

THE PRIVATE FINANCING OF NHS HOSPITALS: POLITICS, POLICY AND PRACTICE

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This article outlines and critiques the main fiscal and economic rationales for the Private Finance Initiative and examines the impact of the policy on the long-term financial viability of NHS trusts. It concludes that the PFI funding of capital investment is highly problematic. Its high costs can have a negative impact on the finances of health systems.

Keywords: Department of Health, hospitals, hospital-building programme, National Health Service, Private Finance Initiative, PFI, procurement.

Introduction

The Private Finance Initiative (PFI) involves long-term arrangements between the public and private sectors, in which the latter finances the design and build of new or substantially upgraded public facilities and provides some of the services within them. The legal and bureaucratic reforms necessary for PFI were introduced to the UK by John Major's Conservative government in 1992 and the policy now accounts for a significant proportion of large-scale capital projects in areas such as healthcare, defence, transport, roads, education, social housing and waste management. As of March 2008, 627 PFI schemes had been signed in the UK, delivering private finance of £58.2 billion (HM Treasury, 2008a).

England's National Health Service (NHS) – the focus of this article – has undertaken a large programme of hospital rebuilding over the last 11 years (see Tables 1 and 2). Contracts for 127 hospital projects have been signed since 1997, of which 97 came through PFI; and private finance accounts for approximately 90% of the £11.64 billion committed. Over the next few years, PFI is set to retain its dominant role in large-scale investment projects. An additional 21 PFIs with a total capital value of £3.14 billion were at the planning stage or in procurement in April 2008. This compares with just one scheme, valued at £243 million, being planned or procured on the basis of public financing.

This article outlines and critiques the main fiscal and economic rationales for the PFI and

then examines the impact of this policy on the financial viability of NHS organisations. It concludes that the PFI system of capital investment is highly problematic, given that its high costs can impact on the finances of health systems in very significant ways.

Rationales for PFI in the healthcare sector

The fiscal argument

Under PFI, the up-front capital cost of projects usually does not appear on the national accounts. It therefore appears to allow for relatively high levels of investment in public facilities while maintaining a 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 *et al.*, 2001). Public investment in healthcare varied between 0.2% and 0.4% of GDP in the early half of the 1990s and the NHS estate in England faced a huge backlog of maintenance and repairs (Gaffney *et al.*, 1999a). However, the Conservative administration of the early 1990s was keen to limit the size of the public sector borrowing requirement (PSBR), while keeping tax-rises to a minimum.

The ability of PFI to deliver investment within a 'prudent' fiscal framework was also an important attraction for the Labour government from 1997. The year after Labour

Table 1: The hospital-building programme – progress between April 1997 and April 2008

Project type	Number of projects	Capital value of projects (£m)
<i>In operation</i>		
PFI	69	4,484
Non-PFI	23	814
Sub-total	92	5,298
<i>At financial close and in construction</i>		
PFI	28	6,007
Non-PFI	7	339
Sub-total	35	6,346
<i>In procurement</i>		
PFI	5	472
Non-PFI	1	243
Sub-total	6	715
<i>In the pipeline</i>		
PFI	16	2,673
Non-PFI	0	0
Sub-total	16	2,673
Total	149	15,032

Source: Department of Health (2008) 'Prioritised Capital Schemes'. Available at: <http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/Privatefinanceinitiative/Newhospitalschemes/index.htm>.

Table 2: Numbers and capital values of PFI projects signed per year (full calendar years)

Year	Number of schemes	Total capital value (£m)	Average capital value (£m)
1997	3	206	68.67
1998	7	580	82.86
1999	10	618	61.80
2000	11	635	57.72
2001	7	339	48.43
2002	10	580	58.00
2003	8	1,012	126.50
2004	17	1,665	97.94
2005	5	716	143.20
2006	6	2,098	349.67
2007	11	1,661	151.54
Total/Average	95	10,110	106.42

Source: HM Treasury (2008) 'PFI Signed Projects List'. Available at: http://www.hm-treasury.gov.uk/documents/public_private_partnerships/ppp_pfi_stats.cfm.

took power, 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 gross domestic product. Keeping within this target had political importance for the Labour government because it was viewed as a measure of its fiscal responsibility and overall economic competence. Financing projects through PFI rather than public borrowing assisted the Labour government in meeting this rule while increasing investment, at least until recently.

However, the fact that privately financed investment is invisible to national debt, by virtue of its 'off-balance sheet' nature, 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. The effect of PFI is simply to alter the *timing* of payments to creditors, not reduce or eliminate them (Heald and Geaghan, 1997). PFI

projects require a commitment of future resources in much the same way as conventional borrowing and cannot provide governments with any 'additional' resources (Heald and Geaghan, 1997). In recognition of this, a number of 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 – 'value for money'

Perhaps in recognition of the weakness of the 'fiscal argument' for PFI, the policy is also justified on cost-efficiency grounds – in the jargon, '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.

Financing costs in PPP

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 a public authority would pay if it had borrowed money on its own account for a similar project. Similarly, in a study of the first 12 PFI hospital projects in England, Shaoul *et al.* (2008) found private finance costs of about 8% – well in excess of the 4.5% available on public finance in the relevant period. Financing costs matter in a PFI, just as they do in projects funded through direct borrowing, as they are part of a project's costs and to a large extent determine the level of the annual payments that the public authority must deliver.

The Freedom of Information Act (2005) has enabled independent scrutiny of PFI documents which contain estimates of a project's profitability. Cuthbert and Cuthbert (2008) looked at the cost of two completed hospital schemes in Scotland, the Edinburgh Royal Infirmary and Hairmyres, and compared this with an estimate of what these projects would have cost had public finance been used. They compared for each scheme the net present value (NPV)¹ of returns to investors with the amount of private capital raised to finance the construction work.

On the Edinburgh Royal Infirmary scheme, they found the cash value of the returns on private capital (excluding payments for operations, maintenance and service provision) was £760 million. This was then discounted at 5% – the rate of interest that would have been paid by these hospitals on public finance at the time their contracts were signed – to give £416 million, more than twice (2.04 times) the £181 million of capital raised by the private sector to build the hospital. The same analysis was applied to the £68 million Hairmyres scheme, and a similar ratio (1.97 times) was calculated. The authors concluded that PFI is a 'one hospital for the price of two policy' (p. 5).

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 scheme, but any additional costs (e.g. due to time and cost overruns in construction, or problems in operation) are passed on to current and future taxpayers. In contrast, in a PFI, these project risks are borne by private investors, rather than taxpayers, 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 therefore 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 able to manage this risk and deliver projects more cheaply, then the total cost of a PFI could be lower than a public project. However, the available evidence suggests that this is not the case. Research commissioned by the Office of Government Commerce (OGC) demonstrates that PFI financing costs are in fact higher than is predicted by the Treasury's claim.

PricewaterhouseCoopers (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 scheme with a benchmark 'weighted average cost of capital' reflecting the return that should be expected from a project by an investor, given project risks. 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 fees charged by banks; and (3) limited competition in the market.²

It is significant that the UK government's own evidence base suggests there are 'excess returns' to investors. This implies that to be value for money the private sector must be so much more efficient than the public sector that it can *more than offset* its higher cost of finance through being more able and better incentivised to manage risk. In principle, it is possible that this is the case, but there is clearly a high burden of proof given the evidence of excessive profitability. As we see below, no valid evidence has been provided by the government in support of its assertions.

A look at the supporting evidence: the public sector comparator

Under Treasury rules, public authorities must subject their private finance plans to a value-testing exercise, part of which is based on a *public sector comparator* (PSC) – an estimate of what the project would cost under public finance. In theory, where a PSC concludes that private finance does not represent value for money, a public procurement method should be chosen. In practice, PFI almost always comes through the PSC exercise as the more efficient option and this has been presented by the Treasury as good evidence that the model is cost-efficient (HM Treasury, 2000).

Since the logic of PFI is that it leads to greater cost efficiency through the private sector managing more effectively project risk, the principle is that risk should be added to the PSC to make this comparable with the cost of PFI. However, this process has been fundamentally discredited by academics and auditors. Gaffney *et al.* (1999b) note 'a tendency' for public authorities engaged in the PSC process to ascribe risks to PFI consortia that they will never in fact be asked to bear and thereby artificially inflate the cost of the PSC relative to the PFI. For example, 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. The authors conclude that the PSC process was 'often spurious'.

Jeremy Colman, former deputy general of the National Audit Office, the supreme public sector audit institution in the UK, outlined 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). Mr Colman noted that many appraisals were guilty of 'spurious precision', based on 'pseudo-scientific mumbo-jumbo'. He noted the perverse incentive facing authorities to manipulate appraisals, in a context in which private finance is the only funding source available: 'If the answer comes out wrong you don't get your project. So the answer doesn't come out wrong very often.'

A look at the supporting evidence: time and cost overruns

More recent government attempts to justify the dominance of PFI in large-scale capital investment have focused on the model's ability to deliver projects 'on time and to budget'. For example, the Treasury (2003) states: 'Treasury research into completed 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' (p. 43). This conclusion has had a major impact on regulations governing the way in which public authorities carry out their PSC appraisals, in particular the calculation of risk transfer.

However, requests for the Treasury's work on cost and time overruns indicate that no research report exists. Indeed, Treasury officials have stated this in a correspondence with one of the present authors. Meanwhile, the 'previous research' noted above refers to two reports from the National Audit Office, *Modernising Construction* (2001) and *PFI Construction Performance* (2003). But neither of these studies compares performance under different procurement routes. The first is based on interviews with industry about the scope for improved construction. The second is a census of 38 project managers. Neither study examines the relative performance of PFI and conventional procurement. Indeed, the authors of *PFI Construction Performance* conclude: 'it is not possible to judge whether these projects could have achieved these results using a different procurement route' (National Audit Office, 2003).

In any case, comparing PFI and non-PFI projects for post-contractual price increases (what the Treasury appears to mean

by 'time and cost overruns') would not be a valid method for testing value for money. Under a PFI, the risk of cost and time overruns is transferred to the private sector, so it has little flexibility to increase its price during capital works unless major problems emerge. Instead, under PFI, the private sector increases its price *before* contracts are signed. It is assisted in doing so by the *preferred bidder* stage – a post-competitive phase of PFI procurement in which the public authority enters into a long and exclusive negotiation process with a single consortium.³

During this period, the private sector can 'hold-up' the public sector, pushing up prices and reducing the extent of risk transfer.⁴ Meanwhile, the scope for public authorities pulling out of such negotiations is limited by the unavailability of other procurement routes. 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 bound to favour the PFI method. 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

A significant public interest concern, given the weakness of the economic case for PFI, is the cost it imposes on the 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.*, 1999b). 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 (National Audit Office, 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' (p. 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 (Hellowell and Pollock, 2007) that an affordability gap remains. The remainder of this paper looks at financial problems created by the fixed costs of PFI projects in England's NHS and their relationship with further reductions in capacity and quality.

How PFI works in the NHS

In the NHS, the public sector contracting authority is typically an NHS trust. The trust awards the private sector partner a 30-year contract for the construction and maintenance of a new or refurbished hospital facility and, in many cases, certain 'soft' services such as cleaning, catering, portering and security. In

return for the capital invested by the private sector and its ongoing service activity, the trust pays to the private sector an annual *unitary charge*. The money for this payment comes from the trust's own budget, though there are various sources of central subsidy from both the Department of Health and the NHS Bank.

The unitary charge comprises two elements: the *availability 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 paper.

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 these *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 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 (Department of Health, 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.⁵ 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 Department of Health (DH) in a Freedom of Information response (Department of Health, 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 (Department of Health, 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 to a sample of early projects (Department of Health, 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.⁶ Using these data we calculated for each of the 40 trusts that were paying PFI unitary charges in 2005/06 their annual capital costs 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).

These figures were compared with 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 – i.e. 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 experienced an average funding shortfall of 4.3%.⁷

Reductions in healthcare capacity

Our findings show a strong pattern of underfunding in PFI trusts compared with all other NHS trusts. The scale of underfunding 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 underfunding they give rise to in the context of the tariff system.

In a separate joint study, the National Audit Office and Audit Commission (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' 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 with an NHS average of 23% for that year (House of Commons, 2007). In addition, among trusts that did not record a deficit in 2005/06, several recorded underlying financial problems in their annual accounts.

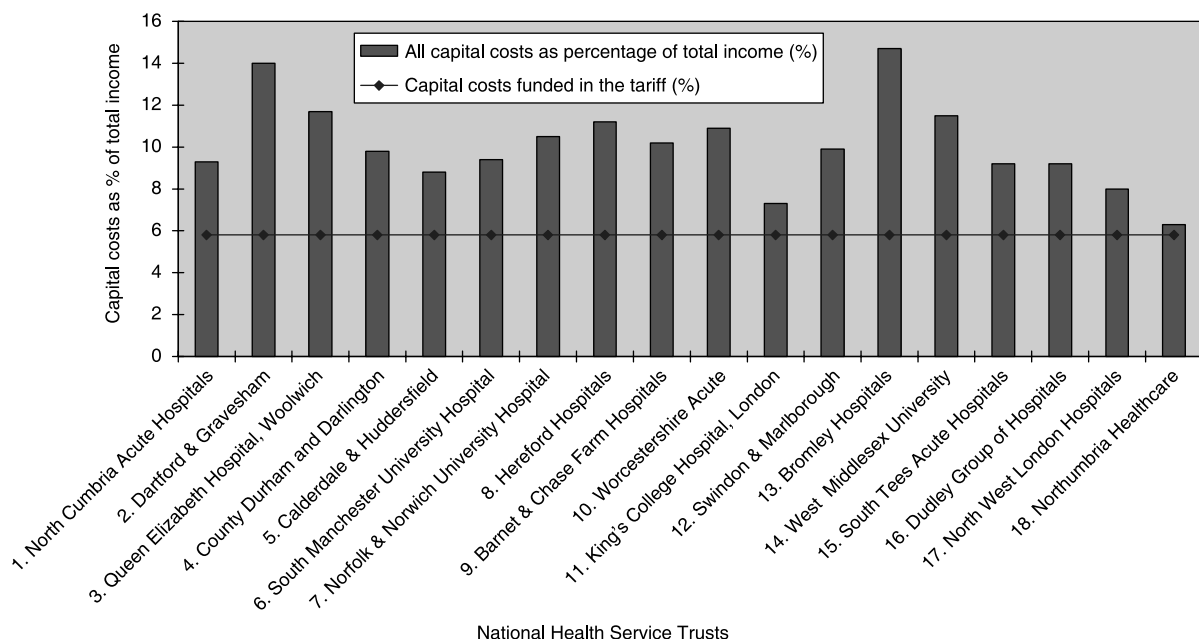


Figure 1: Capital costs for trusts with PFI schemes with a capital value of over £50 million, in 2005/06

In a more recent study, the National Audit Office (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 (i.e. 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 with 35% for NHS trusts as a whole.

The impact at the local level

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 *et al.*, 2000) showed how the planning of the replacement Worcestershire Acute Hospital led to affordability 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 (House of Commons, 2006).

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' (*ibid.*, p. 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' (*ibid.*, p. 153).

In South-East London, the outcomes are similar. According to a paper from the South-East London and Maudsley Strategic Health Authority (SHA), 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 (South London and Maudsley 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 SHA document, the deficits of both trusts arise 'because the cash costs of the PFI availability charge exceed funding for capital charges in tariffs' (*ibid.*, p. 5). Both trusts had capital cost/income ratios of over 10%, against the 5.8% funded in the tariff. The SHA 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' (*ibid.*, p. 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' (*ibid.*, p. 10).

Conclusion

This paper shows that the unfunded costs of trusts with operational PFI contracts remain significant and damaging, 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 underfunded by some 2.5% of their income. The extent of underfunding 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 underfunded 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 underfunding 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 reconfiguration, which are likely to include the reduction and closure of acute and other healthcare services.

PFI is a policy that is driven by a questionable politico-economic rationale. It is associated with reduced capacity in England's healthcare system. Of course, how PFI will impact on other healthcare 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 at least the potential to impact on health systems in material ways.

1. Based on a discount rate of 5% – the National Loan Board rate at the time these projects reached financial close.
2. The cost of bidding for PFI projects is, on average, between 2.5% and 3% of a project's capital value, a much higher level than average for publicly financed schemes, according to the National Audit Office (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 National Audit Office 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.
3. According to the National Audit Office (2007a), the average length of preferred bidder negotiations for projects signed between 2004 and 2006 was 15 months.
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 these circumstances because, as time progresses, the buyer will be increasingly reluctant or unable to reverse the procurement process and hold another. This reluctance causes a shift in the balance of power, which the supplier can exploit by seeking to renegotiate its winning bid.
5. Sources of subsidy include the 'smoothing mechanism', 'deferred asset support', 'balance sheet support' and 'transitional support' (Department of Health, 2006c). We do not provide a full account of the nature and justifications for these subsidies here.
6. 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 – that is, 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. Where soft services are not included, the availability charge component of the unitary charge will obviously be much greater relative to the services element.

7. 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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