RAB “may not be applicable to all markets or sectors”<sup>86</sup>
- RABs are also better suited to natural monopolies and cases in which “there are large investment requirements over time”<sup>87</sup>
- RABs require a steady revenue stream
- They have so far been used for utilities, housing and transport only, with no current applications in health, raising questions as to whether this is one of the applicable sectors

**Design Build (DB)** In contrast to the Design Build Finance Operate (DBFO) mode of operation common in British PFI schemes, DB only hands private contractors the responsibility to design and build the project, with the public sector financing the project, owning it and operating it after construction is complete. The level of public sector involvement in the design process may vary, but potentially the contractor is still left with some discretion as to the final design of the building.<sup>88</sup> This approach avoids the difficulties associated with private financing altogether and will allow the government to take advantage of the low borrowing rates the UK government can currently benefit from<sup>89</sup>, although whether it is preferable for the private contractors not to be involved on the operational side remains a more complex issue. For this reason, another model

of Public-Private Partnership is **Design Build Operate (DBO)**, under which the public sector still provides the financing and therefore can retain ownership, but still contracts out operational responsibilities to the private sector<sup>90</sup>.

- The Treasury Select Committee has argued that DB or DBO would be more appropriate than the DBFO model preferred under PFI, in at least some instances<sup>91</sup>
- Design-Build projects have a clear point of responsibility for design and construction<sup>92</sup>
- However, under DBO schemes, 'operations' refer in part to soft services, which may clash with the current government preference for cutting the cost of PPP schemes by removing these from deals

In addition to the numerous models of PPP that exist, another important option to consider is a return to the **traditional public procurement** model that dominated before the introduction of PFI, in which projects were fully developed, owned and operated by the public sector. Some traditional public procurement continued during the PFI era, it is worth noting, but this was on a small scale. The benefits of this when compared to PFI are clear, in that spending is on-balance sheet and fully accounted for, as with DB and DBO schemes. However, in addition to arguments as to whether this feature would have prevented the late-1990s/2000s-era investment in NHS infrastructure given the political consensus around the need for fiscal restraint (or at least the appearance of it), other issues can be raised:

- The 2010 Lords Economic Affairs Committee report highlighted that traditional procurement "did not enjoy a high reputation for efficiency", with cost overruns and delays reported in the "vast majority" of cases according to DH research<sup>93</sup>
- Furthermore, there was often a lack of public sector accountability for such failures<sup>94</sup>
- Although it is debated whether PFI adequately transfers risk in practice, the lack of risk transfer and a division of expertise in public procurement was one of its original appeals<sup>95</sup>
- In 2002, Alan Milburn gave evidence that even when the DH tried applying PFI-style contracting terms to traditional public projects, full PFI appeared preferable. On a project in Hull, payments were staged over a number of years in order to encourage private contractors to take more responsibility beyond the basic completion stage, but Mr Milburn described the result as "catastrophic value for money", as contractors tended to respond to the staged payments by simply bidding up the price of the project<sup>96</sup>

However, the Milburn argument about the value for money of PFI comparative to public procurement is difficult to take too seriously in light of the debt burden faced by parts of the NHS as a result of high-interest repayments. Therefore, at least in this regard, public procurement retains a clear advantage over PFI from the perspective of honest accounting and ultimate fiscal impact. Furthermore, the results of the assessment carried out in Hull should perhaps be taken in light of what we know about the perverse incentives public sector managers had to make PFI seem more attractive than other options and the suggestion in the study by The Infrastructure Forum that public managers may in fact have learnt lessons from PFI procurement efficiency.<sup>97</sup> Therefore, renewed expansion of public procurement may be worthwhile, even if on a trial basis.

It is difficult to fully assess alternatives given the dominance of PFI and thus the limited opportunities that exist to observe and evaluate alternative models in practice, but it is advisable that both a renewed willingness to use public procurement and wider application of some of the emerging forms of PPP would allow us to get a better sense of which alternatives are most workable. Most importantly, public sector managers need to be able to judge projects case-by-case based on what is most suitable in specific instances, rather than be incentivised to choose PFI regardless of merit.

## Conclusion

Overall, it appears that PFI has not been value for money. This is primarily due to the extremely high cost of borrowing under PFI, due to the higher rate of interest on private borrowing when compared to currently low rates of interest on government gilts and the fact that each hospital constructed under PFI costs several times as much as they would have if procured conventionally, which makes cost-efficiency arguments in favour of PFI difficult to mount. Further, although we should not overestimate the impact of PFI on the fiscal position of the NHS writ large, given that PFI debts amount to only 1% of the entire NHS budget<sup>98</sup>, the impact that it has had on financial and clinical stability in certain trusts has nevertheless been severe. PFI has also allowed politicians to operate on a 'buy now, pay later' ethos while concealing the true fiscal impact of these new projects, which has proven to be a danger to the health of our public finances.

Further, evidence on the supposed efficiency advantages of PFI compared to traditional public sector procurement appears mixed. Studies have indicated that soft services may be performed better in PFI-built facilities, but whether this is due to them being PFI is unclear and as a result of concerns about costs and contract inflexibility, a consensus has developed around removing soft services from PFI contracts.<sup>99</sup> Scandals associated with soft services, such as £333 lightbulb replacements, have also done severe perceptive damage to the scheme. Moreover, although project risk appears reduced, difficulties can still occur and there has been scepticism about the extent to which project risk is effectively transferred to the private sector. A continual problem with comparing PFI to traditional procurement is the relative lack of examples of alternative procurement over the past fifteen years, due in part to the perverse incentive public sector managers had to ensure that Public Sector Comparator (PSC) assessments favoured the use of PFI, which means that it is hard to adequately compare the two and determine whether PFI schemes are empirically more efficient, without caveat. Taken in light of the extremely high cost of PFI, this all makes cost-efficiency arguments in favour of PFI difficult to mount.

This is not to dismiss some of the positive outcomes of the programme, most notably the large number of hospitals that were delivered that may not have been otherwise given the lack of political support for NHS infrastructure investment through more conventional channels, which means that PFI has contributed hugely to patient care in a sense. However, this has clearly come at a high price and even according to some of the most positive assessments of the programme, PFI was used too often and perhaps on the wrong type of projects, delivering large hospitals rather than smaller community care facilities that may have been better attuned to modern health priorities, for example. Further, in many cases a mismatch between public and private sector experience with contract negotiation and tendering led to poor deals, even though there may later have been a process of learning on this point.

However, a more difficult question, and a crucial one if we are to overcome the ‘only game in town’ ethos that has long pervaded Whitehall, is the issue of what else can be done. The ‘PF2’ reforms now confirmed by the Treasury (public representation on project boards, the removal of soft services from contracts, more openness about profits and liabilities, 18-month bidding and perhaps a somewhat more sparing approach to the authorisation of PFI projects) are a start and are strongly advisable if the current government intends to continue to use PFI. However, these can be viewed as fairly piecemeal reforms and may not remedy some of the core problems outlined above.

The government should therefore continue to experiment with private sector involvement in the procurement and, under some circumstances, the financing of health infrastructure, given the possibility that the private sector may to some extent provide more efficient procurement. Above I have explored several different PPP models, but as seen, there is variance in the extent to which they have been fully trialled in the UK or in the UK health sector specifically, making it difficult for us to fully evaluate them at this stage. However, in the meantime there is great interest in projects using such new models and it is advisable that the government should continue to pilot a variety of different PPP models, as well as public procurement, in order to assess their applicability and move away from the previous overreliance on the flawed PFI model.

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