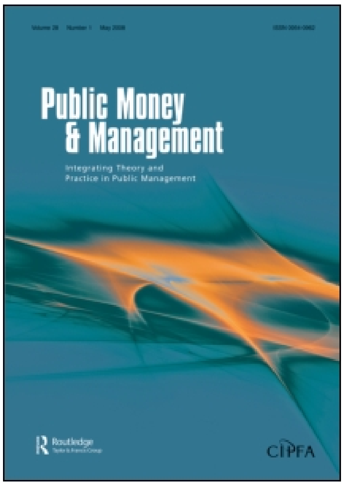

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New Development: The PFI: Scotland's Plan for Expansion and its Implications

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New Development: The PFI: Scotland's Plan for Expansion and its Implications

Mark Hellowell and Allyson M. Pollock

The public expenditure implications of PFI projects in Scotland's NHS are substantial. This article compares PFI capital expenditure with projected unitary charges, examines the annual cost of existing PFI schemes and looks at future costs arising from the planned expansion of PFI. Unless the new Scottish National Party-led administration applies the breaks, the annual cost of PFI to Scotland's NHS is to increase almost five-fold, from £107.1 million in 2005/06 to £500 million by the early part of the next decade.

Since 1992, most large-scale capital investment in the NHS has come through the private finance initiative (PFI), whereby funding for projects is raised on the financial markets by groups of banks, builders and service contractors. These consortia design, build, finance and (in accounting terms) own the newly-developed health facilities and, in addition, provide 'facilities management' services upon completion.

This approach differs from traditional arrangements in which a public authority engages an architect to design new facilities and a construction contractor to build them. Under this, the public procurement model, capital works are financed directly by central government, with money raised through taxation and/or the issuing of Treasury gilts; the building is owned and operated by the public sector.

The Labour government signed the first health PFI contract in 1997; the first PFI hospitals were completed in autumn 2000. Since 1997, all Scottish hospital projects with a value of over £10 million that have been approved by ministers have been procured through PFI.

Financing the New Investment

Hospitals financed by PFI are leased by the NHS from the private sector for periods of 30 to 60 years. The health board pays the contractor an annual fee for the duration of the contract from the day the hospital opens, at which point the PFI contract is said to be 'operational'. The money to pay the fee comes from the board's own revenue budget, which is also used to provide clinical services, staff and supplies.

In the NHS, PFI contracts combine two types of transaction: the provision of *assets,* such as buildings and equipment; and the provision of *services,* such as buildings maintenance, cleaning and catering. The payment for the provision of assets is called the availability charge; the payment for the services is called the service charge. Together, these are known as the unitary charge.

The Availability Charge

The availability charge is a fixed cost which varies only if new requirements outside the terms of the contract arise, or if the consortium is penalized for failing to meet performance standards. The charge covers three types of cost:

- It funds interest and principal payments on the debt taken out by the PFI consortium. This claim takes precedence over all others, and accounts for a significant proportion of the availability payment. The lending institutions have an interest in ensuring that this payment stream is clearly identifiable and protected, and PFI financial models are structured accordingly.
- The consortium has to build up cash reserves in order to meet 'lifecycle' costs—expenditure that may be required in the later years of the contract in order to maintain the condition of the facilities. This reserve is the consortium's property and will only be spent to the extent that is deemed necessary. Any unused funds will be passed over to the shareholders at the end of the contract period.

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- Once these costs have been met, the availability payment funds returns to shareholders in the form of dividends. Under normal financing arrangements (which are subject to change if schemes are refinanced), an increasing proportion of the availability payment funds profit to shareholders of the PFI consortium as debt is paid off over the contract period.

The Service Charge

The range and specification of services delivered under PFI will vary from project to project. All PFI contracts include the contracting out to the PFI provider of so-called 'hard' facilities management services, including routine building maintenance work. The majority of NHS PFI contracts also involve the outsourcing of 'soft' services—catering, cleaning, security, helpdesk support and portering.

Prior to June 2001, staff involved in PFI contracts were transferred to private sector employment under TUPE regulations, and many subsequently received less favourable terms and conditions. Since June 2001, however, most facilities management staff involved in PFI agreements have transferred under secondment arrangements, and have thereby retained their NHS employment (Unison, 2003).

In this article, we enumerate the scale of current and planned PFI investment in the Scottish NHS, and estimate the current and planned public expenditure implications of these PFI commitments for each health board. The purpose is to inform the current debates on the future of PFI in the Scottish NHS: debates which have risen to greater prominence since the Scottish National Party (SNP), which has a manifesto commitment to seek alternatives to the policy, won the Scottish elections and formed a minority government in May 2007.

The Long-Term Cost of Signed PFI Schemes

We looked at total capital expenditure delivered through PFI for all schemes in Scotland signed before 28 November 2006, and compared this with projections of actual and future annual NHS revenue spending on these deals. Two responses by the Scottish Executive under the Freedom of Information Act provided (*a*) aggregate data on capital expenditure by the private sector and (*b*) the actual and projected annual unitary charges for all PFI contracts. This information was not publicly available. The capital expenditure on deals signed was £602 million, but the projected debt facing health boards is £4 billion in nominal terms (Hellowell and Pollock, 2006).

The Annual Cost of Operational PFI Schemes

For each health board in Scotland we calculated the aggregate capital value of PFI schemes and the annual unitary charge associated with them in 2005/06.

Table 1 shows that, in 2005/06 alone (the latest year for which actual data was available at the time of writing), the annual cost to the NHS of schemes completed and in operation was £107 million—some 23% of the total capital invested through these schemes (£475 million). Currently, two health boards, Lothian and Lanarkshire, with large operational schemes (defined as completed schemes with a capital value over £20 million), account for around 83% of the total debt, with actual PFI charges of £46.1 million and £41.2 million respectively in

Table 1. Health boards with operational PFI projects in 2005/06, capital values and actual annual unitary charges for 2005/06.

Scheme	*Capital value (£M)**	*Unitary charge 2005/06 (£M)***
Lothian	205.7	46.1
Lanarkshire	174.7	41.2
Ayrshire & Arran	8.6	2.1
Dumfries & Galloway	10	1.3
Grampian	3.8	1.9
Highland	25.3	4.4
Tayside	24.3	4.4
Glasgow and Clyde	22.9	5.4
Totals	475.3	106.8

*Data on capital values are taken from Health Department project list, updated October 2006, available at: www.pfcu.scot.nhs.uk/projects.html.

**The unitary charges figures shown in this table were provided by the Scottish Executive in response to a Freedom of Information request (received July 2006). They are for years ending 31 March.

2005/06.

The Scottish Executive 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. However, Department of Health research (Department of Health, 2000) shows that, on average, the availability charge accounts for 58.7% of the cost, and facilities management 41.3%. We rounded these percentages to 60% and 40% respectively and applied them to the unitary charges in order to estimate these components.

Using this approach, we estimate the availability charge component of the repayments to be £64.2 million annually, or 13.5% of the total capital invested. This appears to be an extremely high figure given that these deals run for 30 years and in some cases for significantly longer.

The Cost of Future PFI Schemes

While NHS Lothian and Lanarkshire currently bear the brunt of PFI costs, this will change in the coming years, as more health boards take on major investment projects through private financing. As table 2 shows, 23 new hospital PFI schemes with a capital value of £1.6 billion* are in the planning stage or are in negotiation, with a total estimated unitary charge of £377.3 million a year.

The exact unitary charges on these schemes is not known, but they can be estimated using the norm of 23% of capital value from current operational schemes. On this basis, NHS Lothian's expanded PFI programme will result in increased unitary charges, from £46.1 million in 2005/06 to £108 million when the new projects become operational.

Annual unitary charges for NHS Forth Valley and NHS Fife, which currently have no PFI schemes in operation, will be £82.6 million and £30.9 million respectively. Future revenue projections for Glasgow and Clyde's PFI plans alone exceed the total revenue commitments of all NHS Scotland's current operational PFI projects.

For schemes in the early stages of planning, such as those in Glasgow, these figures will be significant under-estimates, for two reasons. First, there is a trend for capital and net present values to increase dramatically during procurement. For example, Forth Valley's PFI scheme increased in capital value from £200 million at outline business case stage to £300 million in the final business case. A second reason is the trend, noted by the National Audit Office in an unpublished report completed in 2006, for unitary charges to increase after contracts are signed at a higher rate than that anticipated at financial close, as minor variations to contracts are subject to monopoly pricing.

Table 2. Health boards with approved future schemes not operational as of 31 March 2006, capital values and projected annual unitary charges.

Scheme	*Capital value (£M)*	*Projected annual unitary charge on completion (£M)*
Lothian	269.3	61.9
Ayrshire & Arran	20	4.6
Fife	134.5	30.9
Forth Valley	359	82.6
Glasgow and Clyde	770	177
Grampian	8.1	1.9
Tayside	60.9	14
Highland	19.2	4.4
Totals	1641.0	377.3

Source: Data on projects, capital values and contract terms are taken from Health Department project list, updated October 2006, available at: http://www.pfcu.scot.nhs.uk/projects.html

Implications of PFI for Local NHS Budgets

Research has documented how the PFI charge creates an affordability gap which NHS organizations seek to minimize at the project planning stage (Pollock *et al.*, 1999). All PFI business cases studied include plans to reduce both the numbers of acute and community beds and services and staff. Extra money to bridge the affordability gap is also generated by selling land or by cutting services in other areas.

Notwithstanding these service reductions, 'operational' PFI hospitals (i.e. those on which construction work has been completed, services delivered, and charges levied) continue to experience financial difficulties. In England, the Audit Commission noted a 'marked correlation' between the presence of new large building projects and the presence of deficits (Audit Commission, 2006).

The Queen Elizabeth Hospital NHS Trust in Greenwich attributes its deficit of £19.6 million in part to the PFI contract which contributes £9 million in 'excess costs' (PricewaterhouseCoopers, 2005). Services across south east London are at risk, according to documents released by the South London and Maudsley Strategic Health Authority

*If these schemes are signed then the total unitary charge will increase from £107 million in 2005/06 (table 1) to almost £500 million in nominal terms within the next five years.

(2007a and b), in which the case is made for closure of non-PFI parts of the area's NHS estate, to help ease deficits which it claims are caused by the high cost of three 'whole hospital' PFI contracts.

And Worcestershire Acute Hospitals NHS Trust had an underlying deficit in 2005/06 of £20 million, of which it believes £12 million is due to higher than average expenditure. (Worcestershire Acute Hospitals NHS Trust, 2007). Of this expenditure, £7 million of 'additional' costs relate to the PFI scheme. The trust is now planning large scale staffing cuts, and 'a comprehensive review of services' in each of its three hospitals, including the downgraded Kidderminster hospital, amid 'serious questions about their sustainability'.

It appears that service reductions that occurred prior to financial close after PFI negotiations are being followed by further waves of closures subsequent to schemes becoming operational and PFI charges taking full effect.

The problems highlight some of what may be in store for Scotland. PFI is already a severe burden for the two health boards with major operational schemes:

- NHS Lothian reported an overspend of £15.9 million for the six months to September 2006 (Lothian Health Board, 2006). It has only met its financial targets in recent years through non-recurrent funding, and in particular £19.6 million of capital-to-revenue transfers. However, new Treasury rules disallow these transfers after 2005/06, a factor that the board's auditors see as a 'major risk' to the achievement of its financial plans (Audit Scotland, 2006).
- NHS Lanarkshire's accounts show a recurrent deficit of £21.66 million as of 1 April 2006 (Lanarkshire Health Board, 2006). It currently has to find £41.2 million each year to pay the PFI charge. Again, NHS Lanarkshire's auditors highlight the board's reliance on £17.8 million in capital to revenue transfers in 2005/06 (Audit Scotland, 2006), which cannot be repeated.

Conclusion

In August 2006, Lanarkshire Health Board announced that the accident and emergency unit at the publicly-owned hospital, Monklands hospital—which serves an area of great deprivation and high health care need—was to close with further downgrading of services. These plans are currently under review, following the change of administration in Scotland.

Prior to the May 2007 election, the Scottish Executive maintained that its acute services review across the Scottish NHS would not be distorted by PFI expenditure and affordability problems, but would be motivated by the health care needs of local communities. But it is clear that the high cost of PFI, and the huge increase in its scale that is envisaged, will place a burden on the non-PFI parts of the NHS estate, and provide pressure for closure of services within them. ■

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