

Private finance initiatives during NHS austerity

(Taken from BMJ 2011; 342:d324)

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Ring fencing of private finance initiative payments prioritises investor returns over patient care and calls for tighter monitoring and renegotiation.

The NHS is facing serious revenue pressures if it is to meet the target of £15bn-20bn efficiency savings by 2013-4. One important pressure for trust budgets in England is the annual private finance initiative (PFI) charge, which is ring fenced and indexed to inflation. Since 1991, all NHS trusts have had to pay a charge on NHS buildings and equipment to the Treasury, which averages around 6% of income. However, NHS hospital trusts with PFI contracts may spend up to 18.6% of their annual income servicing the cost of privately financed investment; this money goes to the private sector. PFI contractors are insulated from efficiency targets. This, coupled with serious deficiencies in contract monitoring, compliance, and contract enforcement at departmental level, means that there are real concerns over the value for money of the policy. Lack of control over PFI costs has serious implications for quality and levels of NHS care.

Rise of PFI

Since 1992, most large scale public capital investment in the UK uses the PFI procurement route under which a consortium of investment banks, builders, and service contractors raises the finance and designs, builds, and operates the facilities for the public authority through a project company. Soft facilities management services such as laundry, maintenance services, catering, and cleaning are also often contracted out to project companies.

By December 2009, 159 PFI hospital contracts with a capital value of £13.16bn (€16bn; \$22bn) had been signed in the UK, with NHS England being the biggest procurer in terms of numbers (72%) and capital value of the assets (86%). Of the 135 new NHS hospitals constructed between 1997 and 2009 or currently under construction in England, 101 were financed through PFI, accounting for about 90% of the £12.2bn committed to building programmes. Trusts make an annual payment, called the unitary charge, which comprises an availability fee (covering the capital and lifecycle costs) and a facilities management fee (covering the costs of services such as cleaning). The aggregate of all PFI repayments in 2009-10 is £42.79bn. In 2010-11, NHS Trusts paid the private sector a total of £0.87bn in availability fees. However, the annual

aggregate payments are set to increase, and at a time of real term reductions in public expenditure.

Relative cost of finance

The high cost of private finance is acknowledged and documented. Cuthbert and Cuthbert looked at the cost of PFI hospital schemes mainly in Scotland compared with an estimate of what these projects would have cost had public finance been used. In the case of the Edinburgh Royal Infirmary, for example, they found that payments to investors over the life of the contract would have funded more than twice the original capital cost of the hospital (£189m) had the government borrowed directly to finance the deal instead of private banks and shareholders.

Under conventional procurement, the government borrows to finance the construction of new public buildings. Financial markets regard lending to governments as low risk compared with private borrowing. The interest rate is therefore lower than under PFI schemes, in which a private consortium borrows on behalf of the government. The effect of higher interest rates can be seen in levels of debt repayment. In several schemes, annual debt repayment to the consortiums was between 1.49 and 2.04 times higher than the amount that would have been charged to the UK government if it had borrowed directly for the construction. Higher repayment schedules are a reflection of higher interest rates resulting from risk assessment by financial markets and from profits that are excessive when evaluated against conventional standards of profitability. PFI interest rates have risen since the banking crisis and have added to the difficulties of PFI hospitals.

Consequences of risk transfer

The Treasury justifies higher rates of interest in terms of risk transfer—that is, the private sector carries the additional costs, or risks, associated with building and operating facilities. In a typical PFI contract, the public sector pays private investors to bear these risks instead of the taxpayer. This risk transfer is achieved through a commercial contract that imposes financial penalties on the project company for failure to perform.

According to the Treasury, when risk transfer is taken into account private finance is no more expensive than public finance. The Treasury argues that the cost of private finance is potentially lower because the private sector is better able to manage risks transferred to it. This efficiency claim is controversial because it is difficult to identify and cost the risks and because of doubts about the ability of the public sector to transfer risks through PFI contracts.

Monitoring performance

Performance data are crucial to measuring quality and compliance with contracts in PFI schemes. The June 2010 National Audit Office report examined value for money outcomes and processes in 76 operational PFI hospitals. The schemes represented an aggregate £6bn capital investment, with unitary payments to the private sector totalling £890m a year. Although 2002 Department of Health guidance makes the collection of performance data from operational PFI facilities mandatory for all trusts, the audit office reported a lack of centrally held data on the “PFI portfolio,” which it attributed to the department’s inability to “require Foundation Trusts to provide performance data” and its failure to make reporting mandatory for other trusts.

According to the audit office, performance data at trust level and monitoring is deficient. Monitoring systems were based on self-reporting by project companies, and one quarter of trusts in a small sample of eight case studies, failed to audit the returns. The cost of building maintenance, which is a component of the unitary charge, is set at the beginning of the contract, and the payment period may be more than 30 years. However, the audit office found that “contractors do not share with Trusts information on their maintenance spend.” It estimates that one full time contract manager is a minimum requirement for a small PFI to protect value for money. Large PFI contracts employed an average of 13 people in contract management at an estimated cost of £672 000 a year. However, nearly half (48%) of trusts did not meet this standard, and 12% did not dedicate resources to monitoring contracts for even a day a week.

Risk transfer for enforcing contracts

Risk transfer depends on the public sector’s legal or contractual right to penalise contractors if services are substandard or not forthcoming. It requires the contract to build in financial penalties for poor performance at a level that affects profitability for shareholders when performance is below standard. However, the audit office reported that trusts were often disinclined to impose penalties and that trusts and project companies “are sceptical that their systems and deductions provide sufficient incentives to contractors.”

Risk transfer also depends on the ability of trusts to enforce contracts on the basis of performance data. The audit office found weak contract enforcement in about half of the sample and concluded that “contractors will try to pass the risk back to taxpayers when contracts are not enforced.” On the other hand, project companies are not contractually obliged to pass on to trusts any efficiency gains they secure, and trusts are looking for other ways to save money. For example, the audit office reports a tendency among PFI trusts in financial difficulty to ease the

performance requirements on project companies in exchange for reduced unitary charges. This approach effectively waives contractual risk transfer in order to resolve trust deficits.

Value for money

The audit office judged that some trusts were paying more for PFI services than they needed to but could not examine sources of variation because of “the lack of reliable data.” Service cost analysis could not be done after 2008-9 because “the NHS stopped collecting the data.” The office identified substantial but unexplained variations in the facilities management fee component of the annual unitary charge (the fee charged by contractors for outsourced, non-clinical services and amounting to millions of pounds). For example, in the sample of trusts the price for feeding a patient varied fourfold (from £3.16 to £12 a day) and the price per item of laundry varied from 20p to 96p.

The audit office concluded that, in the absence of formal mechanisms for assessing whether the initial prices which trusts agreed to pay for maintenance remain value for money, the price is likely to become unrelated to the actual cost of delivering the maintenance services. Evidence of poor value for contracted services is not new. A 2007 unpublished, though informally circulated, review by the audit office, based on Healthcare Commission data, raised serious concerns about the relative cost and quality of security, linen and laundry services, portering, and cleaning services among the first wave of NHS PFI projects.

Affordability

Under PFI, payments to the private consortiums have to be met from the budgets of public authorities and, in the case of the English NHS, from trusts’ annual financial allocations under the national tariff system. The PFI capital payments are considerably higher than the charges for capital that NHS trusts have been required to pay since 1990 and are underfunded. This creates an “affordability gap” that hospitals have typically resolved by shifting costs on to local authorities, generating additional NHS and private income, cutting the clinical workforce budget, and increasing productivity. A National Audit Office study of productivity in a sample of PFI hospitals found that 72% had increased bed occupancy rates above the recommended upper limit to cope with affordability problems created by PFI.

Under current provisions for hospitals, 5.8% of the tariff allocations or prices components for trusts are reserved for capital costs. However, in 2005-6, the actual capital cost for hospitals with a PFI element was on average 2.5% higher than the amount provided for under the tariff system (4.3% higher for larger schemes with a capital value over £50m). This

shortfall was reflected in hospitals' financial performance. In 2006, over half of the larger PFI hospitals were in financial difficulties, compared with a quarter of non-PFI hospitals. The cost variations in components of the PFI charge reported by the audit office strongly suggest trusts may be paying more than necessary and therefore worsening the affordability problem.

The recent government rescue of the banks to the tune of hundreds of billions of pounds since the financial crisis in autumn 2008 presents an ideal opportunity for reopening the contracts. Many of the rescued banks are large investors in hospital and other PFIs. The government recapitalised the Royal Bank of Scotland (RBS) Group and the Lloyd Banking Group and is now the major shareholder in both banks, holding 83% of RBS shares and 43.5% of Lloyd shares. In addition the government agreed to protect the RBS Group from losses on risky assets up to £282bn.

The government rescue means that bank ownership and its attendant risks have been transferred, completely or in part, from the private sector back to the public and the taxpayer. However, the case for paying bank lenders and shareholders higher interest rates under PFI rests on the claim that risk has been transferred to them. There can be no case therefore for not reopening these contracts. Management consultants McKinsey & Company estimated last year that a reduction of 0.02%-0.03% in interest charges paid to contractors by NHS hospitals could save £200m a year. We have shown that current NHS PFI contracts are not good value and are endangering patient care. The need for renegotiation is openly discussed by the PFI industry. The ministries involved in PFI should take a leaf from the Ministry of Defence, which routinely reopens contracts when they do not deliver value for money. The current situation which privileges investor returns at the expense of public healthcare and services cannot be allowed to continue.