The Centre for International Public Health Policy

The impact of PFI on Scotland's NHS: a briefing

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Summary of the main findings

1. PFI buildings cost the NHS more than non-PFI buildings: the annual PFI availability charge that the NHS pays for acute PFI facilities is around 11-18.5% of hospital turnover, compared to 5-8% in non-PFI facilities.

2. This extra cost creates an 'affordability gap' which can only be met by diverting revenue from clinical services, staff, and supplies. Thus, PFI schemes are associated with service cuts even before contracts are signed.

3. Despite this, it is becoming clear that further cuts may be necessary to meet the high costs. There is growing evidence that PFI payments are a key causal factor behind the large deficits of many NHS trusts in England.

4. PFI projects create a debt for the NHS, which is far greater than the investment it provides. The total capital value of signed PFI contracts in Scotland's NHS is £602 million, but the debt created is in the order of £2.4 billion.

5. This debt is putting the finances of some health boards in Scotland under strain. NHS Lothian and NHS Lanarkshire, the two boards with 'major' PFI schemes, are paying £46 million and £41 million respectively.

6. This means that the health boards must divert a much greater proportion of their revenue to buildings than boards without major PFI schemes – around 4% of total revenue compared to less than 2.5% for other boards.

7. Both Lothian and Lanarkshire are experiencing financial difficulties. Lothian reported a £15.9 million overspend in its financial statement for the six months to September 2006. NHS Lanarkshire's accounts also show a recurrent deficit of £21.66 million.

8. Despite its extra costs, the PFI programme is being significantly expanded. The annual cost of PFI to the NHS will rise from £107.1 million in 2005/06 to almost £500 million within the next five years.

1 Introduction

The aims of this briefing are to:

- describe what PFI is and show how it is paid for
- detail the current scale of PFI in Scotland's NHS
- outline the costs that existing schemes are generating for Scotland's NHS and
- examine the planned extension of PFI over the coming years.

2 What is PFI?

Since 1992, most large-scale capital investment in the NHS has come through the private finance initiative (PFI). Under the PFI, funding for projects is raised on the financial markets by groups of investment banks, builders, and service contractors. These consortia design and build new health facilities, and operate 'facilities management' services within them after construction work is completed.

This is different from the traditional public procurement model in which a public authority would engage an architect to design the required facilities, and a construction contractor to build them. The construction work would be financed directly by central government, paid for through taxation and/or the issuing of Treasury gilts. The building would be owned and operated by the public sector.

3 How is it paid for?

Hospitals and other health facilities funded by the PFI are leased back from the private sector to the NHS for periods of 30 to 60 years. The public authority – in the case of Scotland, the NHS health board - pays the contractor an annual 'unitary charge' for the duration of the contract from the day that the hospital or health facility opens. At this stage, the PFI contract is considered to be 'operational'. In Scotland, the money to pay the PFI charge must be found from the health board's revenue budget, the part of the budget also used to provide clinical services, staff and supplies.

4 The composition of PFI payments

PFI contracts combine two types of transaction: the provision of *assets* such as buildings and equipment; and the provision of *services* such as facilities management and catering. The payment for the provision of assets is called the *availability charge*; the payment for the provision of services is called the *service charge*.

4.1 The 'unitary charge'

Other charges may be levied in addition to the availability charge and the service charge, including a variable payment known as a 'volume' or 'usage' charge, which is usually a minor part of the total PFI payment. Together, all these payment streams constitute what is called the *unitary charge*, that is, the payment made by the public sector client to the PFI contractor. The unitary charge is usually fixed for the period of the PFI arrangement at contract signature. Normally the contract allows for an annual uplift for inflation, and the services component of the charge may vary as a result of benchmarking and market testing every five to seven years.

4.2 What does the availability charge pay for?

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 penalised for failing to meet performance standards. The charge covers three types of cost.

First, it funds interest and principal payments on the debt taken out by the PFI contractor. This claim has to be settled before any others, and generally accounts for the bulk of the availability payment. The lending institutions have an interest in ensuring that this payment stream is clearly identifiable and protected.

Second, the PFI contractor has to build up reserves for various purposes, the most important of which is to meet 'lifecycle' costs, that is, capital expenditure that may be required in later years in order to maintain the value of the assets.

This lifecycle reserve will usually be the property of the PFI consortium 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.

Finally, once these costs have been met, the availability payment funds returns to shareholders in the form of dividends.

As debt is paid off over the contract period, an increasing proportion of the availability payment consists of profit to shareholders. (However, in cases where refinancing occurs, most of the profit accruing to the contract is taken at an early stage in the contract term.)

4.3 What does the service charge pay for?

The exact specification of services delivered under PFI will vary from project to project. However, in most PFI contracts, the specification includes so-called 'hard' facilities management services, such as building maintenance work, and 'soft' services, such as catering, cleaning, security, helpdesk support, and portering. Staff are transferred from the NHS to the private sector in order to carry out this work.

5 Meeting the unitary charge

Most health board income is committed to providing clinical services and paying for labour and supplies. Since 1992, however, NHS organisations have been required to run an annual surplus of income over expenditure, which is used to pay 'capital charges' to the Treasury. Under the capital charging policy, boards are obliged to operate in such a way as to produce annual surpluses equivalent to 3.5% of their existing capital assets, ie, buildings, land, and equipment.

When a health board signs a PFI contract for a hospital and, as is normally the case, transfers the assets of the hospital to the private sector, it is no longer obliged to pay charges on it. In theory, this creates a source of revenue for the board to pay the 'availability charge'. The capital charge and the availability charge can be thought of as the 'rent' the board pays for its hospital buildings (with the difference that the capital charge remains in the public sector while the availability charge is paid to private consortia, and is money lost to the NHS).

In practice, however, the availability charge of the replacement hospital has proved to be much higher than the previous capital charge, with the result that the 'rent' of the hospital increases. While the capital charge typically accounts for between 5-8% of a hospital's turnover, research shows the availability charge can consume between 11% and 18.5%.[1]

Since health boards do not receive extra money to pay for PFI schemes, the increase in rent results in a problem of affordability - an 'affordability gap'.

This gap is the difference between what the PFI consortium charges and what NHS purchaser can afford to pay. The health board can only bridge this gap by using its revenue budget – the part of the budget that is normally used to fund operating costs such as clinical care, labour and supplies. This diversion of funding from clinical services to capital has had very serious consequences for patient care.

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[1] Gaffney D, Pollock AM, Dunnigan MG, Price D, Shaoul J. PFI in the NHS: is there an economic case? *BMJ* 1999;319:116-9.

Research has documented how NHS organisations seek to minimise this affordability gap at the project planning stage.[1] All PFI business cases contain plans to downsize the scale of patient care, through reductions in numbers of beds and/or staff. Extra money to bridge the affordability gap is also generated by selling land. Despite these efforts, it is now clear that operational PFI schemes (ie, those on which construction work has been completed and services are being delivered) continue to cause financial problems for NHS organisations.

In England, the Audit Commission has shown that there is a "marked correlation" between the presence of new large building projects and the presence of deficits.[2] Of the 28 NHS hospital or foundation trusts with 'major' PFI schemes in operation in England[3], 14 (50%) recorded a deficit in 2005-06, compared to the average of less than 30% across all NHS hospital and foundation trusts.[4]

Currently in England, many NHS hospital trusts associate the costs of PFI with their deficit problems. For example, Queen Elizabeth Hospital NHS Trust in Greenwich has a cumulative deficit of £19.6 million, to which the trust believes its PFI contract contributes £9 million in "excess costs".[5]

High profile Worcestershire Acute Hospitals Acute Hospitals NHS Trust overspent by £4.9 million in 2005-06, and has a cumulative deficit of £31.8 million,[6] to which the trust believes the £7 million of "additional annual costs" accruing to its PFI are the main cause.

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.[7]

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[1] See, for example, Pollock AM, Dunnigan MG, Gaffney D, Price D, Shaoul J. Planning the 'new' NHS: downsizing for the 21st century. *BMJ* 1999; 319:179-84.

[2] Audit Commission. Learning the lLessons from financial failure in the NHS. London: Audit Commission July 2006.

[3] This data is from the Department of Health, and is current as of October 2006. This information is available on the DH website at www.dh.gov.uk/assetRoot/04/13/99/31/04139931.pdf

[4] Department of Health. *The 2005-06 provisional outturn NHS trust surplus / (deficits)* http://195.33.102.76/assetRoot/04/13/57/66/04135766.pdf Monitor. NHS foundation trusts – preliminary results for year ending 31 March 2006. http://monitor-nhsft.gov.uk/documents/Monitor_Q4_report_WEB_FINAL_050606.pdf These documents show that 81 of 272 NHS trusts and fundation trusts were in deficit in 2005-06, or 29.78%. This includes 14 of the 28 organisations with major operational PFI schemes.

[5] PricewaterhouseCoopers. *Queen Elizabeth Hospital NHS Trust: Public Interest Report*. London: Audit Commission December 2005:7.

[6] Worcestershire Acute Hospitals NHS Trust. Health Committee written evidence. Not published. Available from the clerk of the House of Commons Health Select Committee.

[7] Pollock AM, Price D., Dunnigan M. *Deficits before patients: a report on the Worcester Royal Infirmary PFI and Worcestershire hospital reconfiguration*. London: University College London June 2000.

So service reductions that occurred prior to financial close after PFI negotiations are now being followed by further waves of closures subsequent to schemes becoming operational and PFI charges taking full effect. The 'acute service re-configuration' plans in Scotland, and the large number of hospital closures being proposed for England, are clearly associated with the high costs of PFI hospitals.

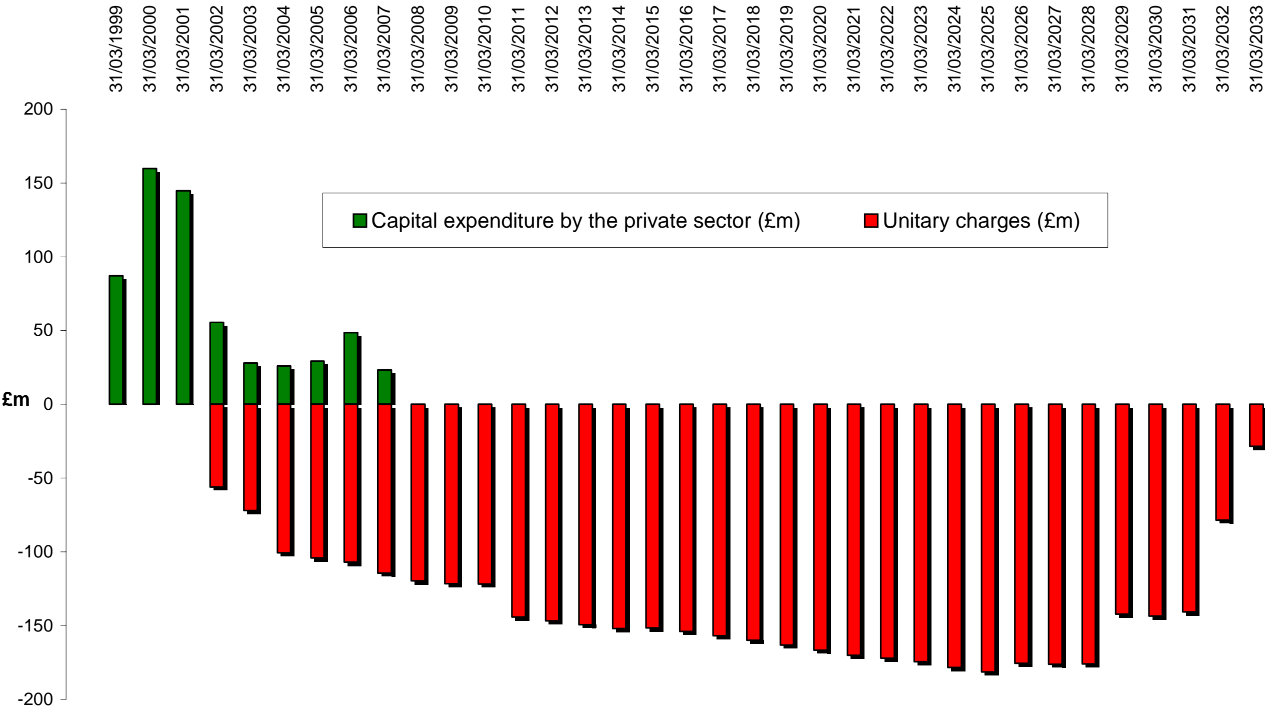
6 The public expenditure implications of existing PFI schemes

This section provides an overview of the costs of PFI to Scotland's NHS.

6.1 PFI: capital investment and revenue commitments

The Scottish Executive does not publish aggregate data on the capital expenditure accruing to health PFI schemes, or the public expenditure implications. However, we were able to obtain these data (ie, capital expenditure by the private sector and the actual and projected annual unitary charges that flow for all PFI contracts signed by 28 November 2006) through Freedom of Information legislation. Figure 1 shows total payments from the NHS to private consortia over the contract life compared with the capital expenditure raised under the PFI. As stated, the data is for schemes signed as of 28 November 2006. Projects in negotiation or planning are not included.

Figure 1. Payments incurred by the NHS in Scotland under signed PFI contracts[i,ii]



i Projections are at current prices.
ii Data provided by the Scottish Executive in response to two Freedom of Information requests. The first, showing unitary charges, was received May 2006, the second, showing capital expenditure, was received in November 2006.

The capital value of deals signed before 28 November 2006 is £602 million. However, the amount of future NHS spending accruing to these deals is in excess of £4 billion. It should be noted that a portion of this expenditure relates to payment for services, and that this portion should be regarded separately from the availability charge.

Department of Health research shows that the breakdown of availability to service charges is in the order of 60:40 respectively.[1] On this basis, we can estimate that the availability charge over the length of the contract is in the order of £2.4 billion, or four times the capital expenditure. The Executive refused to provide an exact breakdown of the unitary charge into its availability and service charge elements on the grounds that it did not hold this information centrally.

6.2 The financial pressures facing Scotland's health boards

Using data from the health department's website and data on unitary charges from two further Freedom of Information requests we show the capital value of all operational deals (as of March 2006) and the actual and projected annual cost to Health Boards over the seven years from 2000-01 to 2006-07. (Only operational schemes are included because, as recorded above, payments to private consortia are not made until the construction phase of the project is completed.)

Table 1 shows that total annual PFI expenditure is projected to reach £111 million in 2006-07. This is some 23% of the total 'value' of the capital invested and the charges will be paid every year for 30 years or more.

However, two health boards, NHS Lothian and NHS Lanarkshire, with large operational schemes (defined as 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 2005-06.

Note that variation between the years is caused by a number of factors. These include (i) the onset of the operational phase occurring within-year, (ii) inflation, and (iii) adjustment for penalties owing to service under-performance.

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[1] These estimates are based on a Department of Health analysis of financial models for 23 NHS PFI projects in England, published in Health Select Committee. *Public expenditure on health and personal social services 2000 memorandum received from the Department of Health containing replies to a written questionnaire from the Committee*. London: The Stationery Office 2000:152-6. The analysis found that, on average, availability charges account for 58.84% of the cost, and facilities management 41.18%. These percentages have been rounded to 60% and 40% in the above analysis.

Table 1. Annual unitary payments for PFI healthcare projects (operational as of 31 March 2006)[i]

Health board / project	Capital value (£m)[ii]	2000-01 (£m)[iii]	2001-02 (£m)	2002-03 (£m)	2003-04 (£m)	2004-05 (£m)	2005-06 (£m)	2006-07 (£m)[iv]
Ayrshire & Arran								
East Ayrshire Community.	8.6	1.3	2.1	2.1	2.1	2.1	2.1	1.5
Total	**8.6**	**1.3**	**2.1**	**2.1**	**2.1**	**2.1**	**2.1**	**1.5**
Dumfries & Galloway								
Maternity Unit	10.0		0.3	1.3	1.3	1.3	1.3	1.6
Total	**10.0**		**0.3**	**1.3**	**1.3**	**1.3**	**1.3**	**1.6**
Glasgow & Clyde								
S Glasgow Uni Hospital	8.0		2.4	2.5	2.6	2.7	2.7	2.9
DME	2.4	0.5	0.7	0.7	0.7	0.7	0.8	0.9
S Glasgow Uni Hospital	2.5	0.6	0.6	0.6	0.7	0.7	0.7	0.6
(ICT)	10.0		1.4	1.4	1.4	1.4	1.5	1.5
Yorkhill Hospital (ICT)	**22.9**	**1.1**	**4.1**	**4.2**	**5.2**	**5.3**	**5.4**	**5.9**
Larkfield Hospital								
Total								
Grampian								
Kincardine Community	3.8				1.9	1.9	1.9	2.0
Total	**3.8**				**1.9**	**1.9**	**1.9**	**2.0**
Highland								
Easter Ross Community Hospital	8.8	2.3	3.2	3.2	3.2	0.1	1.0	1.1
New Craigs Hospital	16.5					3.3	3.4	3.6
Total	**25.3**	**2.3**	**3.2**	**3.2**	**3.2**	**3.4**	**4.4**	**4.7**
Lanarkshire								
Wishaw DGH	100.0		17.9	21.7	22.4	22.9	23.5	23.4
Hairmyres DGH	68.0		14.7	14.8	15.4	15.7	15.8	17.4
Stonehouse Hospital	3.9	3.3	3.2	2.9	3.4	0.4	0.5	0.5
Bupa Care Homes	2.8	0.5	0.5	0.5	0.5	1.4	1.4	1.4
Acute Hospitals (ICT)								
Total	**174.7**	**3.8**	**36.3**	**39.9**	**41.7**	**40.4**	**41.2**	**42.7**
Lothian								
Ferryfield House	2.5	0.9	0.9	0.9	0.9	0.9	0.9	1.0
Ellen's Glen House	2.65	0.8	0.8	0.9	0.9	0.9	0.9	0.9
Findlay House	4.0	0.5	0.7	0.9	0.4	0.6	0.6	0.6
Tippethill/ Bathgate	2.3				0.9	1.0	1.0	0.9
Edinburgh RI	180.0		2.4	14.0	37.3	40.2	39.5	40.5
Lothian University HIS	12.0		0.5	0.0	0.8	1.6	2.0	2.7
LU Picture archiving	2.2					1.1	1.2	1.3
Total	**205.65**	**2.2**	**5.3**	**16.7**	**41.2**	**46.3**	**46.1**	**47.9**
Tayside								
Carseview Psych. Unit	10.0		1.5	1.6	1.7	1.8	1.9	1.8
Forfar Community RC	12.0					0.3	1.3	1.3
Tayside University Hospitals (small projects)	2.3	2.0	2.3	1.9	2.2	1.3	1.2	1.4
Total	**24.3**	**2.0**	**3.8**	**3.5**	**3.9**	**3.4**	**4.4**	**4.5**
TOTAL FOR NHS	**475.3**	**12.7**	**56.1**	**71.9**	**100.7**	**104.3**	**107.1**	**110.8**

i Some of the smaller projects have been grouped together.
ii Data on capital values are taken from Health Department project list, updated October 2006, available at: www.pfcu.scot.nhs.uk/projects.html.
iii 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.
iv The figures in this column are Scottish Executive projections contained in a Freedom of Information request (received by The Herald newspaper in November 2006 and forwarded to the authors).

6.3 Comparing the cost of capital in PFI buildings with non PFI NHS buildings

As stated above, a charge on buildings is not unique to PFI. Since 1992 all NHS organisations are required to make an annual surplus of income over expenditure, known as the 'capital charge', which is paid to the Treasury. This charge is the 'rent' which the health board pays to the Treasury for the use of its buildings. As such, it is the publicly owned building analogue of the PFI 'availability charge'. The impact of these payments depends on the proportion of total annual revenue they absorb. More budget pressures will arise among health boards that have to devote relatively high proportions of annual revenue to rental payments.

Using data from annual accounts and NHS finance departments, we show for each of the 14 Scottish health boards the NHS capital charge, the PFI charge, and the combined total charge as a percentage of Health Board revenue.

Table 2. Capital charges on publicly owned buildings and PFI charges for all 14 Scottish health boards, and as a percentage of annual revenue, 2005-06

Health board	Capital charge as % of revenue[i]	Availability charge as % of revenue[ii]	Capital charge plus PFI availability fee as % of revenue
Grampian	1.5	0.2	1.7
Fife	1.7	0	1.7
Highland	1.3	0.8	2.1
Tayside	1.7	0.5	2.1
Borders	1.6	0	1.6
Ayrshire and Arran	1.3	0.4	1.5
Dumf. and Galloway	0.7	0.4	1.06
Forth Valley	1.4	0	1.4
Lothian	**1.2**	**2.8**	**4.0**
Lanarkshire	**0.8**	**3.4**	**4.2**
Shetland	2.0	0	2.0
Orkney	5.6	0	5.6
Western Isles	2.5	0	2.5
Glasgow and Clyde	1.8	0.3	2.0
Average for NHS	**1.6**	**1.1**	**2.6**

i The figures here relate to health boards' 'cost of capital' and are taken from either health boards' 2005-06 annual accounts, or personal communication with boards' finance departments.

The majority of the PFI schemes signed in Scotland are small, and their impact on the finances of health boards is minor, as can be seen above.

However, the two health boards with 'major' PFI schemes in operation – namely, Lothian and Lanarkshire - must allocate almost twice as much of their annual revenue to rental payments than boards which do not (with the exception of Orkney, which has very high capital to population requirements, owing to its extreme rurality).

Both Lothian and Lanarkshire have experiences considerable financial difficulties over recent years. NHS Lothian reported an overspend of £15.9 million for the six months to September 2006.[1] NHS Lanarkshire's accounts show a recurrent deficit of £21.66 million as of 01 April 2006.[2] This has motivated a programme of asset sales, and in August 2006, the health board announced that the accident and emergency unit at Monklands hospital – which serves an area of great deprivation and high health care need – is to close, in the face of strong and sustained local opposition.

7 Public expenditure implications of future PFI schemes

We estimate that the cost of PFI to Scotland's NHS will almost quadruple by the early part of the next decade. Across Scotland, 23 new NHS schemes with a capital value of £1.6 billion are in the planning stage or are in negotiation. This is shown in Table 3 (below), which uses publicly available data on the estimated capital value of future PFI projects, their status – Initial Approval, Outline Business Case, Financial Close - and the charges that we estimate will accrue to them.

The cost of PFI to the NHS will rise from £107.1 million in 2005-06 to almost £0.5 billion (in today's prices) within the next five years. Indeed, the figures in Table 3 are likely to be significant under-estimates, particularly with respect to less developed schemes, given the trend for PFI projects to increase in capital cost in the latter stages of public-private negotiations.

For example, the Executive's capital cost estimate for the Forth Valley Hospital PFI has escalated from £200 million at the Outline Business Case stage to £300 million as of October 2006.[3]

Table 3 shows Lothian's plans to expand its PFI programme so that its annual PFI debt servicing commitments will almost double. Forth Valley, Fife, and Glasgow and Clyde health boards are planning major PFI schemes that are also projected to account for significant proportions of their revenue.

1 Lothian NHS Board. *Financial position to 30 September 2006.* 22 November 2006.
2 Lanarkshire NHS Board *Annual accounts 2005/06*.
3 For other examples, see Gaffney D, Pollock AM., 'Pump priming the PFI: why are privately financed hospitals being subsidized? *Public Money and Management*, January-March 1999.

Table 3. Future PFI schemes (not operational as of 31 March 2006)[i]

Health Board	Status	Capital value(£m)	Forecasted annual unitary charge (£m)[ii]
Glasgow and Clyde			
Stobhill Psy Unit	Financial close	17	3.9
MH at Gartnavel	Financial close	17	3.9
Glasgow ACAD	Financial close	180	41.4
Energy/Env Init	OBC approved	6	1.4
Southern General/ Glasgow Sick Kids [iii]	In planning	400	92
Glasgow RI [iii]	In planning	150	34.5
Total		**770**	**177**
Lothian			
Investing in Change [iv]	IA approved	201.3	46.3
PACS	OBC approved	8	1.8
Royal Sick Children	IA approved	60	13.8
Total		**269.3**	**61.9**
Ayrshire and Arran			
Crosshouse Matn [v]	Financial close	20	4.6
Total		**20**	**4.6**
Fife			
St Andrews Comm	OBC approved	20	4.6
Fife DGH	OBC approved	114.5	26.3
Total		**134.5**	**30.9**
Grampian			
Forres Hospital	OBC approved	8.1	1.9
Total		**8.1**	**1.9**
Forth Valley			
Clackmannanshire	ITN returned	19	4.4
Forth Valley DGH	OBC approved	300	69
Prim/Comm Care	IA approved	40	9.2
Total		**359**	**82.6**
Tayside			
MD offenders	IA approved	32.9	7.6
Gen psychiatry	IA approved	28	6.4
Total		**60.9**	**14**
Highland			
Mid Argyll Comm. [v]	Financial close	19.2	4.4
Total		**19.2**	**4.4**
TOTAL FOR NHS		**1,641**	**377.4**

i 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, unless otherwise indicated.
ii This is an estimate, based on the current unitary charges for existing operational PFI schemes in Scotland's NHS, relative to the capital value of those schemes (see Table 1 and discussion).
iii Information on this project is based on the content of a speech by Mike Baxter, Director of the health department capital investment group, to the Public Private Finance conference, February 2006.
iv This scheme incorporates several distinct projects: the Western General Hospital, Royal Edinburgh Hospital, Midlothian Community Hospital, and a new Haddington Hospital.
v This scheme is now operational (but was not as of March 2006 – hence its inclusion here for reasons of consistency, rather than in Fig. 2).

Revenue projections for Glasgow and Clyde's PFI plans alone exceed the current amount spent on all NHS Scotland's operational PFI projects.

These new PFI commitments will require plans for a large programme of service closures as Health Boards find ways to close the inevitable affordability gap. Despite these cuts, the experience of earlier schemes suggests that the emergence of future deficits will require additional savings to be made down the line, with serious implications for patient care.

8 Conclusion

The use of PFI by the NHS in Scotland is a source of severe financial problems for health boards with major operational schemes. The annual cost to Scotland's 14 health boards is currently £107 million. This is met from revenue budgets – money that is usually earmarked for running costs such as staffing, equipment, and clinical services.

However the PFI programme is projected to expand in scale, with the capital value of operational projects rising from £475 million in 2005-06 to an estimated £2.1 billion by the early part of the next decade. We estimate that the additional cost of meeting the unitary charge on these planned schemes will increase from £107 million in 2005-6 to almost £0.5 billion a year, about £300 million of which will be the availability charge.

Without a major increase in public expenditure, more of the NHS budget will be diverted away from services to private companies, making already serious financial problems more severe, and creating new pressures for hospital, community, and primary care service closures in the medium and long term.