

RESEARCH AND EVALUATION

Do PPPs in Social Infrastructure Enhance the Public Interest? Evidence from England's National Health Service

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This article outlines and critiques the main fiscal and economic rationales for the Private Finance Initiative – by far the dominant form of public-private partnership in the United Kingdom (UK) – and examines the impact of the policy on the long term financial viability of the National Health Service. It shows that the interest rate on private finance contains a significant element of 'excess return' to investors, and there is no evidence that this 'excess cost' to the public sector is offset by greater efficiency through the contracting process. It concludes that the private financing of public capital investment is highly problematic – and can have a serious impact on the finances and capacity of public authorities.

Key words: *private finance initiative, national health service, NHS trusts*

Since 1992, the UK's Private Finance Initiative (PFI) has involved the private sector in the financing and building of public infrastructure and the delivery of related services. This article starts by outlining the motivations and rationales underpinning the implementation of PFI in the UK. It argues that PFI is one expression of the philosophical preference among successive governments for enlarging the private sector's role in the economy, and is driven by a (related) ideological belief in the inherent superiority of private over public models of investment and service delivery in addition to a political imperative to deliver high levels of capital investment into social and economic infrastructure while maintaining the appearance of a tight fiscal stance.

Both Labour and Conservative governments have argued that PFI enhances the public interest through the provision of *additional* resources for public investment, and delivering infrastructure and services *more efficiently* than the available alternatives, such as public procurement. The contention of this article is these arguments are flawed. Investment through PFI

cannot, in and of itself, lead to fiscal savings; and the economic case for the method is based on false assumptions and misleading evidence. If the economic and fiscal arguments for PFI are not justified, the key question becomes: what is the real impact of this procurement model on the public interest? The bulk of this article provides an evaluation of the impact of PFI on the health system in England, the National Health Service (NHS), a component of the public sector in which public interest considerations ought to be at the fore of decision-making. We show that, far from enhancing the public interest, the effect of PFI has been to reduce NHS capacity, thereby threatening its ability to meet need.

Origins and Current Scale

The PFI was introduced by John Major's Conservative government in the autumn budget of 1992. This began the process of legal and bureaucratic changes necessary for the application of the Design, Build, Finance and Operate (DBFO) model to the English public

sector (and indeed that of the rest of the UK). Since that budget statement, the policy has accounted for the vast bulk of large-scale public capital projects in England, including defence, public transport, roads, education, social housing and waste management.¹ As of April 2008, 466 PFI schemes had been signed in England with a total capital value of £51.5 billion (HM Treasury 2008). PFI has become the dominant source of capital investment for the country's tax-funded National Health Service (NHS), in which a major hospital re-building program has been underway since the mid-1990s. Between April 1997 and April 2008, 97 PFI hospital contracts were signed by the NHS, out of a total of 127 hospital procurements. With private financing worth more than £10.5 billion committed under signed schemes, PFI accounts for more than 90% of the total capital invested under the program (DH 2008). A further 21 planned PFI projects with a capital value of £3.4 billion were, at the time of writing, being developed or procured by the NHS in England, compared to only one scheme, with a capital value of £243 million, progressing on the basis of public finance.

Political Attractions

For successive governments, PFI has had a political as well as a practical significance. To the Conservatives, it was as a means of growing the private sector's role in parts of the public sector such as healthcare and education where outright privatisation was politically unachievable (Hellowell 2003). As such, it was an expression of that administration's strong philosophical preference for private over public solutions; and a general desire to shrink the size of the state as a proportion of the economy. The Labour Party gave half-hearted support to the policy while in opposition, after a consultation paper backing it was produced by the then Shadow Chancellor (and now Prime Minister) Gordon Brown, along with senior Labour colleagues (Brown, Cook and Prescott 1994). By the time 'New' Labour took power in 1997, the expansion of PFI was a priority, and viewed by the leadership as an important expression of 'third way' philosophy – one element of which was the de-

velopment of a more positive relationship with the private sector corporations and the City of London.

The Fiscal Argument

For both modern administrations, PFI's alleged ability to deliver 'fiscal savings' has been an important attraction of the policy (Broadbent, Haslam and Laughlin 2000). Under PFI, the up-front capital cost of projects does not score on the national accounts. It thereby appears to allow for relatively high levels of investment in public infrastructure while at the same time maintaining an apparently tight fiscal stance. At the time of the policy's introduction, there was a pressing need for investment in infrastructure after years of capital starvation. Public sector net investment had fallen as a proportion of GDP from 7% in 1970 to less than 1.6% in 1992 (Clark, Elsby and Love 2001). Public investment in healthcare varied between 0.2 and 0.4% of GDP in the early half of the 1990s and much of the NHS estate in England was considered unfit for its purpose. However, the Conservative administration of the early 1990s was keen to limit the size of the Public Sector Borrowing Requirement, while keeping tax rises, especially income tax rises, to a minimum. In this context, borrowing through an intermediary such as a PFI project company was very attractive to the Conservative administration.

The ability of PFI to deliver investment within a 'prudent' fiscal framework has also been an important attraction for the Labour government. In 1998, Gordon Brown introduced two new fiscal rules, one of which, the 'sustainable investment rule', limited (and still limits) the level of public sector net debt to less than 40% of GDP. Keeping within this target has political importance because it is viewed as a measure of the party's fiscal responsibility and overall economic competence. Financing projects through PFI rather than public borrowing has made it easier for the Labour government to ensure that this rule is met. This is the source of the claim that PFI is able to deliver 'additional' investment – a claim that continues to be made.²

However, the economic rationale for the sustainable investment rule has been called into question, for example by the UK's Institute for Fiscal Studies (2001). It has pointed out that: 'The government has provided no justification for a net debt target of 40% of GDP – it could just as easily have chosen 38% or 42%'. Indeed, the European Union (EU) Stability and Growth Pact, widely seen as conservative, caps 'gross government debt' at 60% of GDP, which is consistent with level of public debt in the EU generally being considerably higher than the British level. While politically important, it is therefore not clear that this rule is in the public interest, since a higher level of capital spending may actually enhance societal welfare. Furthermore, the fact that privately financed investment is invisible to national debt, by virtue of its 'off-balance sheet' status, is little more than a quirk of national accounting standards. In reality, the underlying economic impact of investments undertaken through public or private finance is exactly the same, all other things being equal. PFI projects require a commitment of future resources in much the same way as conventional borrowing (Heald and Geaughan 1997). In recognition of this, economists have recommended that fiscal policy considerations should play no part in the decision-making process over procurement routes (World Bank 2007).

The Microeconomic Argument

Perhaps in recognition of the weakness of the 'fiscal argument' for PFI, the policy is also justified on cost-efficiency grounds, or 'value for money'. At first blush, the cost-efficiency case for PFI appears weak since public finance is always cheaper than private finance. In lending to government, creditors are taking no risks with their money – governments, unlike private companies, are unlikely to go bankrupt and default on their payments. The transaction costs of government financing are also low and the market in government debt is typically liquid and efficient (Yescombe 2007). Governments such as that of the UK are therefore able to borrow at a very attractive rate of interest. In its examination of private sector financing costs in the Scottish schools sector, Audit Scotland

(2002) found overall rates of return on private finance (the 'Project Internal Rate of Return') in the range of 8–10% a year, some 2.5% to 4% higher than the relevant public authorities would have paid if they had borrowed money on their own account for a similar project. Financing costs matter in PFI, just as they do in projects funded through government borrowing, as they are part of project costs and to a large extent determine the level of the annual service fee that the public authority must pay.

However, the Treasury argues that the higher cost of private finance is simply a function of the risk of investment being explicitly priced (HM Treasury 2003). On this analysis, when government finance is used for a project, the risks associated with the investment are the same as in a PFI, but any additional costs (for example, due to time and cost overruns in construction, or problems in operation) are passed on to current and future taxpayers. In contrast, in PFI, these project risks are borne by investors and are priced according to standard methodologies. The claim that the cost of private finance is simply the cost of public finance plus a 'risk premium' is fundamental to the microeconomic case for PFI. If the cost of private finance is the same as public finance after allowing for risk, and the private sector is more able and better incentivised to manage this risk, then PFI could in principle be more cost-efficient than public procurement.

Yet the government's own evidence base suggests that this is not, in fact, the case. Research commissioned by the Office of Government Commerce (OGC) demonstrates that PFI financing costs are higher than is predicted by the Treasury's analysis. PricewaterhouseCoopers (PwC 2005), the accounting and management consultancy, analysed 64 projects that reached financial close between 1995 and 2001, covering a wide sample of sectors, such as health, education, prisons, transport, defence and water. The study compared the post-tax project internal rate of return anticipated for each project with a benchmark 'weighted average cost of capital' reflecting the return that should be expected from a project by an investor, given the project's exposure to risk. The study found the average difference between the

internal rate of return and the benchmark cost of capital was some 2.4%. It concluded that this 'excess cost' was due primarily to three factors: (1) bidders pricing projects so as to cover the costs of losing bids; (2) high banking fees; and (3) limited competition in the market.³

It is significant that the UK government's evidence base suggests there are 'excess returns' to investors, despite Treasury claims to the contrary. This calls into question the extent to which the policy justification for PFI actually interacts with the public interest. It implies that, due to various forms of market failure, the rate of return on private finance will be higher than the rate available to the government, even after adjusting for risk. The financing component of the DBFO structure therefore contains an element of bad value for money for the public sector purchaser.

This implies that, to be value for money, a PFI project must *more than offset* the higher cost of finance through the private sector's better management of risk. While, in theory, it is possible that the private sector is able and incentivised to achieve this, there is clearly a need for proper evidence to be supplied in support of this analysis. Unfortunately, the evidence base on PFI's performance is extremely poor. Until recently, the evidence base was underpinned by the fact that most PFI projects had emerged as such after being subjected to value-testing against a so-called 'public sector comparator' (PSC). In theory, where a PSC exercise concluded that PFI did not represent value for money over public financing, the latter procurement method would be chosen. In practice, PFI almost always came through the exercise as the more efficient option, an outcome that was taken by the government as clear evidence of the model's cost-efficiency (HM Treasury 2000). However, the PSC process has been fundamentally discredited as an objective exercise by academics and auditors.

Gaffney et al. (1999) note 'a tendency' for public authorities engaged in the PSC process to ascribe risks to PFI consortia that they will never be asked to bear. On one hospital project, one of the risks supposedly transferred to the private sector was that targets for clinical cost savings would not be met. The cost of this

risk was estimated at £5 million and added to the PSC figure. However, the consortium had no responsibility for ensuring such savings would be made, and faced no penalty if they were not. They conclude that the PSC process was 'spurious'. Jeremy Colman, former deputy general of the National Audit Office (NAO), the supreme public sector audit institution in the UK, came to a similar conclusion. In comments made to the *Financial Times* newspaper (since confirmed by Colman in a personal communication with one of the present authors), Colman noted that many appraisals were guilty of 'spurious precision', and often based on 'pseudo-scientific mumbo-jumbo' (Timmins 2002). Others were simply 'utter rubbish'. He noted the incentive facing authorities to manipulate appraisals in favour of the PFI route: 'If the answer comes out wrong you don't get your project. So the answer doesn't come out wrong very often'.

More recent government attempts to justify the dominance of PFI in large-scale capital investment have focused on the model's alleged ability to deliver projects 'on time and to budget' more consistently than public projects. For example, the HM Treasury (2003:43) states: 'Treasury research into completed PFI projects showed 88% coming in on time or early, and with no cost overruns on construction borne by the public sector. Previous research has shown that 70% of non-PFI projects were delivered late and 73% ran over budget'. This conclusion has had a major impact on regulations governing the way in which public authorities carry out their PSC appraisals, and has also been an important part of the 'evidence base' used to by government and industry to 'export' the PFI concept overseas (Pollock, Price and Player 2007).

However, it is important to note that comparing PFI and non-PFI projects for *post-contractual* price increases (which is what the Treasury appears to mean by time and cost overruns) is not a valid method for testing value for money. The contract price in traditional procurement is obtained at a particular stage of project design and specification that is equivalent to a less advanced procurement stage than financial closure in PFI. The notion of

contract price in PFI has risk control mechanisms built into it that it does not in traditional procurement, and these are factored into the PFI 'unitary charge' before signing. It is known that contract costs increase significantly during the preferred bidder stage (NAO 2006), an exclusive stage of the procurement in which the public authority is in a very weak negotiating position. The private sector has an incentive to adopt the practice of 'hold-up' during this stage, pushing up prices and reducing the extent of risk transfer.⁴ In proposing that post-contractual price certainty can be taken as an arbiter of overall efficiency, the Treasury is setting up a comparison which is certain to favour PFI. A project that is delivered to time and to budget (in post-contractual terms) may represent poor value for money if the price paid for the risk transfer that led to that outcome was too high.

The Impact of PFI on England's National Health Service

Having explored the economic arguments for PFI in England's public services and found them to be problematic, we provide a case study of the impact this policy has had on its largest consumer, England's National Health Service (NHS).

The NHS is the UK's healthcare system, which is tax-funded with services largely provided in the public sector, though there is some private sector provision in areas such as diagnostic and elective care (for example, cataract removal). NHS services are free at the point of use to anyone normally resident in the United Kingdom, with the exemption of eye tests, dental care, prescriptions, and certain aspects of personal care. The NHS is a heavily centralised system with overall stewardship of the organisation provided by the Secretary of State for Health and his or her Department of Health (DH). There is an element of regional control under the Strategic Health Authorities, but these are essentially agents of the DH in terms of regional planning and coordination.

The bulk of the NHS budget (over 70%) is held by community-based organisations called 'Primary Care Trusts'. These provide primary

care services and *commission* acute and specialist services from a variety of 'NHS Trusts' – publicly owned provider organisations typically located in large district general hospitals.⁵ The modern NHS therefore contains a 'purchaser-provider' split within the public system, the financial nature of which is described in more detail in the paragraphs below.

Economic theory predicts that the PFI method has the capacity to damage societal welfare where it is employed in the provision of *merit goods* – that is, goods that have a societal value over and above their private value, such as healthcare. An important loss in societal welfare could arise if providing healthcare facilities and services through PFI compromises the supply of services, moving the economy away from its welfare optimum. For this reason, economists tend to see the case for PFI as involving a trade off between productive efficiency, which, it is assumed, may be delivered if the market for contracts is adequately competitive, and the overall public interest (Reiss 2005).

Social welfare losses are likely because contracts are necessarily incomplete. PFI contracts are based on broad *output specifications*: asset and service inputs are not specified, measured or monitored and therefore the supplier has an incentive to cut costs to the detriment of quality (Hart 2003). This is seen to be especially problematic in complex areas of service delivery such as healthcare. Grimsey and Lewis (2004) mention an English hospital in which the PPP contractor chose 45-degree windowsills, resulting in lower cleaning costs (since cleaners do not lose time removing items on sills). But this had a negative effect on patients and their families since they no longer had the ability to place flowers, gifts, and the like on sills. The utility lost by this investment is probably small, but there is nonetheless an observable and unverifiable deterioration in service quality. The potential for this type of outcome is lower in public procurement, since the public sector can always choose whether or not to cut costs in such a way that service quality will be affected. Meanwhile, post-contractual changes are likely to be very expensive in a PFI, since incumbent providers are likely to exploit their monopoly

position to capture an undue proportion of the gain from any contractual variation (Lonsdale and Watson 2007).

A significant public interest concern, given the weakness of the economic case for PFI, is the cost it imposes on a healthcare system and the potential impact of this on the ability of services to meet needs. Research has shown that an ‘affordability gap’ emerges for NHS organisations during the PFI procurement process, and strategies to bridge this gap are identified in planning documents. Examples of bridging strategies are: increasing patient throughput; selling NHS land and reducing beds and staff across health economies (Gaffney et al. 1999). With many schemes now in the operational phase, it has become possible to examine empirically the impact of these strategies on capacity. In a recent examination of the first 18 operational PFI hospitals, official auditors found that 13 had bed occupancy rates higher than the NHS average (NAO 2007b). Almost all the trusts involved (17 of 18) had higher bed occupancy rates under PFI than in their former buildings. The NAO comments that such levels ‘raise issues about capacity and patient care’, including the ‘adequacy of capacity to meet peaks in admissions’ and ‘infection control’ (NAO 2007:18).

While cuts and closures planned for in PFI planning documents have clearly had an impact on healthcare delivery, it is evident from more recent research by the present authors that an affordability gap remains. In the remainder of this article we show that financial problems created by the high fixed costs of PFI projects in England’s NHS are leading to reductions in capacity and quality, further damaging the public interest.

How PFI Works in the NHS

Hospitals delivered through PFI are paid for by ‘trusts’ – NHS providers of acute and specialist care – which lease facilities from the private sector for 30 to 60 years. The trust pays an annual fee, or ‘unitary charge’, from the day the hospital opens until the end of the contract period. In healthcare PFI, the unitary charge comprises two elements: the *availabil-*

ity charge, which pays the private sector for providing buildings and equipment (providing returns to senior and subordinated debt, and dividends to equity holders); and the *service charge*, which pays the private sector for the provision of facilities management, and ancillary services such as cleaning and catering. It is the former type of charge that is of most interest to us in this article.

How NHS Trusts Pay for their Facilities

Since 1991, NHS trusts have had to pay for the use of their buildings by paying a charge on public dividend capital (now equivalent to 3.5% of their assets, down from 6% previously) plus a charge for depreciation. Since most assets delivered under PFI are considered to be private assets, they are generally ‘off-balance sheet’ in terms of trusts’ annual accounts, and thus *capital charges* do not have to be paid on them; the availability charge is paid instead. However, most trusts with operational PFI schemes retain some public assets as part of their estate and therefore pay a *combination* of availability and capital charges. For most trusts with PFI projects, then, *capital costs* means the combination of the charge on public dividend capital, depreciation and the availability charge. In addition, a minority of PFI assets are recorded ‘on-balance sheet’ in trust accounts, and both the capital charge *and* the availability charge must be paid on these (an anomaly that applies to two of the trusts discussed below).

The fact that capital charges do not, for the vast majority of PFI schemes, need to be paid for PFI assets releases funds out of which the trust can pay the availability charge. However, if the cost of the availability charge is higher than average charges in the NHS, this creates pressures on the budget. This is because, under *Payment by Results*, the current system of resource allocation for NHS hospitals, trusts receive most of their income through a standard tariff for each patient, based on the average cost of providing the treatment across the NHS (DH 2006c). This includes funds for trusts’ capital costs, which are designed to equal the average across all English trusts. Currently, the average cost of the charge on public dividend

capital, depreciation and the PFI availability charge is 5.8% of trust income. Trusts also receive various sources of PFI subsidy as part of their total income allocation. In 2005–06, some £50 million was paid to trusts under these mechanisms.⁶

Trusts that devote a higher than average amount of their income to capital costs will tend to incur a deficit on their income-expenditure accounts (Palmer 2006). There are a number of reasons why we might expect availability charges to be higher than average costs across the NHS. First, irrespective of the method of financing, new buildings are likely to cost more than old ones: the cost of capital on a new facility is almost certain to be higher than that on an old, more fully depreciated asset (Audit Commission 2004). Second, as noted above, the cost of finance on PFI schemes is higher than is the case for publicly financed schemes, even after adjusting for risk.

For our study, data on capital charges and the total incomes of all 236 NHS trusts existing in 2005–06 were provided by the DH in a Freedom of Information response (DH 2006a). Data on the unitary charges paid by all 40 NHS trusts with operational PFI projects that year were provided by the department under a separate response (DH 2006b). The department declined to provide a breakdown of the unitary charge into its availability and service charge elements on the grounds that it did not hold this information. Accordingly, we had to apply the findings of the department's research on a sample of early projects (DH 2000). In this sample, the availability charge on average accounted for 58.8% of the unitary charge, with the service charge accounting for 41.2%. We rounded these percentages to 60% and 40%, and applied them to the figures received for unitary charges in order to estimate the availability and service components.⁷

Using these data, we calculated the annual capital costs for each of the 40 trusts that were paying PFI unitary charges in 2005–06. This was achieved by adding public dividend capital, depreciation and the estimated availability charges paid that year, and calculating this as a percentage of their total income (including the sources of PFI subsidy outlined in note 5

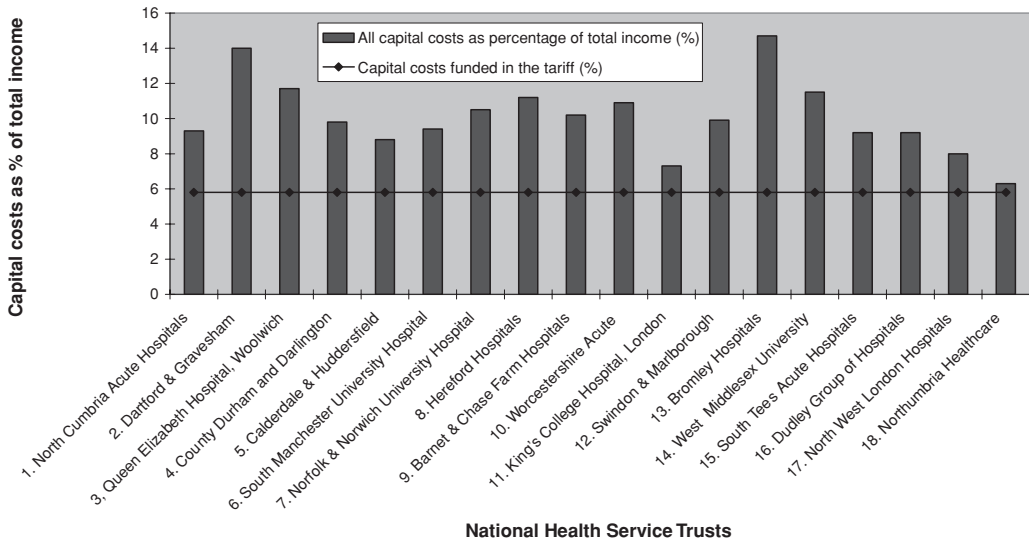
above). These figures were compared to the funding for capital provided under the tariff. We found that, of the 40 NHS trusts paying PFI unitary charges in 2005–06, 33 had capital costs in excess of funding under the tariff. On average, trusts with PFI schemes that were operational and incurring charges in 2005–06 had capital costs of 8.3% that year – that is, these trusts experienced an average shortfall in income of 2.5%.

However, many of the 40 PFI schemes that were operational in 2005–06 are small, and their impact on trust expenditure correspondingly minor. For the 18 trusts that were, in 2005–06, paying charges on schemes with a capital value of over £50 million, the impact of PFI costs was much more significant. For these trusts, average annual capital costs were 10.1% of total income in 2005–06, compared with 5.8% in the tariff. As Figure 1 illustrates, these trusts experience an average funding shortfall of 4.3%.⁸

Reductions in Healthcare Capacity

Our findings show a strong pattern of under-funding in PFI trusts compared with all other NHS trusts. The scale of under-funding was strongly associated with the size of the PFI scheme and therefore the size of the availability charge. These findings help to clarify the association between PFI and NHS trust deficits noted by managers in the NHS, and discussed in official literature. For example, the Audit Commission (2006) noted a 'marked correlation' between the presence of large new building projects and deficits in the NHS, but suggested this was likely to be caused by the amount of management time devoted to the process of constructing and moving into new facilities. A more obvious explanation for the correlation is simply the high cost of PFI charges and the under-funding they give rise to in the context of the tariff system.

In a separate joint study, the NAO (2006) reported a higher incidence of deficits amongst bodies with PFI schemes than those without (31% versus 26% respectively). Our analysis of NHS trust accounts for 2005–06 shows that this proportion is much greater for 'major'

Figure 1. Capital costs for Trusts with PFI schemes with a capital value of over £50m, in 2005-06

schemes – those which have a significant budgetary impact. In 2005–06, 50% of trusts with PFI projects with a capital value of £50 million or more were in deficit, compared to an NHS average of 23% for that year (HCHSC 2007). In addition, among trusts that did not record a deficit in 2005–06, several recorded underlying financial problems in their annual accounts. In a more recent study, the NAO (2007c) found a relationship between the presence of operational PFI schemes and the incidence of particularly serious financial problems. Of the 17 NHS trusts in ‘special measures’ in 2006–07 (that is, where financial problems were such that the DH could not give a loan because the trusts could not afford to meet the repayments, or where a loan was agreed, but the amount could only be repaid over an extended timescale), 53% had an operational PFI project. This compares to 35% for NHS trusts as a whole.

Case Studies

Two case studies serve as a further illustration of the problems currently faced by NHS trusts with large PFI schemes in operation. Earlier published work (Pollock, Price and Dunnigan 2000) showed how the planning of the replacement Worcestershire Acute Hospital led to af-

fordability problems which triggered the downgrading of Kidderminster hospital and bed reductions of 30% across the trust estate. Nevertheless, written evidence from the trust to the House of Commons Health Select Committee shows that affordability problems remain, such that the combined overspend for the trust in 2005–06 was £4.9 million, with an underlying deficit of £20 million (HCHSC 2007). The trust attributed £7 million of this deficit to the ‘additional costs’ of their PFI hospital, which it has said are ‘not reflected equitably in the national tariff and for which the trust does not receive sufficient income’ (HCHSC 2007:152). This was despite £1.5 million of subsidy provided that year by the DH and the NHS Bank. In response, the trust has developed a recovery plan, which involves a reduction of staff numbers by 675. It has also warned that achieving recurrent financial balance will not be achieved without ‘even more radical action’, involving ‘a comprehensive review of services’ across its three hospitals, amid ‘serious questions about their sustainability’ (HCHSC 2007:153).

In South East London, the outcomes are similar. According to a paper from the South East London and Maudsley Strategic Health Authority (SELSHA), the area’s four district general hospitals had a combined deficit of £66 million in 2005–06, with the largest losses

at the Queen Elizabeth and Bromley trusts (SELM SHA 2007). Both Queen Elizabeth and Bromley have operational PFI schemes with capital values in excess of £50 million. Bromley's PFI scheme is on-balance sheet with the effect that both availability and capital charges are paid on the asset; and both trusts received DH subsidies in 2005–06 (£1.1 million and £4.9 million respectively).

Nonetheless, according to an SELMSHA document (2007:5), the deficits of both trusts arise 'because the cash costs of the PFI availability charge exceed funding for capital charges in tariffs'. Both trusts had capital cost/income ratios of over 10%, against the 5.8% funded in the tariff. The Authority explains that these trusts 'incur recurrent [income/ expenditure] and cash flow deficits even if they operate as efficiently as the average hospital trust in England' (SELM SHA 2007:7). It suggests that achieving financial balance in the area cannot be achieved without significantly reducing 'controllable costs', including 'further substantial reductions in staff costs and staff numbers' in the area (SELM SHA 2007:10).

Conclusion

This article shows that the unfunded costs of trusts with operational PFI contracts remain significant, despite the well-documented service cuts made in earlier attempts to bridge the affordability gap at the full business case stage, and despite various types of subsidy. On average, according to our estimates, the 40 trusts that were paying PFI unitary charges in 2005–06 were under-funded by some 2.5% of their income. The extent of under-funding increases with the size of the PFI and for many trusts leads to significant financial difficulties. Trusts with PFI schemes with a value of over £50 million are on average under-funded by some 4.3% of their total income under Payment by Results. In 2005–06, there was a clear relationship between the presence of major PFI schemes in operation and the incidence of trust deficits. The under-funding generated by PFI costs creates pressure for cuts in service provision to reduce deficits. In Worcestershire and South

East London, NHS officials are acting on these pressures, largely through plans for area-wide re-configuration which are likely to include reduction and closure of acute and other health-care services.

PFI is a policy that is driven by a questionable politico-economic rationale. It is associated with reduced capacity of England's health-care system. In other words, it has reduced the provision of this merit good, harming the public interest. Of course, how PFI, or variants of it, will impact on other health and social systems depends to a large extent on how money moves around those systems, and in particular how those systems provide funding for capital costs. But it is clear that the high costs of PFI have the potential at least to impact on health systems in very material ways. In England, in 2005–06, some £50 million was provided to trusts with PFI schemes in order to help them meet their costs. Those efforts proved insufficient. In light of this, an evidence based economic justification for the policy appears overdue.

Endnotes

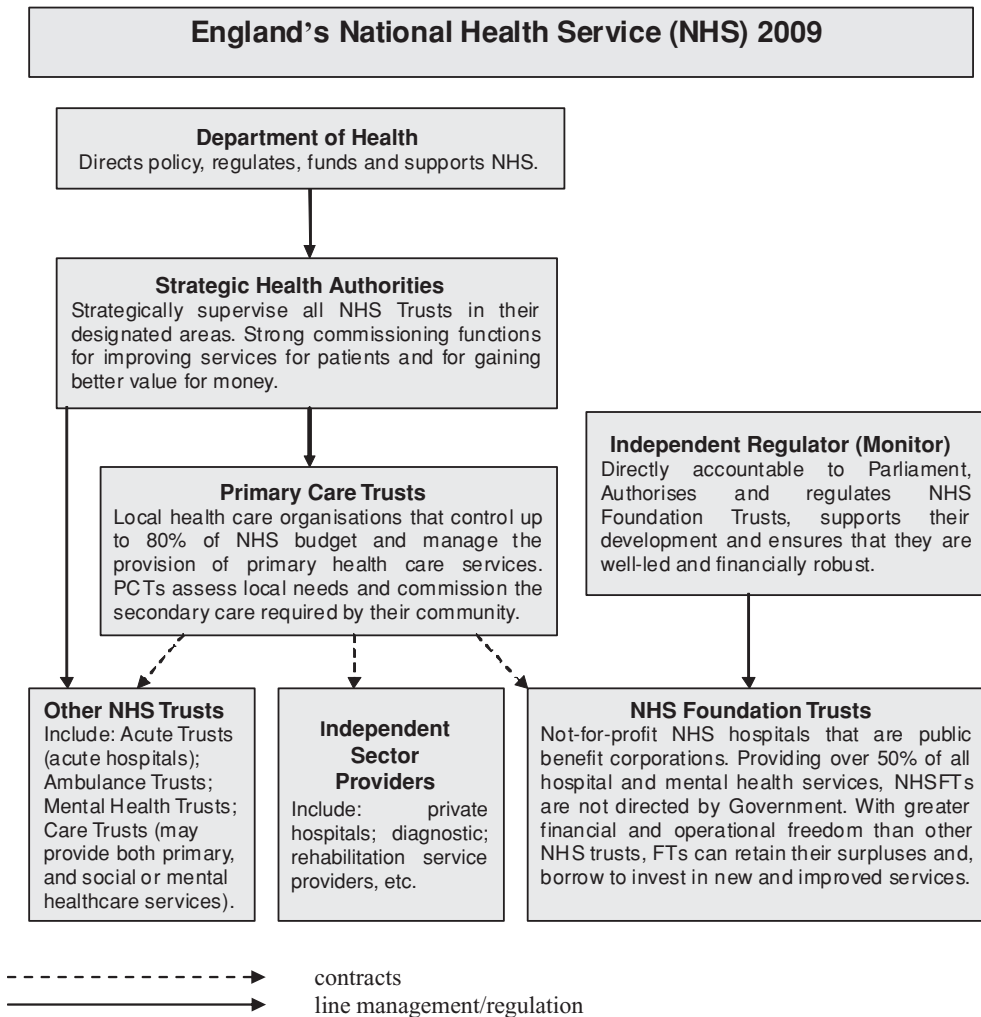
1. The other constituent nations of the UK have developed independent approaches to public capital investment since devolution in 1999. In outline, Scotland and Northern Ireland have continued to use PFI, or, more recently, variants of it, but the policy has been abandoned in Wales.
2. Giving evidence to the House of Commons Treasury Committee on 18 March 2008, UK Chancellor of the Exchequer Alistair Darling said: 'What I would say to you is that the PFI has enabled us to do a lot of building of schools and hospitals and so on that we would not otherwise have been able to do'.
3. The cost of bidding for PFI projects is, on average, between 2.5–3% of a project's capital value, a much higher level than average for publicly financed schemes, according to the National Audit Office (NAO 2007a). The high transaction costs of PFI have an impact on cost efficiency in creating a significant 'barrier to entry' to potential bidders, preventing

firms from joining the bidding process and undermining the extent of competition. The NAO report shows that the level of competition is relatively low in the PFI market, and is declining. Between 2004 and 2006, only 67% of PFI projects received three or more bidders. Meanwhile, one third of the projects included in the audit body's census attracted only two bidders at the point at which detailed bids were submitted.

4. 'Hold-up', a term from transaction cost economics, is said to have been executed when A has been able to force B to accept a disadvantageous movement in the terms of the contract because of the lack of alternative solutions outside of the A-B relation available to B

(Lonsdale and Watson 2007). Hold-up can occur in this type of circumstance because, as time progresses, the buyer will be increasingly reluctant to reverse the procurement process and hold another competition. This reluctance causes a shift in the balance of power, which the supplier can choose to exploit by seeking to renegotiate its winning bid.

5. England's National Health Service has a complex and frequently changing structure of authorities and trusts. The figure below provides a simplified illustration of the structure as at September 2009. While the Department of Health determines the NHS operating structure, allocates resources and develops national level policies, legislation and regulation, it does



not necessarily have a direct line management relationship with the various subordinate level NHS Trusts and Authorities which are established as legal entities in their own right.

6. Sources of subsidy include the ‘smoothing mechanism’, ‘deferred asset support’, ‘balance sheet support’ and ‘transitional support’ (DH 2006c). We do not intend to provide a full account of the nature and justifications for these subsidies here.

7. For many schemes, the figure of 60% will be an underestimate of the availability element of the unitary charge. This is because, in the DH’s sample of 23 schemes, 21 included ‘soft’ facilities management services within the contract – ie, services such as cleaning, catering, security, portering and helpdesk support, as opposed to ‘hard’ facilities management, primarily buildings maintenance. It has subsequently become much more common for soft services to be excluded from projects (Hellowell and Pollock 2007). Where soft services are not included, the availability charge component of the unitary charge will obviously be much greater relative to the services element.

8. Figures for the Bromley, and Barnet and Chase Farm trusts (14.7% and 10.2% respectively) include the ‘double-payment’ on PFI assets noted above, by virtue of these schemes being ‘on-balance sheet’.

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