

**The Private Finance Initiative and NHS Hospital Development**

by Allyson Pollock, Declan Gaffney and Jean Shaoul

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Professor Allyson Pollock

School of Social Policy  
University College  
London

Declan Gaffney,  
School of Social Policy  
University College  
London

Dr Jean Shaoul  
School of Accounting and Finance  
Manchester University

## **The Private Finance Initiative and NHS Hospital Development**

### **Introduction**

*Under the PFI the public sector does not buy assets, it buys services. The private sector is responsible for deciding how to supply these services and what investment is required to support these services. (Kenneth Clarke 1992)*

The Private Finance Initiative was launched by the Conservative administration in November 1992 as a new way of providing capital funding for investment in public services. Under PFI, the finance for capital projects such as roads, hospitals, prisons, schools, leisure services and computer systems would be raised by private sector consortia which would design, construct, own and operate the facilities. These would then be leased to the public sector for contract periods of anything from 10 to 60 years. The PFI consortia make a return on their investment by charging the public sector for the use of the facilities. Services associated with the availability of facilities for public sector use, such as cleaning, laundry and catering, are also provided by the consortia, usually with the effect that public sector employees are transferred to the private sector.

Government tends to place considerable stress on the provision of services in PFI arrangements, arguing that PFI contracts should be seen as service agreements rather than arrangements for the financing of new infrastructure. The motivation for this approach is the hope that service agreements will not count as public sector borrowing. PFI is therefore presented as part of a consistent government policy of transforming the role of the public sector from being the direct provider of services to commissioning services on behalf of taxpayers.

While the first major schemes to be completed under PFI were for roads, bridges and prisons[ref], the new system has spread across the public sector. Capital projects with an estimated value of £12.9bn are currently in progress in such areas as education, health, defence, fire and police stations, and courts. [something on capital budgets] The annual expenditure commitments early in the next decade from just the existing contracts amount to 3% of government expenditure, excluding transfer payments.

This briefing note is mainly concerned with large scale acute hospital developments, e.g., new build hospitals, new wings and major refurbishments involving investment of over £25m., rather than relatively small scale investments which are also taking place in, for example, incinerators and IT projects. Nor does this report cover PFI in primary and community care, although the *modus operandi* is broadly the same.

In 1994, it became compulsory for hospital trusts to test private finance for all hospital developments with a capital cost of more than £500,000. Public funds would not be made available unless there was a 'clear demonstration that private finance alternatives have been adequately tested' (Health Service Guidelines [94]31).[Value for money] In reality the refusal to make public funds available results in PFI becoming the only funding option. There is therefore an overwhelming incentive for NHS trusts to demonstrate that privately financed developments provide superior solutions.

However, Approval for PFI funded developments depends on the NHS trust involved preparing a business case demonstrating that private finance will produce a scheme which represents better value for money than a (notional) publicly funded equivalent. This in turn means that trusts, health authorities, Department of Health and the Treasury all sign up to business cases that purport to demonstrate that they are good value for money in order to get approval for the new developments. These business cases, which are the only documentary source presenting the rationale for long term expenditure commitments and the large scale disposal of public assets,

have not been made available for public scrutiny until after contracts have been signed. This lack of public scrutiny can be compared with the sale of the privatised utilities, which at least went through Parliament. It is worth noting that hospitals's proposals to become self governing trusts under the 1990 Act were also approved as financially sound by the government without any public scrutiny: within a few years many of these trusts could not meet their financial targets. There is no reason to suppose that these proposals will be any more successful.

No major PFI contracts were signed in the NHS before the Labour election victory of 1997. Since then 10 contracts for schemes with capital values ranging from £38m. to £214m. have been signed. Labour's success in getting PFI off the ground in health is mainly due to an approach which limits the number of trusts engaged in PFI at any one time by 'prioritising'. In what promises to become an annual process, two waves of prioritisation involving some 26 schemes have been announced since the election. Geoffrey Robinson, the then Paymaster General said: "We are now seeing many strong, well structured schools and hospital projects coming through, reflecting the Government's key priority areas." (Treasury press release 21/10/98). [Emphasis added]

The purpose of this report is to consider how strong and well structured the hospital projects really are and what the implications for healthcare are likely to be. PFI projects are only supposed to go ahead if they can demonstrate clear benefits to patients, value for money (VFM), affordability, and good management. PFI has fundamentally changed the way in which hospitals are planned, and the role of the private sector is not confined to construction, operation and financing. Private companies now play a crucial role in the planning of future hospital services. When undertaking a PFI development, NHS trusts issue a design brief to the private sector consortia that have expressed an interest in the project. Each consortium comprises bankers, builders and service operators who tender and submit outline bids. Under the Department of Health's PFI guidelines, the specification should deal with the services to be provided and not with the means necessary to provide them (HSG 95[15] Annex A). Thus the specification for a new

hospital should state the level of clinical activity anticipated, but it is up to the private sector to propose an appropriate number of beds to meet the demand. In reality, as we will show, financial considerations and not clinical need, dictate bed requirements.

But first it is necessary to make some additional points in order to appreciate the significance of PFI in the context of hospitals. First, unlike the roads and prisons thus far built under PFI, the private sector enterprise that will own and run the hospital is not an existing corporation but a joint venture or consortium known as a Special Purpose Vehicle (SPV) which will need to establish itself as a new legal entity and raise the necessary finance. The SPV typically includes construction, IT, medical supplies, domestic services, pharmaceutical supplies, etc., corporations????banks?. Once the SPVs become established, they are likely to become involved in similar schemes. But it does mean that thus far the private sector partners have had little or no practical experience of working either with each other or the trust.

Secondly, the activity involved in the provision of healthcare is inherently diverse and complex to manage. Each hospital trust typically employs several thousand people in a wide range of occupations and operates within a wider social framework, including the professional colleges, universities, social services, etc. The acute care sector is subject to enormous technological and social change, and operates under intense public and political scrutiny. All of these factors require flexibility to adapt to change on the part of NHS hospitals. However, the contracts to provide PFI hospitals will run for at least 25 years and any variation to an NHS trust's requirements over that period will necessarily involve increased costs.

Thirdly while all the schemes differ, those so far announced, and those under consideration, have several common features. They concentrate the clinical activities of several hospitals onto a single site. This location, which may be either a greenfield site or the site of existing facilities, is usually in the suburbs. Most of the schemes transfer NHS land and buildings to the SPV. Those assets surplus to requirements, usually in the city centre, will be sold on for commercial development.

The cost of the scheme is such that the value of the new or enhanced hospital, plus the remaining facilities, will be considerably higher than the existing facilities. The new facilities will provide fewer beds, carry a similar or lower caseload and thus a higher throughput, than those they replace. The hospital will usually be owned by the SPV. The duration of the contract varies between 25 and 35 years, although the design life of a hospital is 60 years. The SPV will provide all the non-clinical services not simply for the new hospital but any other facilities which are retained. At the expiry of the contract, the SPV retains ownership of a hospital whose capital costs have been fully recovered, implying no residual value risk .

This report is structured as follows : the first section how the PFI developments are funded, and the implications for both the trusts and the hospital system as a whole, while the second brings out the inevitable consequences for healthcare. The third section deals with the public consultation process and the final section draws out the implications. CHECK THIS\*\*\*\*

### **Paying for PFI Hospitals**

*Trusts are free of bricks and mortar to manage services". (NHS Executive)[Ref]*

The private sector will only involve itself in providing NHS services if it can satisfy the requirements of the City for dividends and capital growth: this will have to be paid for out of the NHS budget. At the same time, raising capital is more expensive for the private sector than for the government, which pays a lower rate of interest reflecting its low credit risk status. Both the shareholders' demands and these higher financing costs will have to be met by NHS health authorities and trusts. So where is a health service that can barely fulfil its existing commitments going to find the extra money to fund private sector returns?

Before the introduction of PFI, all substantial investment in NHS hospitals, new infra-structure and equipment was classified as capital expenditure and was funded through a separate capital budget. Between 1990 and 1995 this was equal to 3-5% [CHECK] of the revenue budget. Over the years the capital budget has notoriously failed to match pace with need. In 1996/7 NHS Estates put the backlog in maintenance costs at £2.4 billion (fig 1) while actual and real spending on capital projects has fallen over recent years (figures 2 and 3)[actual and real?]. At the same time, as the Secretary of State has recently pointed out, half of all beds are provided in pre-1914 accommodation.

Under the Private Finance Initiative, by contrast, new investment in the NHS will primarily be paid for from the annual revenue budget, through the prices paid to NHS trusts for hospital services by NHS purchasers (Health Authorities (HAs), as purchasers, therefore play a crucial role in approving the trusts' investment plans, as these are likely to impact on HAs' expenditure. Schemes can only proceed if the main purchasers agree to any change in service delivery or costs that affects their expenditure and the mix of treatments they will be paying for. Generally, health authorities are unwilling to agree to major increases in their bill for hospital services from one hospital, .

The illusion is fostered by purchasers, trusts and government that the trusts are buying hospitals, like dishwashers and washing machines, on hire purchase agreement. But in fact the trusts will neither own or control the new hospitals in the way that people own or control the use of their car under a hire purchase agreement. This follows from the need to keep the hospitals off the public sector balance sheet and the investment off the PSBR. Furthermore the PFI's annual tariff must be paid for out of the trusts' revenue stream. Since this in turn must be met out of the health authorities' revenue budget, this raises the question of how these new projects are to be paid for since there has been no corresponding increase in health authority funding.

In practice, PFI investment schemes are paid for in a number of different ways which mask the true costs of the hospital developments. The cost to individual health authorities is not the same as the cost to the NHS as a whole, as funding from other sources is being used to keep the price to purchasers down. This leads to the costs being spread through the system, falling on those trusts which are not engaged in PFI deals. Putting a price on the PFI demands tracing the costs of PFI deals through the different levels of the public sector economy to find out where the bill is being met.

### ***1. How the NHS Revenue Budget pays for PFI***

This section explains how NHS trusts pay for PFI hospitals, the annual tariff and its implications for the trusts; how the capital charging system works and provides a mechanism for paying for and disguising the cost of PFI projects; why the cost of PFI for the NHS as a whole is higher than for individual trusts and health authorities; how PFI hospitals will show a return to the private sector which is out of proportion to the assets to be provided; the increased cost of PFI schemes has to be met from the clinical services budget which means fewer beds, fewer staff and fewer services.

#### **(i) Annual Tariff**

Under a PFI contract, an NHS trust pays an annual tariff known as a unitary charge, for the use of the new hospital. This comprises two elements: an *availability fee* for the use of the building and a *services fee* for non-clinical services provided by the consortium (such as catering, laundry and portering). The size of the unitary charge depends inevitably on the capital cost of the project and on the services provided. Before we discuss the size of the fee and how it is to be paid for, it is crucial to understand the financial regime under which NHS trusts operate.

The 1990 NHS and Community Care Act led to the introduction of the internal market, the purchaser/provider split and the reconstitution of hospitals as self governing trusts. The financial framework for the new trusts was designed to reproduce the internal financial structure of private

sector companies, with the stated aim of introducing incentives for greater efficiency. A crucial aspect of this restructuring was the introduction of capital charging, which assigned duties to the trusts modelled on the relationship between the management of a company and the providers of its capital: banks and shareholders. The roles of banker and shareholders were taken by government. The trusts were obliged to make a surplus of income over expenditure (equivalent to a margin for profit in a private sector enterprise), equal to 6% of the value of their assets every year. These assets in question include buildings, equipment and land, valued at current replacement cost. Trusts are also obliged to make a charge for the depreciation of buildings and equipment. The trusts would charge the health authorities and GP fundholders at prices that reflected the full cost of each treatment, including the imputed cost of capital. The surplus would be returned to the health authorities and be recycled within the internal market.

[Make clear that this is not the devolution of public sector capital costs]

The explicit aim of charging for capital in this way was to give trusts an incentive to make the most efficient use of their resources, to get rid of any assets which were not being fully used and hence reduce the cost of healthcare treatments. It would also enable a comparison of costs between hospitals within the NHS and between public and private hospitals. The aims of the policy thus included opening the NHS up to competition from private sector providers.

Capital charges amount to 8-10% of trusts' annual income and placed an enormous financial burden on the NHS hospitals which was not fully funded for the system as a whole. Is this true???. The valuation of assets at replacement costs, which necessarily places a higher value on the old NHS estate and increases the depreciation charge imposed a financial regime on the hospitals that has led to repeated financial crises. In 1997-8, % of trusts failed in one or more of their financial duties. [ref: National Accounts]

It will be appreciated that, from the point of view of an NHS trust, the PFI involves a transition between two systems which are more marked by the similarities than their differences. All that has

happened is that returns on capital are made to banks and shareholders rather than to government. The PFI, of course, does involve real additional economic costs to taxpayers: the capital charging system simply circulated funding within the public sector at no net cost, whereas PFI charges pass from the public sector to the private sector. However, this cost is registered at the distant level of the total NHS budget, not at the level of health authorities and trusts, where the substitution of private for public capital is only visible if it leads to annual revenue consequences for the agencies concerned.

Considering first the capital cost of the PFI hospitals, it is important to note that the justification for the capital charging system introduced in 1990 was to make managers use their assets more efficiently. The clear implication was that hospitals were extravagant in their use of capital resources and could run their services with less. Given budgetary constraints, capital charging would force managers to choose between staffing and buildings. Prudent managers would therefore seek to reduce their capital base to a level commensurate with their income and labour efficiency and would not increase their asset base without significantly increasing labour efficiency.

But what is so striking about all the proposals is that at the same time as taking out capacity, most of the trusts are significantly increasing and some trusts are doubling the capital stock (Table X). This is because the proposals typically include a new hospital costing more than the current value of the asset base, plus the retention of some of the old facilities. Irrespective of how the new hospital is financed, and who is the owner, a higher capital value carries the penalty of higher capital charges or return on capital employed from an essentially static income base. But this in turn raises two important questions. Firstly since a new hospital costing more than the current value of the existing hospital, plus the value of any retained facilities, must pose affordability problems, what are the implications for both the trust and hospital system as a whole? Secondly what are the implications for patient care in a service whose main cost is labour? We will consider each of these in turn.

*(a) Implications for the trust*

It is quite clear from the PFI business cases that affordability turns in the first instance upon the amount the trust currently pays in capital charges and on facilities management. If the annual fee exceeds the current capital charges and amount paid for services, then the trust will have to cut back on other budgets in order to afford the payments. Since the annual tariff, based in part on a larger capital base, is very larger than the current capital charges (Table 8), this must imply a big reduction in costs, meaning clinical staff, over and above that implied by the transfer of the non-clinical staff to the SPV and the reduction in capacity. That the trusts recognise this is evidenced by references to 'very challenging performance targets' that will put the trust among the top quartile or top 10% of hospitals in terms of efficiency (SMUHT 1997, Walsgrave 1998).

But it is far from obvious that the implications of the annual tariff have been assimilated. It is not just patient care and staff that will be affected by such heroic case loads. Failure to deliver these performance targets, due to lack of hospital staff or shortcomings in social services that prevent early patient discharge, will affect trusts' revenue streams, since income depends on the number of patients treated and will lead to an ever downward spiral of ward closures and sackings in a cash strapped sector. For example, SMUHT, in its annual report and accounts, attributed a loss of income to staff shortages in its orthopaedic department.

More than one trust has different values for both the tariff itself and the split between the availability and service element of the tariff in the same document (Table X). In some cases both the tariff and its split have changed quite considerably as the negotiations with the SPV proceeded (Table X). Edinburgh and Walsgrave, despite broadly similar capital expenditure plans, have a very different tariff split. Do the trusts know what services are to be provided by the SPV? In so far as they regard the allocation of funding between buildings and services as easily manipulable, they can have only a limited grasp of the issues. [Ref: national accounts] It does not augur well

when hospitals are having difficulty meeting their existing financial targets under a regime that is less onerous than the PFI regime.

Clearly some trusts, unable to afford the annual tariff, have been able to secure a long term commitment from the (chief) Health Authority to increase its purchase of healthcare treatments from the trust. Table 7 shows that some purchasers would increase their purchasing commitment, switching resources from neighbouring trusts, in order to make the scheme viable, as the West Kent Health Authority had to do in the case of Dartford and Gravesham (Gaffney and Pollock 1997). While this resolves the problem for the individual trust, this can only lead to further financial instability for the acute hospital sector as a whole. This may in part explain why so many trusts, and their staff, appear to be eager to embrace the PFI : they realise that if they don't, the trust down the road will get in first and take their share of the 'market'.

#### *(b) System wide implications*

The important point about capital charges is that they do not, under normal circumstances, represent a net cost to the public sector. Charges paid to the Treasury are returned to the Department of Health which then passes them on to health authorities. The result is a *circular flow*, with no revenue leaving the system. Because capital charging was introduced without funding the hospitals either at the individual or system wide level on a scale commensurate with the value of their asset base, there are winners and losers. In general large hospitals with expensive estates and high tech equipment and hospitals with low throughput lost out.

The circular flow is only the case, however, as long as only public sector bodies are involved. Under the PFI regime, since the hospital does not own its assets, there are no interest and dividend payments to be recycled back to the internal market. Under the PFI deal, the hospital pays an annual fee or tariff for the availability of the building and equipment and the non-clinical services provided by the consortium which owns and manages the hospital. This is an extra cost

to the health service, but it only shows up at the level of the total NHS budget: at the level of the individual health authority and trust, it appears to make no difference whether funds are going to the Treasury or to private companies. Thus a major component in the price of PFI schemes (corresponding on average, we repeat, to 8-10% of the revenue a trust receives from selling its services to purchasers) is rendered invisible.

If we take the example of a trust with an annual income from the hospital services it provides of £100m. a year. Its asset base (buildings and equipment) is valued at £120m. It thus has to return £7.2m. (6%) a year to the Treasury, and it recovers the cost of that return in the prices it charges to purchasers. So £7.2m. of the £100m. annual income represents the capital charges component of the trust's prices. At the same time, the trust's purchasers are funded by the Department of Health to pay those prices.

If the trust disposes of its assets in a PFI arrangement, it will no longer have to make a return to the Treasury on them. Let us assume that the trust's overall income remains constant at £100m. The £7.2m. previously returned to the treasury will be used to (partly) fund its PFI repayments. It will continue to recover this through its prices to purchasers, and purchasers will continue to be funded to pay those prices. From the perspective of the trust and the health authority, not much will have changed.

If we change perspective, it is a different story. Before PFI, our trust's £7.2m. is paid by the trust to the Treasury. When aggregated with the interest and dividend payments from all the other trusts, this comes to a sum of roughly £2.4bn (5% of the total budget). This is then returned to the Department of Health, where it is incorporated into the NHS budget out of which purchasers will be funded to purchase hospital services.

Once the trust enters a PFI contract, that circuit is broken. No return is made to the Treasury, to then be passed back to the NHS. The annual £2.4bn. has shrunk by £7.2m. The NHS budget has

decreased by £7.2m. This is not just a one off reduction but will recur every year. This means that the NHS hospitals will be funded from a diminishing pool of resources. But since the remaining trusts will, as we have shown, have less income, it will be even harder for them to meet their statutory financial targets, including the 6% surplus. Thus PFI will increase the financial instability of the hospital sector as a whole and prejudice the financial viability of the remaining trusts. In other words, once the cuckoo is in the nest, it will chase all the other birds out.

In reality, the scale of depletion and the future revenue implications of capital charges allocation will be very large indeed. There are currently 25 prioritized acute schemes in England, with another three in Scotland and one in Wales. If the trusts involved transfer on average £6m. of their current capital charges to the private sector this will mean a drain of £150m.. a year.

A further contradiction is that the asset base developed under PFI is always considerably smaller - albeit more expensive- than the one it replaces due to the closure of sites and reductions in bed numbers and staff. Indeed, this sort of reduction in capacity seems to be the *aim* of most of the current privately financed developments. Yet for these downsized facilities the NHS will be paying a larger fee than the capital charges which, while the hospitals were publicly owned, were deemed to be appropriate to the trust's original assets *if they were earning a private sector rate of return.*

## ***2. Raiding the NHS capital budget***

*"Under the PFI the NHS does not have to pay maintenance costs." F Dobson*

In this section we explain how, in order to make PFI affordable, PFI schemes currently in progress are benefiting from subsidies from the NHS capital budget, which is being raided at the expense of publicly owned hospitals. These subsidies also include the sale and disposal of NHS land and assets

Hospitals built under PFI arrangements do not belong to the NHS but to the private sector consortium that builds and operates them. The basic principle of PFI, that the public sector is contracting for *services* rather than *assets*, carries the direct implication that there should be no additional drain on capital budgets, which are used to pay for development and maintenance of publicly owned assets.

By late 1996, the principle that PFI schemes should be paid for out of revenue budgets had been comprehensively abandoned. Hospital PFI schemes had become bogged down in 'affordability' problems: costs were exceeding what the health authorities could afford on the basis of their annual revenue budgets. In other words, PFI in the health service had failed on its own terms. With enormous political pressure to get PFI off the ground, the NHS capital budget was raided in order to provide the injections of cash necessary to close deals.:

This was done using two mechanisms .The first was the diversion of NHStrusts' annual 'block' capital allocations (or 'unconditional capital', to distinguish it from one-off allocations of capital for specific purposes). These are used to pay for maintenance and the replacement of equipment (and should not be confused with funding for capital charges). As PFI hospitals do not belong to the NHS, they would not ordinarily be entitled to this funding. However, NHS regions have considerable discretion in allocating 'block' capital, and most PFI schemes will benefit from these allocations either by payment of the allocations to the PFI consortium (through the trust or the health authority) or - and this comes to exactly the same thing - by the removal of equipment from the PFI deal: if equipment is taken out and paid for through the capital budget, the effect is the same as if it was included and the capital was made over to the consortium.

To give an indication of the kind of sums involved, we give the current allocations of block capital for the prioritized schemes: it should be borne in mind that these are annual allocations.  
(DETAILS NEEDED HERE)

The second way in which the NHS capital budget has been used to bail out PFI schemes is the 'smoothing mechanism' introduced by the Conservative government in January 1997. This mechanism was introduced with the aim of closing a number of PFI hospital deals before the 1997 general election. Of course no contracts were signed by that date, but the Labour government decided to continue the subsidy for those schemes which had received the offer and which had been prioritized in July 1997. In all, ten schemes currently in progress are receiving this subsidy. As with the diversion of block capital, it is important to remember that these are annual payments.

The 'smoothing mechanism' was presented as a 'loan' by the Department of Health, designed to even out the annual cost of PFI payments (which would tend to be higher in earlier years as the private sector would seek to recover its investment as quickly as possible). trusts will be required to 'pay back' the loan to the Department of Health once the PFI consortium had paid back its lenders - in 25-35 years time.

This was an extremely complicated way of increasing the public sector's contribution to PFI schemes. The notion of a loan by the public sector to the public sector with the first payments due in thirty years time is an amusing distraction. Even if the 'smoothing' is indeed a loan to the NHS trust this simply masks the fact that it is a gift to the private sector, which will make its returns on the investment more..

The third way that the NHS capital was used to make PFI both attractive to the SPV and affordable for the trust was to include land for redevelopment as part of the deal. A significant part of the capital cost is defrayed by the land and asset deals with the trust transferring the assets and land to the SPV. As negotiations proceed, the hospital design, location and terms of the transfer become more advantageous to the consortium. The schemes usually involve moving to a (cheaper) greenfield site in the suburbs or relocating the (more valuable) city centre facilities onto the suburban site with increasing problems of access for the public.

Indeed the whole redevelopment is designed primarily to suit the financial needs of the SPV not the NHS. For example, Walsgrave trust originally sought a refurbishment of its 1970s buildings at an estimated cost of £30m which exceeded the £25m ceiling placed on publicly financed projects. The proposal then grew to include the reprovisioning of services from an older city centre site. Various low cost solutions (£50-80m) were identified and rejected in favour of a total new build. Walsgrave acknowledged these were unattractive to PFI saying:

"There is considerable evidence that very large schemes are more attractive to the private sector" (WNHT 1997).

It finally concluded that the best solution was a total new build with less capacity costing about £174m. The £148m replacement for Swindon and Marlborough also started off as a proposal for refurbishing an even newer 1970s hospital. SMUHT, with two large hospitals each larger than the averagetrust serving a large metropolitan area, proposed to relocate most of its older, city facilities on its suburban site despite having the land to reprovision facilities on its more accessible site.

(DETAILS HERE RE EDINBURGH, WH etc.

Not only is the requirement of the private sector for profit determining how acute services should be provided, it is privileging the private sector at the expense of the public, both now and in the future. At the end of the 25-35 years, the SPV will have a long lease on all the land formerly owned by the trust, and own a hospital that, unlike a hire purchase or lease agreement, has been fully paid for by the trust, will not be surrendered to the trust. But that in turn means that the SPV will be in a monopsonistic position in relation to the trusts. It will be able to dictate the terms of any new agreement with the trust which will no longer have any assets in its back pocket to give as

'sweeteners' for any future deal. At the end of the contract, the SPV, as the saying goes, will have the trust over a barrel.

### **Case study: Dartford and Gravesham**

We use the example of the Dartford and Gravesham to show the real cost of these PFI schemes. More than a quarter of the annual cost of the Dartford and Gravesham PFI scheme is funded through subsidy and additional expenditure by the West Kent health authority. In order to meet the extra cost, the health authority had to withdraw funding from planned service developments which were required in the first place because of the PFI scheme.

Dartford and Gravesham NHStrust was the first trust to sign a final PFI contract. In return for the use of a hospital with 100 fewer beds than currently, the trust will pay its private sector partner £16.6m. When the PFI scheme was first put forward, the health authority insisted that it would provide no extra funding for the new hospital.

Dartford and Gravesham's success in suddenly leaping from nowhere to become the first PFI trust (ahead of such widely tipped schemes as those in Norfolk or South Buckinghamshire) came as a surprise to many observers. Just a few months earlier, it had been reported that the scheme had run into serious financial problems. In fact, the closing of the Dartford deal was achieved through a mixture of government subsidy and withdrawal of funding for other services.

In late 1996, it became apparent that the scheme could not be afforded within the health authority's revenue budget. A combination of increased funding from the health authority, 'smoothing' monies and a raid on the NHS region's capital budget produced £4.7m. per annum, 28.6% of the annual charge, to rescue the scheme.

In order to come up with the £2m. extra funding, West Kent health authority withdrew previously planned investment in disability, mental health and children's services, and in community nursing and hospital services. These investments were originally necessitated by the Dartford and Gravesham hospitals plan itself: the community hospital and nursing posts were intended to compensate for the loss of 100 beds under the PFI plan.

West Kent health authority believes it can recover the extra funding by getting Dartford and Gravesham trust to reduce its baseline prices before the new hospital is built. But even if the trust brings its prices down, it cannot reduce its annual PFI payments. In other words, the health authority can only recover its £2m. through the trust's budget for *clinical* services: everything else is ring-fenced under the PFI deal.

This sorry pattern of higher costs to purchasers, supplemented by blatant public subsidies, in return for lower levels of service is repeated in other PFI schemes across the country.

### 3. *Using the clinical services budget to pay for bricks and mortar*

"Yes, we are worried [about the bed reductions]. But we had no choice. We wanted more beds, but the Regional Office said no." Chief Executive of an NHS trust with a leading PFI scheme.

The fifteen prioritized PFI schemes show a consistent pattern of severe reductions in acute bed capacity from the beginning of the procurement process. On average the scale of the reductions is 28% (table ). In some cases, such as Worcester Royal Infirmary, Swindon and Bromley, bed numbers have gone down in the course of procurement as a result of PFI 'affordability' pressure. Health authorities, trusts and the NHS Executive have shown themselves willing to sacrifice future supply in order to avoid losing PFI deals.

When Hereford Hospitals NHStrust began its PFI process in 1995, it estimated that it could reduce its bed numbers from 437 to 341. Estimated capital cost (including equipment and fees) at the time was £52m. By 1997 the capital cost had risen to £63m. and the number of beds had fallen to 250.

It should be remembered that these reductions in acute service capacity are taking place against a background of increasing numbers of admissions, an aging population and rising waiting lists. Moreover over the last four years there have been no closures in acute beds despite the pressure on trusts to dispose of assets. Bed occupancy and throughput figures and decreased length of stay have also levelled out suggesting a system which is at or beyond saturation point. In particular, health authorities are worried about rises in emergency admissions, which have soared in recent years as elective services have been cut back. But, they are buying the message, zealously promulgated by private sector advisors, that their problems in meeting caseload are the result of having *too many beds*: the best way to reduce emergency admissions it seems is to make sure that when people turn up, there's no bed for them, so they can't be admitted!

But bed closures are only one measure of how the NHS is being shrunk. On average, 65% of NHS hospital revenue budget pays for staff - the increased costs of the new hospitals can only be paid for out the clinical services budget and this means staff. Staff account for on average 65% of trust expenditure. Table 1 shows the reductions in staff budgets for a selection of FBCs. There is an 18% reduction in Lothian. A third way in which capacity is being reduced is by reductions in community services. Originally trusts justified the large reductions in PFI schemes by promising to make savings which would be used to supply substitute services in the community. As affordability problems have grown not only have savings not been released but in many areas community services are also being scaled back to pay for the costs of the PFI hospital. For example Norfolk and Norwich reduced acute bed provision by 30% but clinicians and the public were assured that under the radical model of care substitute services would be placed in the community - within a year of signing the health authority launched its community service strategy

which includes plans to close five community hospitals and reduce beds in its community hospitals by 30%.

**The first wave of PFI schemes has thus managed to make a virtue of the higher cost of PFI procurement by using it to reduce NHS acute and community sector capacity.**

The costs of PFI need to be put into this context. These enormous cuts in capacity are not releasing savings to be reinvested elsewhere in the health service: they are being used to fund the profits of the private sector. The NHS is paying more for less, and those in charge have managed to convince themselves that this is what they meant to happen all the time.

### **Public consultation**

In seeking information from trusts and health authorities, it should be borne in mind that they have a duty to provide the public with information. *The Code of Practice on Openness in the NHS* (NHS Executive 1995) states that the NHS "must respond positively to requests for information" and that information should be provided within 20 days.

NHS trusts are not obliged to consult on changes in hospital services. However the trust cannot carry out a new PFI development without the support of the local health authority. When the trust has chosen its preferred partner, it seeks health authority approval for the scheme. The health authority has a statutory duty to consult with the community health council.

There is no statutory duty on health authorities to engage in public consultation, but duties to consult can arise in other ways. Test cases have established that public bodies may have a duty to consult where there is a 'legitimate expectation' of consultation before an action is taken, for example, where a benefit is received. In the case of a hospital development, this would mean the general public in the area served by the hospital.

In fact, most health authorities do consult publicly on major changes to services, and pressure should be put on them through the CHC if they do not do so. In some cases, health authorities have decided to consult with community-based groups rather than undertake an open public consultation. It is important to demand that the authority holds proper consultation meetings, open to the public, where people have the opportunity to speak, rather than discussions with groups nominated by the authority itself.

It is also important to check that the consultation meetings are fully minuted and that the minutes are available to the public. The meetings should ideally be chaired by an agency other than the health authority: the community health council; the local authority; an independent body. In any case, the meetings should allow for members of the public to make comments and express criticism and should not, as has happened in some areas, be set up in such a manner that the public is confined to asking questions. After all, if the authority has decided to consult, it has committed itself to listening to, taking note of and responding to what members of the public have to say. The consultation period should be at least three months.

Health authorities should also consult publicly on any major changes to the scheme (such as a change in bed numbers) which take place after the initial consultation. Experience shows that PFI developments can continue to change right up to the point at which contracts are signed (if not beyond). Moreover, PFI hospital developments are often descended from earlier, publicly funded proposals, and in some cases the health authority has not felt obliged to consult on the PFI because it had previously consulted on earlier proposals.

At the end of the consultation period the trust and authority should respond fully to all concerns expressed. It is normal practice for the health authority to publish its record of the consultation process, including the minutes of all public meetings and all written responses it has received.

Consultation processes are all too often used simply as a way of heading off public concerns about a scheme and of legitimating the actions of trusts and authorities. When the health authority is in charge of setting the terms of the debate and is already clearly in favour of the scheme, the public may feel the exercise to be rather pointless and the result a foregone conclusion. However, a public consultation is the only occasion where the entire range of concerns about hospital schemes can find expression, and where NHS managers have to try to justify their decisions to the general public.

WE have therefore included as a guide to those who wish to question the PFI development a guide to the questions they might want to ask and a further worked example based on West Herts proposals

- \* The current asset value, capital charges, rate of surplus, and income of each hospital included in the review.
- \* The cost and value of the new investment proposed at each site, the value of the retained estate and the projected income.
- \* The current and proposed levels of staffing, facilities, services, caseload and estate at each site.
- \* The caseload to be transferred to the primary and community sectors, the level of new investment to be undertaken there and the revenue to be switched from the acute sector to these other sectors.
- \* The sources of the finance for all capital projects.

## **Conclusion**

*"Changing the balance between the Public and Private Sector. Government policy has been to : reduce the size of the public sector through privatisation and contracting out involve the private sector in providing existing and new services, through the Private Finance Initiative and challenge funding."* Financial Statement, the Budget Report, Her Majesty's government

It is hard to see how developments that reduce capacity, cost more to build and run than existing and more extensive facilities, and distort the operation of the NHS as a whole can satisfy the requirements of strong and well structured projects, as Geoffrey Robinson claimed. PFI projects were only supposed to go ahead if they could demonstrate clear benefits to patients, value for money, affordability, savings to healthcare purchasers and good management. Not one of these criteria are satisfied. In so far as the stated objectives are not satisfied, there must be another agenda.

The current wave of PFI investment aims not at re-providing existing and new services but limiting NHS service capacity. Typically, PFI schemes involve bed cuts of 30% and reductions in staff budgets of anything from 20%. Underfunded purchasers are intent on controlling the rising demand for hospital services by keeping bed numbers down.

This is an important part of the context in which PFI costs need to be placed: PFI drains revenue and capital from the health service in return for *reduced* capacity. So along with the higher costs associated with privately financed investment, it should also be recognized that more is being paid for less. The full cost of PFI includes the reductions in bed numbers, staff and clinical services that characterize all of the leading schemes. If the NHS can manage a reduction in acute beds of over 30% without affecting access and quality of care, the saving to be generated should be reinvested in the system, not used to fund private sector profits. Much is made of the shift from acute to primary and community care and substitute services in the community in the form of

intermediate and step down beds. In reality the escalating costs of the PFI means that substitute services never get funded but remaining community services are also at risk and in many instances are severely reduced in order to fund the affordability gap and the escalating cost of PFI.

The reality is that the PFI will not only privatise the infrastructure of public provision it will also shrink and reduce NHS capacity. Unless the government abandons these policies - for those that can afford it there will be no alternative but private health care, and for those that can not, the lottery of an underfunded shrunken NHS.

**Annual Payments to the PFI Consortium**

<b>Trust</b>	<b>Total PFI tariff (£m)</b>	<b>Availability %</b>	<b>Services %</b>	<b>Capital Cost of PFI (£m)</b>	<b>Tariff as % capital cost (£m)</b>	<b>Current asset base (£m)</b>	<b>Current capital charges (£m)</b>
<b>Dartford</b>	18.643	62%		137	12%	68	5.852
<b>FBC (1)</b>	15.887	67%	39%				
<b>(2)</b>	16.649	63%	33%				
<b>1998</b>			37%				
<b>N Durham</b>	13.450	51%		96	14%	27	3.589
<b>FBC</b>	12.088	58%	49%				
<b>1998</b>			42%				
<b>Edinburgh</b>	29.703	67%		180	17%	115	
<b>FBC (1)</b>	31.485	81%	33%				13.800
<b>(2)</b>			19%				
<b>Walsgrave</b>	29.147	37%		174	21%	76	7.400

<b>FBC SOC</b>	36.310	55%	63% 46%				
<b>S Manchester</b>	17	N/A	N/A	89 plus current assets	19%	95	8.743
<b>Calderdale</b>	12.280	71%	29%	77	16%	36	4.964
<b>Greenwich</b>	17.294	66%	34%	84	20%	81	10.679
<b>Carlisle</b>	10.9	unitary	unitary	85	12%	23	2.888
<b>S Bucks</b>	8.4	unitary	unitary	38	21%	70	6.829
<b>Norfolk and Norwich</b>	31.7	unitary	unitary	214	15%	19	3.611

Sources :

Most recent of DoH press release, Full Business or Strategic Outline Case, Replies to Parliamentary Questions, Offering Circular for PFI Bond, Annual report and accounts

Notes :

For some hospitals, the same document lists different values for the PFI tariff. The PFI capital cost excludes the NHS contribution

The table shows the annual tariff to the SPV, the split between the rental or 'availability' and the service charge, the capital cost of the deal, the current value of the asset base and capital charges. The scale of the difference between the tariff and capital charges means that services must be cut to make room for the tariff.

**Table 7 : Increases in Health Authority Purchasing Commitment from OBC Stage**

<b>Purchaser</b>	<b>Trust</b>	<b>Increased Annual Commitment (£m)</b>
<b>County Durham HA</b>	Bishop Auckland	2.4
<b>Bromley HA</b>	Bromley	0.7
<b>West Kent HA</b>	Dartford and Gravesend	2.0
<b>Norfolk HA</b>	Norfolk and Norwich	16.9*
<b>Barnet HA</b>	Wellhouse	2.8

Sources : HA reports on FBC for hospital PFI schemes

\* includes money originally intended for transfer of 10% of caseload to other providers

Appendix

West Herts Paper

## Further Reading