

**The Centre for
International
Public Health Policy**



**Four Lessons for Western Australia:
The Experience of Public-Private Partnerships /
Private Finance Initiative in the UK's National Health Service**

August 2009

**Moritz Liebe
Prof Allyson M Pollock**

Summary

This briefing¹ focuses on the Private Finance Initiative (PFI) and its relevance to the UK National Health Service in the light of the current economic climate. The UK experience can be a valuable lesson for the Western Australian Health Department:

- As of April 2009, 149 PFI projects, worth £12.27 billion (AUD 24.68 billion), had been signed to UK's NHS. Since 1997, of the 133 new hospitals built in the NHS England, 101 were financed under the PFI, accounting for around 90% of the capital committed.
- Over the course of the contracts the public sector will pay £70.5 billion (AUD 141.8 billion) in charges for PFI investments, of which approximately £41.4 billion (AUD 83.2 billion) is for the availability of the buildings.
- Investment in public infrastructure projects through PFI is simply borrowing by other means and does not free additional resources.
- Private finance is more costly than public borrowing, but government has a perverse incentive to use PFI because current accounting standards still allow it to disguise public liabilities. Currently 96% of all NHS PFI projects do not show up on the public sector net debt figure.
- The higher cost of private capital is not simply a function of risk adjustment but includes high returns to the investors.
- The UK government is now the majority shareholder in two large banking groups, but the banks continue to charge excessive risk premiums to the taxpayer.
- Under PFI, soft facilities management services, including cleaning services, have been shown to provide less value for money compared to non-PFI hospitals.
- PFI hospitals schemes absorb a high proportion of NHS trusts' revenue streams through charging for capital, and this creates affordability problems. In the NHS an average of 5.8% of activity-based reimbursements to hospitals are for capital costs but the average capital costs for PFI hospitals exceed this tariff by 2.5%. Over half of the larger hospital PFI schemes are in financial difficulties compared to one in four non-PFI hospitals.
- Having bailed out the banks at taxpayer's expense the government is further conflicted because in allowing the banks to charge an excessive premium for the cost of finance and at high rates of return it is protecting shareholders' and investors' interests at the expense of the taxpayer, citizens, and public services.
- The UK government remains committed to PFI despite contested value for money claims and the exceptionally high cost of finance.

TMAuthors:

Moritz Liebe is a Research Assistant and PhD student at the Centre for International Public Health Policy, University of Edinburgh (Moritz.Liebe@ed.ac.uk).

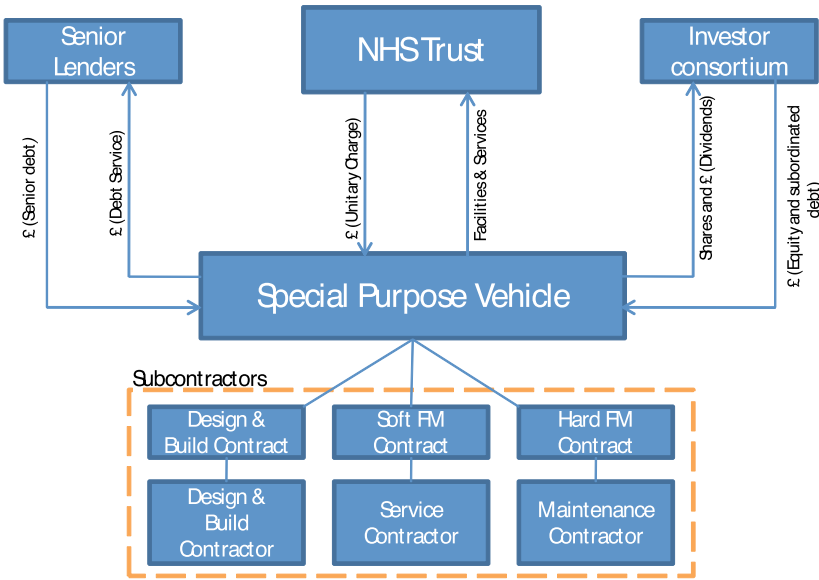
Prof Allyson M Pollock is Director of the Centre for International Public Health Policy, University of Edinburgh (Allyson.Pollock@ed.ac.uk).

¹ This paper is based on Liebe, M. and A. Pollock (2009), The experience of the Private Finance Initiative in the UK's National Health Service, Edinburgh: CIPHP.

Introduction

This briefing focuses on the Private Finance Initiative (PFI), the most significant form of Public Private Partnerships (PPP) in the UK. When governments use PFI, they enter into a long term, 30 to 60 year, contract between the public and the private sector. Under PFI a consortium of investment banks, builders, and service contractors raises the finance² for public infrastructure project, and designs, builds, and even operates the facilities for the public authority through a company established for this purpose (Special Purpose Vehicle). The consortium may additionally provide soft facilities management (FM) services within the project such as laundry, maintenance services, catering, and cleaning (Figure 1).

Figure 1: PFI structure in the NHS



Adapted from Yescombe (2007).

Normally, the private sector retains the control, or even the ownership, of the assets. When the building is up and running the public sector pays an annual performance-linked fee to the private

² PFI schemes use two main types of finance in order to keep the cost of private finance down. One type of finance is low risk and therefore has a lower rate of interest. This is known as senior debt. The other is higher risk and has a higher rate of interest. This is known as subordinate debt or equity. Typically, 90% of finance for PFI schemes is low risk and the remaining 10% is higher risk. The overall cost of finance is the sum of these costs of finance. Subordinate debt refers to lending that is only paid back after senior debtors have been repaid, and equity refer to shares held by shareholders who only receive a dividend when all other costs of the business have been met. Subordinate debt and equity are less secure than senior because they have a lower claim on a project's cash – other providers of capital are repaid first so that should there be a shortage of cash for any reason subordinate debt and equity will be the losers (Pollock, Price and Player, 2004). The function of subordinate debt and equity is to absorb risk, diverting it from the main source of funding. Buffering of this type reduces the interest rate and the size of debt repayment on the largest component of PFI financing, which is senior debt. Subordinate debt and equity therefore command higher rates of interest than senior debt because of the presence of this risk.

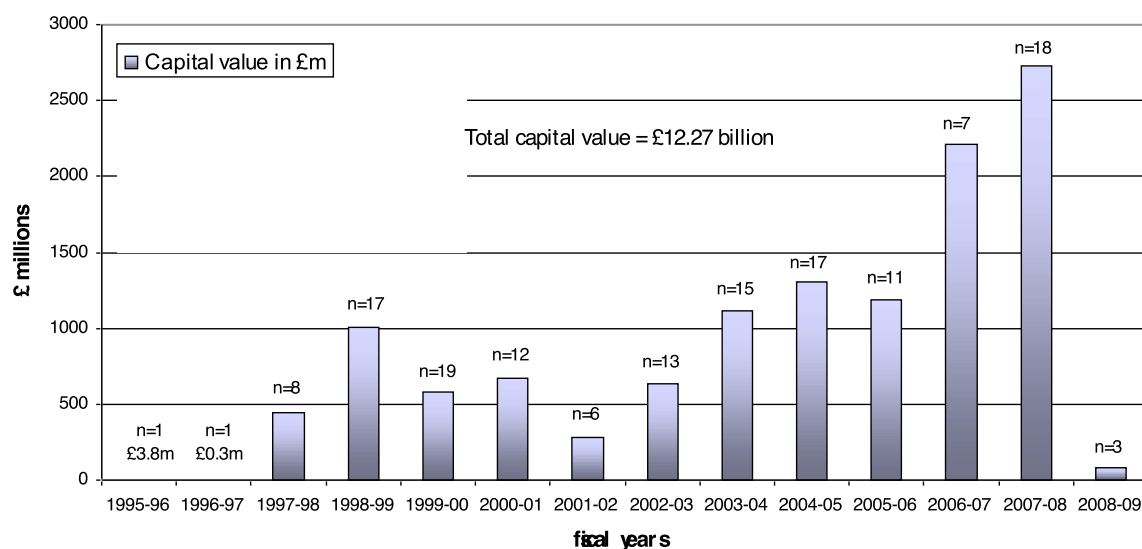
sector consortium for the duration of the contract. This fee, also called unitary charge, is made up of two elements: the availability charge and the service charge. The availability charge is a fixed cost which varies only if the consortium is penalised for failing to meet performance standards. It allows interest and principal payments on the debt taken out by the PFI consortium and the accumulation of cash reserves required during the contract to maintain the condition of the facilities, i.e. to meet the life-cycle costs. Finally, once these costs have been met, the availability payment funds return to shareholders in the form of dividends. The service charge, on the other hand, reimburses the consortium for the routine building maintenance work and, if included in the contract, the provision of soft facility maintenance services (Hellowell and Pollock, 2007a).

This approach is radically different from traditional public sector procurement methods in which the public authority sets out the specific infrastructure requirements and then enters into separate or combined contracts with the private sector for the design, construction, and sometimes operation of the assets. Finance for these projects comes directly from the public sector either through increased taxation or borrowing through issuing of government gilts (Hellowell and Pollock, 2006).

Since its launch in 1992, a significant proportion of large-scale capital investment in UK has been rolled out via the PFI procurement route. As of April 2009, 149 PFI hospital contracts were signed in the UK, with the NHS England being the biggest procurer in terms of numbers (68%) and capital value of the assets (89%) (Figure 2, overleaf, and Annex Table 1). In England's National Health Service (NHS), of the 133 new hospitals which were built between 1997 and 2008 or currently under construction 101 were financed under PFI. This accounts for around 90% of the £12.1 billion committed (AUD 24.34 billion³; Department of Health, 2008).

³ Here and in the following the exchange rate of 3rd August 2009 (£1 = AUD 2.0117) is applied.

Figure 2: Number of signed UK PFI hospital projects (n=148) and their capital value (1995/96 - 2008/09)



One project with a capital value of £6.87m was excluded from the graph because the date of financial close is unknown.

Source: HM Treasury 2009b.

PFI is widely criticised for its high but avoidable costs. The policy is in general unpopular with citizens, staff and users in the UK. There is a significant body of UK research and evidence the Western Australian Health Department should scrutinise before proceeding with its plans to replace the Albany Health Campus through a new AUD 135 million PPP hospital (Hames, 2009). As we will show, the criticisms have added force in the new climate of economic recession and constraints on government expenditure (ABC, 2009).

Lesson 1: PFI provides no additional funding

Large infrastructure projects require substantial sums of upfront investment. In the past, governments have sought to mitigate the direct impact of these costs on their budget by spreading payments over a long period through direct borrowing (Yescombe, 2007). However, increasingly governments are restricted in how much they can borrow on their own account due to internal or external constraints.

Since 1997, public borrowing in the UK is subject to a UK Treasury imposed 'sustainable investment rule' which requires that public net sector debt in the UK should not exceed the threshold of 40% of Gross Domestic Product (GDP). Mandatory limits of 60% apply to members of the Eurozone (Emmerson et al., 2001, 2006). The rule is based on the rationale that limits on public borrowing will lower interest rates and increase economic growth (Hemerijck et al., 2002). However, it is not clear that this policy has the desired outcome (Blanchard and Giavazzi, 2004).

One of the early attractions of PFI was that it allowed governments to evade their own borrowing rules because PFI projects did not necessarily count as public debt in the same way as government borrowing. Investment could therefore be undertaken without threatening spending limits. This was politically attractive but also led to the adoption of PFI in circumstances where a conventional project would have been cheaper (Gosling, 2004).

Nevertheless, PFI is public borrowing even if it is not recorded as such. The public sector must commit to repaying debt to private consortia in the same way as it would when settling any other debt (Heald and Geaghan, 1997). Therefore the perception that PPP/PFI generates additional resources over and above public investment is mistaken. In fact most authorities now acknowledge that PFI does not benefit the economy as whole but simply allows governments to manipulate their reported public borrowing figures.

PFI has provided successive UK governments with an opportunity to keep public sector net debt artificially low – nearly 96% of all UK hospital schemes are excluded from public debt figures (or ‘off balance sheet’) (HM Treasury 2009b). PricewaterhouseCoopers (2008), the government's own advisors, have observed that current accounting standards⁴ – which are similar to the guidance issued by the Australian Heads of Treasuries Accounting and Advisory Committee – are used as “accounting driver for implementing projects through PFI” (p.1.) and that these rules may provide an adverse incentive to allocate risks to the project company wrongly simply in order to preserve the off-balance sheet status of (some) PFI projects (ibid).

Lesson 2: PFI projects do not deliver better ‘value for money’

Cost of finance is higher under PFI – senior debt and equity

In conventional procurement, that is, where the government borrows, the cost of borrowing is relatively cheap because the financial markets regard lending to governments as low risk and therefore

⁴ The government’s accounting standard FRS5 had a misleading effect on reporting public sector liabilities through PFI and was already a concern. It informed the HM Treasury’s decision to move to International Financial Reporting Standards (IFRS) by 2008/09 (HM Treasury 2008). However, some departments encountered problems with switching to IFRS before 2010/11 (Carruthers, 2009). As an intermediate solution, the European accounting standard used by the Office for National Statistics is now applied for the Treasury’s budget with the effect that PFI schemes are accounted for in similar ways as before, i.e. off balance sheet (Timmins, 2009).

they charge low interest rates. By contrast, interest rates charged to the private sector are higher⁵. Agreed payments to the private sector, which refund the consortia for financing and building the asset, were between 1.49 and 2.04 times the amount which would have been charged to the UK government if they had borrowed themselves for the construction (Cuthbert and Cuthbert, 2008, Table 1 and Annex Table 2).

Table 1: Real payments to the private sector to refund borrowing compared to public borrowing rates

PFI project	Ratio: Return to private sector for borrowing / Public borrowing rate
New Royal Infirmary Edinburgh PFI	2.04
Haimyres Hospital PFI	1.97
James Watt College PFI	1.97
Highland PPP2 Schools PFI	1.49
Perth and Kinross Office and Car Park PFI	1.82
Hereford Hospital PFI	1.68

Source: Cuthbert and Cuthbert (2008)

Research into the profits of 64 PFI consortia commissioned by the Office of Government Commerce in 2001 has also shown returns to PFI shareholders around 2.4 percentage points above what would be expected⁶ (PricewaterhouseCoopers, 2002). Rates of return to the consortia may be even higher after ‘refinancing’, a process in which the original PFI debts are repaid early and new loans taken out at

⁵ The HM Treasury (2003) argues that financing costs are similar for the private and the public sector once risk transfer is taken into account. The observed difference between the interest rates of finance is, they claim, nothing more than a reflection of the risks the private sector has to take on in this project. Risk transfer affects the cost of private finance because, unlike public finance, private finance is priced in the market according to the risks associated with it. Public finance has traditionally been provided through government securities, known as gilts, traded on the London stock exchange. Because the government underwrites the risks of public service investment on behalf of all its citizens, gilts attract what is called a risk-free rate of interest, which means they are the cheapest form of borrowing. In PFI-type deals, on the other hand, companies raise finance directly from the market not from government securities. Private finance is linked to specific projects and debt repayment is devolved to the commissioners of services who service the debt from government revenues, local taxation, or user charges. The cost of this finance is greater because the rate of interest in PFI-type deals is determined by the risks associated with an individual project (for example, the hospital, school, or prison project). A higher rate of interest is charged for financing higher risk schemes than lower risk ones and this is reflected in higher levels of repayment (Pollock, Price and Player, 2004).

⁶ The calculation was based on the average internal rate of return (IRR), a measure of the excess return of the investment above and beyond the cost of capital. Although PricewaterhouseCoopers presented the value as an overall return to the private investor it is factually the rate of return for subordinated debt and equity, which accounts, according to experience, for ten percent of the project’s finance. This assumption is based on two omissions in the study. To calculate the overall rate of return (a) an actual gearing ratio (the split between senior debt as opposed to subordinated debt and equity), and (b) the actual cost of debt have to be known.

lower rates of interest⁷. This device has the potential to increase profits because the public sector continues to pay back the debt at the old rate of interest. For example, investors of the Norfolk and Norwich PFI hospital increased their rate of return from 16% to 60% through refinancing. This procedure was described as “the unacceptable face of capitalism” by Edward Leigh, the chairman of the House of Commons Public Accounts Committee (Macalister and Carvel, 2006). The evidence of ‘excess returns’ to private finance investors contradicts the claim that the higher cost of private finance is simply a function of the risks taken on by private shareholders, and represents a significant element of bad value for the public sector (Hellowell and Pollock, 2009).

Relative cost of services in PFI hospitals

In the UK the decision by public authorities to procure a hospital and to deliver non-clinical services through the PFI route has first to be approved in an appraisal known as the value for money (VFM) test (HM Treasury, 2006). This test, which is carried out before PFI projects become operational, involves assumptions about the relative efficiency of PFI and traditional procurement.

However, in 2007 an unpublished review by the National Audit Office (2007a) cast doubt on PFI projects’ VFM performance in practice. The report, based on information provided by the Healthcare Commission, compared the quality and cost of security services, linen and laundry services, portering services, and cleaning services of the first wave of NHS PFI projects with data from with non-PFI hospitals (Annex Table 3).

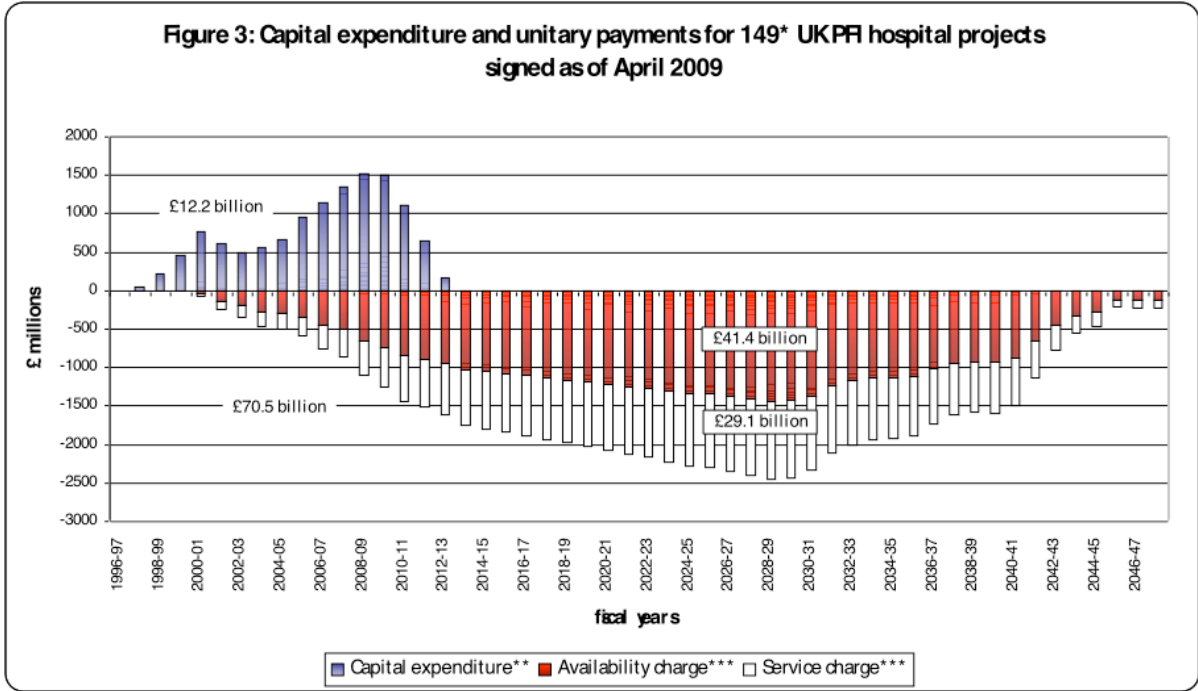
PFI security services had a higher average cost of £3.13 (AUD 6.30) per square meter, compared with £3.03 (AUD 6.10) at non-PFI hospitals. Quality could not be compared properly as the PFI figure omits two schemes with very high costs. The cost of linen and laundry services was significantly lower at non-PFI hospitals with costs of £1,067 (AUD 2,146) per occupied bed compared with £1,204 (AUD 2,422). At the same time the average rejection of laundry haulages was some 0.7% lower. However, late and very late laundry deliveries occurred less often at PFI hospitals. Portering services at PFI hospitals also came at an average higher cost of £147 (AUD 295.75) per occupied bed but did not – according to the judgment of ward managers – perform better. Of greatest concern may be the findings on the quality of cleaning at PFI hospitals whose majority performed below the NHS average. At the same time average cleaning costs per square meter exceeded the average cleaning costs in non-PFI hospitals by £2.30 (AUD 4.63).

⁷ Because PFI projects after completion of the construction stage are less at risk of default the private consortia are able to obtain credit on better conditions. This money is then used to cover the old debt whilst the difference directly flows to the private sector. Although nowadays payment mechanisms are in place which allow the public sector to participate in these gains, incentives for the private consortia to perform well over the whole life cycle of the contract may be distorted as the private sector was already able to recoup its investments in the early life of the contract (Asenova, Beck & Toms, 2007).

Clinicians’ feedback on their satisfaction with soft-FM services in PFI hospitals showed that while at least three quarters of the clinicians regarded security services, laundry and linen services, and portering services as at least adequate, their judgment on cleaning services was less favourable for the PFI model with 41% of the respondents stating that service was poor or very poor (ibid).

Lesson 3: PFI schemes create problems in affordability which require reductions in services

Under PFI, payments to the private consortia have to be met from the budgets of public authorities and in the case of the UK’s NHS, from local hospital trusts’ annual financial allocations. Depending on the service element the contracts cover between 60 and 75% of total payments of £70.5 billion (AUD 141.8 billion) (£62.65 billion (AUD 126.03 billion) in the NHS England; Figure 3) are made to the private sector for providing and maintaining the assets (availability fee⁸). This availability fee can have a significant impact on the revenue streams of a hospital.



* Seven projects (with a capital value of £52.7 million) were excluded from the graph because either no unitary charge payments accrue or the year of contractual close is unknown.

** The Department of Health does not provide separate data on the service and availability element of the unitary payments. Instead an estimate established by Hellowell and Pollock (2007a) was used.

*** These numbers are based on the capital value of the assets and derived by using a formula provided by the Department of Health through Freedom of Information Act 2000.

Source: HM Treasury 2009b.

⁸ Hellowell and Pollock (2007) give a breakdown by availability fee for each PFI hospital.

The impact of these payments on hospital budgets will vary according to the rules and regulations of a country. In the NHS in England, hospital trusts have been required since 1990 to set aside part of their budget to pay ‘capital charges’ to the government (a cost of capital charge equivalent to 3.5% of the value of their buildings). They must also set aside a proportion of their budget to pay for buildings’ depreciation. The UK government originally assumed that these capital charges would be sufficient to pay the availability fee to the PFI provider when a PFI project was introduced to the equation. However, research by Pollock et al. (2002) has shown that this was not the case and that capital costs under PFI required a much greater proportion of annual budgets than the government’s capital charges that they replaced.

Under current activity –based reimbursement provisions for hospitals, 5.8% of the allocated resources are reserved for capital costs. In 2005/06, the capital cost for hospitals with a PFI element was on average 2.5% schemes above tariff (4.3% for larger schemes with a capital value over £ 50 million; AUD 100.6 million). Over half of the larger PFI hospitals had financial difficulties compared with one in four non-PFI hospitals (Hellowell and Pollock, 2009).

To address concerns about the impact of PFI on the financial performance of foundation trusts, Monitor, the independent regulator of foundation trusts, revised its Prudential Borrowing Code for NHS Foundations Trusts in April 2009. Under the new provisions of the code, which are binding on foundation trusts, hospitals’ annual debt repayment (including PFI payments) must not exceed 10% of their annual revenue. Under these new arrangements it will be even harder for foundation trusts planning a PFI project to demonstrate affordability, and a number of future schemes will fail to comply with the new code unless additional subsidies are made available (Gainsbury, 2009). A study of 12 PFI hospitals shows that around 11% of annual hospital revenue is absorbed by PFI payments, although substantial financial support was given to the procuring trusts before the schemes became operational, and despite the fact that trusts’ income has again increased substantially thereafter (Shaoul, Stafford and Stapleton, 2008).

Where annual capital costs increase as percentage of revenue, the money has to be recouped from other parts of the hospital budget (unless the government provides special support for PFI commitments). The need to redirect budgets in this way is known as an ‘affordability gap’. Funding problems of this sort put population needs planning at risk because provision for patient services has to take second place to resolving the financial shortfall (Pollock et al., 1999). Planning for health care needs can be displaced by the following strategies adopted by hospitals to overcome the affordability gap:

- a) a shift of costs outside the NHS to carers or social services
- b) generation of additional income streams, i.e. land sales, increase in primary care services, and additional services to private patients

- c) savings through cuts in the workforce
- d) reducing the scale or quality of the project's design, and
- e) increasing clinical productivity by reducing of bed numbers and length of stay and increasing throughput in order that more patient activity can be carried out with fewer resources (ibid).

Evidence from the UK shows that closing the affordability gap is damaging to access and quality of clinical services. An unpublished inquiry by the National Audit Office (2007a) into operational PFI hospital schemes, for instance, revealed that 72% of the 18 hospitals under study had bed occupancy rates above the recommended upper limit; prior to moving into PFI premises only one in five of these hospitals reached this threshold. Changes in bed occupancy matter as in peak times the clinical services will be inadequate to meet the patients' and clinical needs (Green and Ngyuen, 2001).

Lesson 4: The cost of private finance to the public purse has increased despite the public bail out of the banks

Until recently, the cheapest form of senior debt finance in the UK was bond finance⁹. This was because 'monoline' insurers, which were AAA-rated, issued guarantees for the repayment of capital to the bondholders in return for a risk premium¹⁰. However, with onset of the "sub-prime" crisis the credit-worthiness of these 'monoline' insurers was downgraded. Thus the risks of payment defaults rose and so did the price of finance (Hellowell and Vecchi, 2009).

In the absence of cheap bond funding, projects are now dependent on senior debt provided by banks. However, the cost of finance through bank loans has also become more expensive. Prior to the current economic crisis banks offered money to projects like hospitals at interest rates which were 0.6%-0.8% above the rate they would borrow for themselves (London InterBank Offered Rates (LIBOR)). By the end of 2008 the interest rate for similar projects was 1.5%-1.6% above LIBOR (Hellowell, 2008).

⁹ There are two main types of senior debt, bank financing and bond financing. Bank financing is provided directly by a bank. Bond financing is provided by institutional or individual investors who purchase bonds on the bond market. Bonds are agreements to pay back an investment with dividends on a certain date. The rate of interest charged for privately financed senior debt is estimated to be between 1 and 4 percentage points above the gilt rate.

¹⁰ PFI consortia can cover the risks involved in a project by paying an insurer ('monoline insurance') to bear the risk when the consortium raises money on the capital markets. Agencies, such as Standard and Poors, rate the investor risk using an alphabetic rating system. For example, a triple A rating is a good investment with relatively low risk whilst a triple B rating is known as 'below investment grade', that is, more suited to venture capitalists than institutional investors. Because 'monoline' insurers underwrite the risks of an investment they are also subject to the activity of these credit rating agencies and the interest rate changes accordingly to the insurer's risk rating.

To restore confidence in the financial markets and to free up lending, the UK government decided to increase public borrowing to support the banking sector¹¹. The result is that the public sector is now obliged to make PFI payments to banks it partially owns and at higher cost of borrowing than traditional public borrowing. Banks with government involvement are providers of senior debt to 38 (37.25%) schemes signed in the NHS England; of equity in 16 (15.69%) schemes. In 12 (11.76%) schemes banks are providers of senior debt and equity (table 2, overleaf), which raises conflicts in its own right (Marty and Voisin, 2008). Another issue of conflicting interests arises because banks have an interest in protecting shareholders and investors, not the taxpayer. The question is: whose interest is the government serving?

An indication of this conflict is the extraordinary high cost of private finance. In May 2009, for instance, a £188 million (AUD 378.2 million) PFI hospital project in Fife, Scotland, reached financial close with a credit margin during construction of 2.75% above LIBOR, i.e. well above normal bank borrowing and lending rates (Project Finance International, 2009).

Table 2: Banks with government involvement as equity and senior debt provider for NHS England PFI projects (n=102, 11/2008)

	Senior debt provider (n=projects)	Equity provider (n=projects)	Both senior debt and equity provider
Royal Bank of Scotland Group plc			
Royal Bank of Scotland	10	5	4
ABN AMRO	4	1	1
Greenwich Natwest	4	0	0
	<hr/> 18	<hr/> 6	<hr/> 5
Lloyds Banking Group			
Lloyds TSB	6	0	0
HBOS	14	10	7
	<hr/> 20	<hr/> 10	<hr/> 7

¹¹ The means taken by the UK government comprise the recapitalisation of the Royal Bank of Scotland Group plc (RBS) and the Lloyd Banking Group at a price of £20 billion (AUD 40.23 billion) and £17 billion (AUD 34.20 billion) respectively. In return the government is now the major shareholder in both banks, holding c. 70% of RBS shares and 43.5% of Lloyd shares. In addition the government agreed to protect the Royal Bank of Scotland Group and Lloyd Banking Group from losses on risky assets up to £585 billion (AUD 1177 billion) (£325 billion and £260 billion, respectively) (HM Treasury, 2009a).

Sources: Department of Health, Partnerships UK (2008).

In March 2009, in the absence of bank credit, HM Treasury established the Infrastructure Financing Unit (IFU), to revive lending to PFI projects. However, this arm's length body provides senior debt on "commercial terms" even though interest rates for public borrowing are at an all time low. There are currently proposal to establish similar institutions in Australai to bridge the PPP funding gap (Infrastructure Pertnerships Australai, 2009).

The new arrangements do not bode well for the UK taxpayer. The government is using an agency which will charge commercial rates of borrowing. This means in effect that the government will lend to itself at a commercial rate in order to finance high returns to private providers of subordinate debt and equity. In other words public expenditure is being used not just to restore liquidity and commercial credit lines but to rebuild bank balance sheets and profits. With public sector net debt rising to predicted levels of 80% GDP (HM Treasury, 2009a) the role of private finance in PFI/PPP projects needs to come under close scrutiny and contracts and financial models should be disclosed and analysed to safeguard public accountability for public funds.

Conclusion

Despite the irrationality and unaffordability of the policy the government remains committed to PFI. With fewer resources available for public capital expenditure the policy could find a new impetus due to its ability to keep projects off the government's balance sheet. In contrast to the UK, Australia has a very low public sector net debt (Australian Government, 2009). There is no accounting advantage when choosing the preferred procurement route. Instead decision makers, should not forget the hard learned lesson: PPPs do not free any additional resources. On the contrary, the cost of finance in PFI schemes exceeds the costs of public finance and includes returns to investors which are higher than a reasonable priced risk-premium. These additional costs have to be set against the overall value for money which the whole project is supposed to deliver over its whole life cycle. Early experiences from operational NHS hospital PFI schemes give no evidence of their superiority as most of the soft FM services were more costly and at a lower quality. PFI creates serious affordability problems, diverting money to banks and shareholders at the expense of staff and patient care, taxpayers, and citizens.

References

ABC (2009), *Health Department Budget Woes*, ABC News 18 March 2009, Available at: <http://www.abc.net.au/news/stories/2009/03/18/2519934.htm>. Accessed 3 August 2009.

- Asenova, D. Beck, M. & Toms, S (2007), 'The Limits of Market-Based Governance and Accountability - PFI Refinancing and the Resurgence of the Regulatory State', *Working paper number 35*, York: The York Management School.
- Australian Government (2009), *Budget 2009-10*, Canberra: CanPrint Communications. Available at: <http://www.budget.gov.au/2009-10/content/overview/html/index.htm>. Accessed 17 June 2009.
- Blanchard, O. and F. Giavazzi (2004), 'Improving the SGP through a proper accounting of public investment', /Discussion Paper Series, /4220, London: Centre for Economic Policy Research.
- Carruthers, I. (2009), *IFRS Implementation – Message to Finance Directors*. Available at: http://www.cipfa.org.uk/pt/cipfalasaac/download/IFRS_letter_to_FDs_090309.doc. Accessed: 01 July 2009.
- Cuthbert, J. and M. Cuthbert (2008), *The Implications of Evidence Released Through Freedom of Information on the Projected returns from the New Royal Infirmary of Edinburgh and Certain Other PFI Schemes*. Available at: http://www.cuthbert1.pwp.blueyonder.co.uk/papers%202/c_invest-JimandMargaretCuthbertsubmission1.pdf. Accessed: 16 June 2009.
- Department of Health (2008) 'List of new hospital schemes – Prioritised Capital Schemes – updated November 2008'. Available at: http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/Newhospitalschemes/index.htm?IdcService=GET_FILE&dID=176731&Rendition=Web. Accessed: 20 March 2009.
- Emmerson, C., C. Frayne and Love, S. (2001, 2006), *The government's fiscal rules*, Briefing Note No. 16, updated 2006, London: The Institute for Fiscal Studies. Available at: <http://www.ifs.org.uk/bns/bn16.pdf>. Accessed: 1 April 2009.
- Gainsbury, S. (2009), 'Monitor has 'effectively cancelled' PFI contracts', *Health Service Journal*, 24 June 2009, Available at: <http://www.hsj.co.uk/news/finance/monitor-has-effectively-cancelled-pfi-contracts/5003163.article>. Accessed: 26 June 2009.
- Gosling, T. (2004), 'The PFI, the public finances and value for money'. In: T. Gosling, *3 Steps forward, 2 steps back*, London: Institutur for Public Policy Research, pp. 17-48.
- Green, L. and V. Nyguen (2001), 'Strategies for Cutting Hospital Beds: The Impact on Patient Service', *Health Services Research*, 36(2), pp. 421-442.
- Hames, K. (2009), 'New Albany Health Campus on track', *Ministerial Media Statements*, Perth: Government of Western Australia. Available at: <http://www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=132125&page=2>. Accessed: 3 August 2009.
- Heald, D. and N. Geaughan (1997), 'Accounting for the Private Finance Initiative', *Public Money and Management*, 17(3), pp. 11-16.
- Hellowell, M (2008), 'Unhealthy Options', *Public Finance*, 31 October 2008. Available: http://www.publicfinance.co.uk/search_details.cfm?News_id=59138&keysearch=hellowell. Accessed: 16 June 2009.
- Hellowell, M. and A. Pollock (2006), *The impact of PFI on Scotland's NHS: a briefing*. Edinburgh: CIPHP. Available at: http://www.health.ed.ac.uk/CIPHP//documents/CIPHP_2006_ImpactOfPFIOnScotlandsNHS_Hellowell_000.pdf.
- Hellowell, M. and A. Pollock (2007a), *Private finance, public deficits: A report on the cost of PFI and its impact on health*, Edinburgh: CIPHP. Available at: http://www.health.ed.ac.uk/CIPHP//documents/CIPHP_2007_PrivateFinancePublicDeficits_Hellowell_000.pdf.
- Hellowell, M. and A. Pollock (2007b), *Written Evidence to the National Assembly for Wales Finance Committee with regards to its Inquiry on Public Private Partnerships*. Edinburgh: CIPHP.

Available at: http://www.health.ed.ac.uk/CIPHP//documents/EvidencetoWelshFinanceCommittee_Dec07_000.pdf

- Hellowell, M. and A. Pollock (2009) 'The Private Financing of NHS Hospitals: Politics, Policy and Practice'. *Journal of the Institute of Economic Affairs*, 29(1), pp. 13-19.
- Hellowell, M. and V. Vecchi (2009), *The efficiency of private finance in healthcare infrastructure provision: Evidence from the UK National Health Service*. Presentation held at the 13th IRSPM Conference, Copenhagen, 6-8 April 2009. Available at: <https://conference.cbs.dk/index.php/irspm/irspm2009/paper/download/239/106>. Accessed: 16 June 2009.
- Hemerijck, A., R. Huiskamp and R. de Boer (2002), *Public sector reform under EMU. A literature review*. Luxembourg: Office for Official Publications of the European Communities.
- HM Treasury (2003), *PFI: meeting the investment challenge*, London: The Stationary Office.
- HM Treasury (2006), *Value for Money Assessment Guidance*, London: The Stationary Office.
- HM Treasury (2008), *Budget 2008: Stability and Opportunity: Building a strong, sustainable future*, HC 388, London: The Stationary Office.
- HM Treasury (2009a), *Budget 2009: Building Britain's future*, London: The Stationary Office.
- HM Treasury (2009b) 'PFI Signed Projects List – April 2009'. Available at: http://www.hm-treasury.gov.uk/d/pfi_signed_projects_list.xls. Accessed: 16 June 2009.
- Infrastructure Partnerships Australia (2009), *Financing Infrastructure in the Global Financial Crisis*, Sydney: Infrastructure Partnerships Australia.
- Macalister, T. and J. Carvel (2006), 'Huge windfall for hospital's PFI investors as staff face job cuts', *The Guardian*, 3 May 2006.
- Marty, F. and A. Voisin (2008), *Partnership contracts, project finance and information asymmetries: from competition for the contract to competition within the contract?* Document du travail. Observatoire Français des Conjonctures Economiques. Available at: <http://www.ofce.sciencespo.fr/pdf/dtravail/WP2008-06.pdf>
- Monitor (2009), *Prudential Borrowing Code (PBC) for NHS Foundation Trusts. 1 April 2009*. Available at: http://www.monitor-nhsft.gov.uk/sites/default/files/Prudential%20Borrowing%20Code%20April%202009_0.pdf. Accessed: 26 June 2009.
- National Audit Office (2007a), *The operational Record of the First Wave of PFI Hospitals*, unpublished paper.
- National Audit Office (2007b), *Report on the NHS Summarised Accounts 2006-07: Achieving Balance*. London: The Stationary Office.
- Partnerships UK (2007), *PFI: State of the market 2007*. Available at: <http://www.partnershipsuk.org.uk/uploads/documents/State%20of%20the%20Market%202007.pdf>. Accessed: 3 April 2009.
- Pollock, A., D. Price and S. Player (2004), 'Public Risk for Public Gain?', *Positively Public*, London: Unison.
- Pollock, A., J. Shaoul and N. Vickers (2002), 'Private Finance and 'value for money' in NHS hospitals: a policy in search for a rationale', *British Medical Journal*, 324, pp. 1205-1209.
- Pollock, A., M. Dunnigan, D. Gaffney and D. Price (1999), 'Planning the "new" NHS: downsizing for the 21st century.' *British Medical Journal*, 319, pp. 179-184.

- PricewaterhouseCoopers (2002), *Study into Rates of Return Bid on PFI Projects*, London: PricewaterhouseCoopers.
- PricewaterhouseCoopers (2008), *The value of PFI: Hanging in the balance (sheet)?*, Public Sector research Centre, London: PricewaterhouseCoopers.
- Project Finance International (2009), *Fife PFI hospital*, available at: <http://www.pfie.com/pfideal.asp?dealnumber=2432222158>. Accessed: 16 June 2009.
- Shaoul, J., A. Stafford and P. Stapleton (2008), 'The Cost of Using Private Finance to Build, Finance and Operate Hospitals', *Public Money & Management*, 28(2), pp. 101-108.
- Timmins, N. (2009), 'PFI projects to 'stay off the books'', *Financial Times*, 13 May. Available at: <http://www.ft.com/cms/s/0/143664c4-3f4a-11de-ae4f-00144feabdc0.html>. Accessed: 16 June 2008.
- Välilä, T. (2005), 'How expensive are cost savings? On the economics of public-private partnerships', *European Investment Bank Papers*, 10(1), pp. 94-119.
- Yescombe, E.R. (2007), *Public-Private Partnerships: Principles of Policy and Finance*. Amsterdam: Butterworth-Heinemann.

Annex Table 1: PFI hospital schemes in the UK and their capital value as of April 2009

Fiscal year	NHS England		NHS Scotland		HSC Northern Ireland		NHS Wales		UK TOTAL	
	CV (in £m)	Number of projects	CV (in £m)	Number of projects	CV (in £m)	Number of projects	CV (in £m)	Number of projects	CV (in £m)	Number of projects
1995-96	0	0	3.8	1		0	0	0	3.80	1
1996-97	0	0	0	0		0	0.3	1	0.30	1
1997-98	424.8	5	0	0	7.35	2	10	1	442.15	8
1998-99	571.3	8	421.37	6	0.00	0	13.186	3	1005.86	17
1999-00	505.37	9	59	7	2.70	1	15.742	2	582.81	19
2000-01	590.02	9	9.8	1	0.00	0	69.3	2	669.12	12
2001-02	277.35	6	0	0	0.00	0	0	0	277.35	6
2002-03	580.6	10	16	2	36.70	1	0	0	633.30	13
2003-04	1080.2	11	38.10	4	0.00	0	0	0	1118.30	15
2004-05	1279.3	14	20.8	1	0.00	0	4.995	2	1305.10	17
2005-06	1141.3	8	34	2	15.45	1	0	0	1190.75	11
2006-07	2017.7	5	195.9	2	0.00	0	0	0	2213.60	7
2007-08	2360.45	15	320.08	2	52.00	1	0	0	2732.53	18
2008-09	70	2	0	0	14.50	1	0	0	84.50	3
n/a	0	0	6.87	1	0.00	0	0	0	6.87	1
Grand Total	10898.4	102	1125.72	29	128.69	7	113.52	11	12266.3	149

Source: HM Treasury (2009b).

Annex Table 2: Raised capital and unitary payments of non-service elements in PFI projects

New Royal Infirmary Edinburgh				
	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£189.2m	£760.2m	£416.18m	2.04
<i>of which:</i>				
Senior debt	£161.325m	£369.56m	£229.55m	1.31
Subordinate debt	£19.27m	£60.66m	£38.45m	1.85
Equity Proper	£0.5m	£167.9m	£64.1m	128.2
Sub-debt and Equity	£19.77m	£228.56m	£102.55m	4.8
Haimyres Hospitals PFI				
	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£73.38m	£330.15m	£158.57m	1.97
<i>of which:</i>				
Senior debt	£64.98m	£147.11m	£89.98m	1.25
Subordinate debt	£8.4m	£56.08m	£26.42m	3.15
Equity Proper	£100	£89.14m	£29.77m	
Sub-debt and Equity	£8.4m	£145.2m	£56.19m	6.69
James Watt College PFI				
	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£6.5m	£23.6m	£12.91m	1.97
<i>of which:</i>				
Senior debt	£5.82m	£11.41m	£7.44m	1.27
Subordinate debt	£0.6m	£1.62m	£1.08m	1.71
Equity Proper	£0.08m	£7.14m	£2.55m	30.36
Sub-debt and Equity	£0.68m	£8.77m	£3.65m	4.93
Highland PPP2 Schools				

	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£20.31m	£55.21m	£30.53m	1.49
<i>of which:</i>				
Senior debt	£18.36m	£36.2m	£21.72m	1.17
Subordinate debt	£1.951m	£6.25m	£3.922m	1.99
Equity Proper	£197	£5.91m	£1.9m	
Sub-debt and Equity	£1.951m	£12.17m	£5.82m	2.95

Perth and Kinross Office and Car Park PFI				
	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£20.65m	£73.8m	£38.1m	1.82
<i>of which:</i>				
Senior debt	£18.62m	£31.89m	£20.53m	1.1
Subordinate debt	£1.898m	£6.429m	£3.62m	1.91
Equity Proper	£0.136m	£24.36m	£7.71m	55.47
Sub-debt and Equity	£2.03m	£30.79m	£11.33m	5.57

Hereford Hospital PFI				
	Capital raised	Total Payments (nominal)	NPV of Total Payments (disc@5%)	Ratio NPV/Capital (disc@5%)
Non-service element of PFI project	£74.942m	£257.35m	£137.07m	1.68
<i>of which:</i>				
Senior debt	£65.95m	£133.78m	£90.15m	1.24
Subordinate debt	£8.992m	£36.234m	£20.621m	2.29
Equity Proper	£1000	£55.671m	£18.58m	
Sub-debt and Equity	£8.993m	£91.905m	£39.2m	4.36

Source: Cuthbert and Cuthbert (2008) [http://](http://www.cuthbert1.pwp.blueyonder.co.uk)

www.cuthbert1.pwp.blueyonder.co.uk.

Note: NPV refers to net present value, i.e. an estimate of the value today of a stream of net revenues in the future. The value of the first year will be discounted at a certain rate – the ‘discount rate’ – the second by this rate

squared, the third cubed, etc. The used discount rate of 5% (disc@5%) corresponds to public borrowing conditions at the time being.

Annex Table 3: Cost and Quality of Soft FM services at PFI and non-PFI Trusts

Security Services		
Hospitals	Costs/m²	Quality Response times scored by ward managers; max. score = 5
First wave PFI (n=12)	£3.13	4.6
Non-PFI (n=141)	£3.03	4.0

Linen and Laundry Services			
Hospitals	Costs/m²	Quality	
		Average laundry reject rate	Average number of serious laundry shortages (instances per annum)
First wave PFI (n=17)	£8.44	1.9%	9
Non-PFI (n=192)	£7.64	1.2%	43

Portering Services		
Hospitals	Costs/m²	Quality Reported punctuality scored by ward managers; max. score = 5
First wave PFI (n=16)	£11.82	2.8
Non-PFI (n=192)	£10.65	3.0

Cleaning Services			
Hospitals	Costs/m²	Quality	
		Cleaning Standards scored by ward managers; max. score = 5	Cleaners understanding of their jobs scored by ward managers; max. score = 5
First wave PFI (n=19)	£22.77	2.7	3.1
Non-PFI (n=191)	£20.47	3.4	4.2

Source: National Audit Office (2007a).