Successive governments argued that PFI avoided large one-off and up-front payments, and didn’t show up in government accounts as increased public borrowing. Thus, successive governments were able to claim that PFI was debt-neutral.

But in fact PFI is a much more expensive method of providing NHS facilities than government procurement, and this paper briefly outlines the key arguments and directs you to some essential further reading.

PFI as an expensive form of borrowing

The high costs of PFI borrowing have been recognised by the House of Commons Treasury Committee [1], where PFI was introduced, the government borrowed from the National Loans Fund to finance the construction of new NHS infrastructure such as hospitals. Because financial markets regard lending to governments as low risk compared with private borrowing, interest rates for government borrowing are lower than for PFI schemes in which a private consortium borrows on behalf of the government. Take the example of the Edinburgh Royal Infirmary: the payments made to private banks and investors over the life of the PFI contract would have funded more than twice the original capital cost of the hospital (£189 million) if the government had borrowed to finance the deal [2].

In national PFI finance, the rate of interest on the senior debt element (i.e. 90%) of PFI financing is set at a varying LIBOR+ (see Glossary). This is higher than the rate of interest that would be charged for borrowing from the government on the basis that PFI projects ostensibly carry additional risk.

Since the financial crisis the costs of finance have risen significantly, in particular the senior debt component. Research in 2004 commissioned by the Association of Chartered Certified Accountants (ACCA) studied a sample of 13 NHS Trusts with PFIs. It found that the annual cost of capital for PFI Trusts was at least £45 million more than the cost of a new hospital financed by the government, even though the PFI hospitals were smaller than before [3].

Six of the 13 Trusts with PFI that the survey studied were in deficit [4].

The high costs of private finance have been justified on the basis that rates of interest on project, expressed terms are the...
NHS, are transferred to the private sector. Thus PFI projects are said to offer value for money (VFM). There are at least three problems with this argument.

1. Factoring in risk can add 30 to 35% to the cost of the project. However, the valuation of that risk has been found to be biased and unrigorous, and because of the dominance of ‘accounting logic’ tends to ignore uncertainties. [5] Publicly funded hospitals can be lower cost than PFI funded ones: it has only been after the costs of risk transfer are included that the gap between the cost of PFI hospitals and that of publicly funded hospitals narrows. But it has been suggested that not only is the methodology for risk assessment less than rigorous but, given many hospitals’ need for a capital project (such as a new building) and the lack of any other option, managers may face ‘perverse’ incentives to ‘manipulate’ their assessments to make the PFI look less costly. [6]

2. Although the transference of risk to the private sector is central to the argument that PFIs provide VFM, it is unclear whether or how much risk is transferred. As the ACCA report notes, the credit ratings agency Standard and Poor’s found that PFI companies carry little effective risk. This is partly because the primary risk to investors is during the construction phase (through construction cost overrun or construction time delay, for example). However, during the many years of a PFI contract following construction, when the PFI is primarily concerned with on-going maintenance and facilities, the level of risk is much lower. As the House of Commons Treasury Committee states: “… a PFI contract which lasts for 30 years is not necessary to transfer this risk. There are also other methods such as turnkey contracts which can be used for the same ends. We have seen evidence that PFI has not provided good value from risk transfer—in some cases inappropriate risks have been given to the private sector to manage. This has resulted in higher prices and has been inefficient.” [7]

3. The Special Purchase Vehicle (SPV) that raises the finances for a PFI project is set up in a way to isolate investors from financial risk. Because each contract is held by a separate SPV, whose only activity is the PFI project, there is no cross-subsidy between projects. Although this serves to isolate the private sector’s risk, it also generates extra costs and creates additional risk for the public sector. The monitoring required to ensure service delivery across a range of subcontractors creates extra costs. Additional risk is created because should the SPV fail financially, for whatever reason, it has no recourse to its parent companies. Thus the SPV can walk away from a PFI contract without jeopardising the position of the parent companies. Given that the government underwrites the SPV’s debts, either de jure or de facto, the parent companies that have provided the loan finance are protected. [8]

In practice, when things go wrong the costs are borne by the public purse – the alternative is for the service to collapse. In other words, PFI represents a redistribution of income, from the public to the corporate sector, most notably the financial institutions whose investments are, in effect, underwritten by taxpayers.

Other costs of PFIs

The cost to the public of dividends to SPV shareholders

One report found that SPVs made a post-tax return of more than 100% on shareholders’ funds in each of the three years studied (2000 – 2003), higher than anywhere else in the industry. [9]
Extra layers of administrators
In addition, the PFI requires the creation of new tiers of administrators within and beyond the NHS to write, negotiate and monitor the contracts. In addition, the cost of administration – estimated at between £1 million to £4 million per project – would not exist with normal government procurement.

Overpriced ‘soft’ services
Inflated costs and charges have been associated with services provided under PFI contracts. Research evidence on the cost to the NHS of providing the same services under PFI were more costly than in comparator hospitals.

A National Audit Office report (2010) found that most trusts do not employ sufficient staff to monitor or audit the services provided under PFI contracts. Major variations were found in how much different trusts were being charged for the same services. For example, the price for leasing a patient room doubled (from £3.18 to £12 a day), and the price per item of laundry ranged from 20p to 96p. In addition, Trusts are not given actual building maintenance costs by the contractors. The audit report concluded that the price is likely to become unrelated to the actual cost of delivering maintenance services.

The experiences of Barts Health Trust in London provides just one example of how much service charges can exceed the cost of their provision. In 2014, laundry and linen, receipt and distribution, and telecommunications services were all brought in house – but it, they were withdrawn from the PFI contract. (Patient transport services were removed from the PFI contract and then put out to competitive tender to be provided out of house.) It was anticipated that these changes would remove at least 7% of the cost of the non-wage element from the contract – giving savings in the region of £4m per annum.

The myth of new efficiencies
The excessive costs of PFI projects – and the cuts in services that they have brought about – have been justified on the basis that PFI projects drive new efficiencies. However, the assumption that public sector procurement is less efficient than private has been challenged: private sector costs are often greater. According to a report to the House of Commons Treasury Committee, 11% of PFI projects were delivered late and 35% ran over budget and the quality of buildings was often poor in order to maintain sufficient levels of profitability. This was particularly so for NHS projects.

The loss of tax revenue
NHS PFI schemes are now valued at around £11 billion. Of these, about 70 are suspected of being owned by offshore companies that are paying no tax on their profits to UK Revenue and Customs. Hence the British taxpayer loses twice, once for excessive costs of the service and once in lost revenue to the Treasury. As one commentator has said:'PFI is now an enormous industry dominated by the big construction firms, banks and accountancy firms. Indeed, so lucrative has it become that there is now a thriving secondary market trading in PFI equity, the average profit margin on which was found to be over 50%.'

Less tangible costs
Finally, the costs of PFI are not always financial. We mention elsewhere how excessive PFI repayments are made from a hospital’s operational budget and so reduce the money available for clinical services, leading to fewer beds, loss of staff etc. In addition there are other less tangible costs. For example, the rights and working conditions of staff previously employed by the NHS often decline when transferred to the private sector (as is often the case with PFI projects). In addition, PFIs for hospitals arguably bring about a change in focus, away from planning for the health needs of the public towards responding to the needs of the hospital’s ‘Trust and private capital’.

Overall, the financial impact of the PFI on hospital budgets may be summarised in the stark fact that half of all hospitals with larger PFI contracts for hospitals arguably bring about a change in focus, away from planning for the health needs of the public towards responding to the needs of the hospital’s ‘Trust and private capital’.

Sources


